

MOTHER AND CHILD HEALTH CARE MODELS PROGRAM

(TC-97-07-18-6)

EXECUTIVE SUMMARY

REQUESTER: Confederação das Misericórdias do Brasil (CMB)

EXECUTING AGENCY: The executing agency, which will be the CMB, will coordinate, oversee, evaluate and disseminate information on the undertaking. The five charity hospitals (Santas Casas) selected for this purpose will be the co-executors and they will assume responsibility for each of their projects.

BENEFICIARIES: Women and children from the cities of Sobral and Canindé (Ceará), Barbacena (Minas Gerais) Anápolis and Goiás-Velha (Goiás), as well as the population of the surrounding area. Additional beneficiaries will be the CMB, the five participating hospitals, and other members of the CMB system when the new model is adopted.

AMOUNT AND SOURCE:

IDB (FSO/nonreimbursable national currency):	US\$4,690,000
National	<u>US\$1,020,000</u>
Total:	US\$5,710,000

TERMS:

Execution period:	36 months
Disbursement period:	42 months

OBJECTIVES: The goal of this project is to support the network of charity hospitals operated by CMB, a nongovernmental organization, in its efforts to improve mother and child health, extension work and community participation. It seeks, in this initial stage, to strengthen the promotion and prevention activities performed by the five hospitals chosen for this program (see criteria, paragraph 2.4) by introducing a new model of community mother and child care, which would eventually be replicated throughout the CMB system.

DESCRIPTION: To attain the proposed objective, the program will consist of five integrated projects to be executed by the CMB and each of the Santas Casas. There will be three main components, to wit:

1. Instruction and training (US\$3.2 million): this component would underwrite the training of community health agents selected by the

participating communities, along with technical and managerial training that will enable the participating hospitals' multidisciplinary teaching and supervisory teams to carry out the program. Responsibility for the care of patients from rural and suburban areas will be assigned to the community health agents employed by each hospital. The program would also underwrite training and periodic refresher courses for the coordination and supervision teams, plus training activities (seminars and workshops) for the staff involved in mother and child care, as well as for residents of the communities targeted for such care.

2. Upgrading of physical and functional mother and child care facilities (US\$1.5 million): this component would finance small-scale remodeling works and the necessary equipment to ensure that the outpatient and hospital facilities of the Santas Casas responsible for secondary care of the mothers and children referred by community agents and the respective outpatient centers are equipped to provide such care.
3. Coordination, monitoring, evaluation and dissemination (US\$1 million): in addition to continuous monitoring of the execution process, there would be annual evaluations as well as a final evaluation, based on specific process and impact indicators. The results and the lessons learned from this evaluation process will constitute the basic input for the upgrading of the operating, teaching and training systems in the five pilot hospitals as well as for the dissemination, promotion, replication and evaluation of the new care model throughout the rest of the CMB network. To that end, seminars and discussion workshops will be held, along with study visits and exchanges of hospital personnel in the CMB system.

**ROLE OF THE
PROJECT IN THE
BANK'S COUNTRY AND
SECTOR STRATEGY:**

The strategy agreed on for the country consists of:

- (i) promoting reform and modernization of the federal and subnational governments; (ii) support for economic liberalization and the "Custo Brasil" initiative (the government's campaign to cut spending) by streamlining the production and financial sectors and rehabilitating the infrastructure; and (iii) tackling the problems of social inequity and poverty, including various actions to ensure greater efficiency in social

spending. It also calls for decentralization of social services, gearing them more closely to the needs of the community and civil society. At the same time, it seeks to emphasize basic sanitation and care of the environment.

The proposed program responds to the Bank's strategy and is consistent with the current health care policy, thanks to: (i) its **targeting** of the low-income population, underscoring the need for community agents to attend to the specific health requirements of vulnerable **women and children**; (ii) its **channeling** of **PAB** resources to underprivileged communities through a private system of proven efficiency; (iii) its contribution to **competition** between public and private health services; (iv) the **autonomy** enjoyed by the CMB and its affiliate hospitals as institutions of civil society; and (v) the proposed **integration** with activities in basic sanitation, housing and other sectors at the level of the participating communities.

**ENVIRONMENTAL AND
SOCIAL REVIEW:**

The program will have no adverse environmental impact, given the limited scope of the remodeling works envisaged, which, in essence, will improve the present environmental status of mother and child health care facilities in the five hospitals (see paragraph 4.3).

The program will include the following protection measures: (i) the hospitals must dispose of biological waste products with due care, separating them from common solid waste and using environmentally safe methods for such disposal; (ii) the component for the upgrading of infrastructure will ensure proper installation of potentially dangerous equipment and the requisite training of responsible staff; and (iii) the training will include careful handling of waste matter and hazardous material (see paragraph 4.4).

BENEFITS:

The program is expected to improve overall care of mothers and children in the host municipalities and the area of influence around each of the entities involved.

RISKS:

The main risks would be: (i) the inadequacy of the basic care service (PAB-primary care skills), given the dependency of the participating Santas Casas (and that of the CMB system in general) on the universal health care system; (ii) the CMB's lack of previous

experience with multilateral organizations; and (iii) the need for coordination with other projects, such as REFORSUS and PRMI (see paragraphs 5.1 through 5.5).

**SPECIAL
CONTRACTUAL
CONDITIONS:**

Hiring and/or assignment of the coordinator and of the technical support team by the CMB prior to the first disbursement (see paragraph 3.1).

**TARGETING OF
POVERTY AND
CLASSIFICATION OF
THE SOCIAL SECTOR:**

The program has automatically been classified as a poverty targeted initiative (PTI), since it focuses on the care of mothers and children from low-income groups (paragraph 4.1). It is consistent with the objectives of equity and poverty reduction stipulated in paragraphs 2.13 and 2.15 of document AB-1704.

**EXCEPTIONS TO
THE BANK'S POLICY:**

None.

PROCUREMENT:

The procurement of goods and services will be subject to competitive procedures which are compatible with those utilized by the Bank for nongovernmental agencies. Purchases in amounts below US\$100,000 will be based on a minimum of three quotes. Purchases in excess of that amount shall be done by invitation to submit bids to a minimum of three suppliers chosen from a list of prequalified suppliers approved by the Bank. The co-executor hospitals will be responsible for the respective works-contracting procedures, the purchase of supplies and materials and the hiring of consulting services (see paragraph 3.2 and Annex III-2).

The procurement processes and procedures will be examined in the course of regular supervision of the five projects and the coordinating unit by the Bank, with appropriate measures being established in the event that any irregularities are found (see Annex III-2).

I. BACKGROUND

A. Situation of mother and child health care

- 1.1 Advances in the area of mother and child health care in Brazil have been slow and uneven. Only five countries in Latin America have higher infant mortality rates than Brazil, despite the improvement noted between 1985 and 1995 in all parts of the country (when it dropped from 73 to 42 deaths per 1,000 live births). 1/ Half of the infant deaths, as well as the main causes of the high overall rate of maternal mortality (161 deaths of mothers per 100,000 live births) and the hospital rate (3.70 deaths per 10,000 hospital cases) are associated with complications of pregnancy and birth – many of which could have been prevented. These indicators reflect shortcomings in the coverage and quality of prenatal and birth care that can be remedied with the use of simple low-cost measures aimed at the population that is neediest and at greatest risk. The probability of death in infants of women not receiving these services is around 200 per thousand live births, in contrast to 20 per thousand in those of women who were subject to prenatal control procedures and who were attended by professionals during the birth process. 2/ Comparable differences may be observed in the neonatal and postnatal mortality rates. 3/ The states of Ceará, Goiás and Minas Gerais contain zones of high infant and maternal mortality which include the areas of influence of the five hospitals taking part in the project discussed in this document.
- 1.2 The causes of the group of problems affecting the mother-and-child binomial are: (i) the low priority assigned to preventive services; (ii) the curative bias of the universal health care system (SUS) 4/ and of the hospital system, both charity and profit-oriented – a factor that is also linked to the vested interests of the medical group, among others; and (iii) the perverse incentives of the SUS, which tend to favor the financing of costly high technology services and the use thereof by groups who can afford to pay, at the expense of more cost-effective primary care assignments and treatment available to the neediest population. It is estimated that the SUS spends more than 25% of its annual budget on high-tech services; and in 1997, three of the five procedures most frequently paid for by the SUS were for

1/ UNICEF, Progress of Nations 1997; Situação Mundial da Infância 1995.

2/ Ministry of Health, Saúde no Brasil (Health in Brazil), 1997.

3/ Neonatal: occurring during the first 30 days of life; postnatal: after the first month and prior to the end of the first year of life.

4/ SUS: The federally-financed system of universal coverage for the purchase of health care services from public and private suppliers.

hospital care of problems in the mother and child population. One of the inputs most needed to revamp the present care model is a far-reaching change in the "hospital-centered" culture prevailing today in both public and private charity and profit-oriented hospitals.

B. Responses from the health care sector

- 1.3 To comply with its responsibility for resolving the situation described, the Ministry of Health is now pursuing an aggressive policy of decentralization toward the municipalities, which seeks, at the same time, to introduce a new model of care, predicated on its family health care services (PSF) and community health agents (PACS), 5/ pursuant to the basic operating standards of the SUS for 1996. Funding for implementation of the model will come from: (i) the recently-created basic care service (PAB), financed by the federal government through automatic and direct transfers to all eligible municipalities in the country (to date, more than 3,300 of the 5,500 total) at the rate of about R\$10 per inhabitant-year (a total annual outlay amounting to R\$1,733.4 million for the country); and (ii) SUS funds through the list of preferential rates for reimbursement of the priority procedures identified in the Reform Program Policy Letter of the Health Care Sector (REFORSUS) for various types of hospital treatment (e.g., normal delivery or complications thereof; neonate cases with complications). For their part, the municipalities have reached agreements with selected suppliers enabling them to use PAB resources to purchase a training package of basic primary care services; and they now operate their own services with the help of municipal funds.
- 1.4 The PAB funds are obviously too small to meet the primary care needs of the low-income population - a shortfall made evident by the supplementary allocations which boosted the PAB over the R\$10 level in 22% to 37% of the municipalities in the three states participating in the project proposed here. Accordingly, there is an urgent need to consolidate the correction currently under way to remedy the deficit - either by a substantial transfer of additional SUS funds, or by the allocation of other resources (federal, state, municipal and/or private) to the PAB.
- 1.5 Under the Brazilian Government's initiative entitled "Brazil in Action", the program to reduce infant mortality (PRMI, see paragraph 5.5) is now being carried out with significant budgetary allocations (which might enjoy the additional resources of a loan

5/ Experience with community agents in Ceará and the Children's Hope Project of the Pastoral da Criança has proven to be effective in quickly reducing infant mortality. More than 54,000 community agents have already been trained (the goal is to reach 100,000 in 1998) as well as almost 1,500 family health care teams (well on the way to the goal of 3,500 for 1998).

requested from the IDB). It would provide the 400 poorest municipalities in the country with coordinated activities in health care and other sectors, designed to reduce the principal causes of death in children under one year of age.

C. The Confederação das Misericórdias do Brasil (CMB) Hospital Network

- 1.6 The country has some 2,600 charity hospitals: the Santas Casas, a legacy from the early Portuguese colonization of Brazil, starting in 1543. More than 1,700 of them have been identified as active members of the CMB system, and they meet 25% to 30% of the demand for hospital admissions, beds and the SUS hospital outlays. Given the important local position that many of them enjoy in their respective municipalities, it should be emphasized that it is precisely the hospitals' curative approach and the absence of community projection that have limited the contribution which this extensive network makes to the solution of the levels of maternal and child morbidity and mortality rates cited above.
- 1.7 Aware of the shortage of public services to accommodate the most vulnerable low-income communities - and of its own potential as an NGO, the CMB has decided to play a more active part in mother and child health. In order to transform the curative care model currently used by the Santa Casa affiliates, the CMB proposes to conduct five demonstration experiments in community outreach and improved mother and child care for the underprivileged population in satellite communities of the municipalities of Sobral and Canindé (Ceará); Anápolis and Goiás Velha (Goiás); and Barbacena (Minas Gerais). These initial experiments would mark the starting point for replication in the rest of the CMB system.
- 1.8 The CMB is a permanent nonprofit civilian agency of national scope, inspired by Christian principles. Under the umbrella of the state federations, its 1,700 charity hospitals operate in 18 Brazilian states. CMB activities focus mainly on defending and representing the social and economic interests of its affiliates. It also renders legal, technical and administrative advisory services; provides general information; holds meetings and congresses of regional, national and/or international scope; and it joins governmental policy-setting bodies in discussing and proposing policies for health care and social welfare. The management of each Santa Casa affiliate is nevertheless entirely independent of the CMB. It has recently introduced its own health care plan ("Saúde Vital," i.e., Lifelong Health) on the national market, where it will compete with current plans now offering such services.
- 1.9 The five hospitals participating in the present program share the general features listed in Table I-1.

**Table I-1: Features of the hospitals participating in the program
1996**

ENTITIES	AREA OF INFLUENCE			No. OF BEDS	
	Municipality	Population	%	Total	Per 1,000
Anápolis Santa Casa	20	535,163	27.4	197	0.4
Barbacena Santa Casa	10	202,414	10.3	116	0.6
Canindé Santa Casa	5	159,427	8.7	133	0.8
P. Alcantara Charity Hospital *	11	127,229	6.5	70	0.5
Sobral Santa Casa	39**	927,512	50.9	552	0.6
TOTAL	85	1,951,745	100.0	1,068	0.5

* In the City of Goiás Velha

** Municipalities situated in the most direct area of influence.

Source: CMB, 1997

- 1.10 The **Anápolis Santa Casa** (charity hospital), operated by the Anapolis Social Welfare Foundation (FASA), has been providing social and health care services for its headquarters city and surrounding towns in the State of Goiás and neighboring states for 35 years. Its outpatient services, emergency care and diagnostic center attention reach an average 1,200 patients a day, while approximately 450 to 500 cases are admitted every month. Over the past ten years it has been working with the church welfare service for children in neighborhoods which lack centers for the prevention of teenage pregnancy, information on education and nutrition, and the prevention and control of diarrheal and respiratory infection; immunization programs; and the creation of an "updated prenatal project" (Mothercare Houses). This community endeavor has brought out the need to enhance the capacity and quality of their prevention, mobilization and hospital referral services in order to meet the needs identified among the mother and child population in their sphere of influence.
- 1.11 The **Barbacena Santa Casa**, established some 152 years ago, handles some 1,070 outpatients a day in addition to the 600 cases admitted each month. All of its maternal care patients come from the SUS – in other words, from low-income groups. It is the only hospital in its area of influence that offers neonatal care, round-the-clock emergency attention, internal medicine, orthopedics, traumatology, and other specialized treatment. The elimination of bed space for mother and child care and the other needs in those fields at other hospitals has boosted demand to the point where its installed capacity can no longer meet its present needs – particularly insofar as the demand for mother and child care is concerned.
- 1.12 The **San Francisco of Canindé Hospital Society** has operated this eponymous charity hospital in Canindé for more than 30 years. In

addition to its outpatient services and hospital beds, it maintains nine rural health care posts, a mental health center; and other functions outside the hospital in coordination with the pastoral health program (day care for children, home care for patients suffering from chronic and terminal illnesses as well as help for senior citizens). It is the only hospital in this region that has round-the-clock emergency services. The network it has in its own peripheral area and the surrounding towns has seen a demand for the services provided there rise –especially for mother and child care for patients from low-income sectors in the five municipalities for which it serves as a referral center.

- 1.13 At present, the **São Pedro d'Alcântara Charity Hospital (HCSPA)** in the city of **Goiás Velha** is operated by the Sao Pedro d'Alcântara Health Care Association, which consists of some 30 local establishments of civil society who took possession of the HCSPA at a time when the municipal authorities failed to provide the necessary care. With a track record going back to 1993 of innovative community work initiatives and training for community agents supported by French groups, today its ongoing coordination of home care, assistance to senior citizens, community mother and child care and work with pregnant women have reached the stage where its present installed capacity no longer suffices to meet demand.
- 1.14 The **Sobral Charity Hospital (SCMS)**, founded in 1923, reports to the SCMS Brotherhood, which also operates various other institutions (shelters, physical therapy, a clinical laboratory, x-ray exams, cardiology, dental care, hospices for terminal patients and a hotel) that help to make it financially sustainable. The SCMS receives patient referrals – mainly of low-income persons – from 75 municipalities. It is also a training center for health care personnel (aides and technical nursing staff, university graduates in nursing and medical studies). Prominent among its clinical services are the outpatient consultation, outpatient surgery and clinical pathology. A third of its admissions are from the maternal and child population.

D. The Bank's and the country's strategy

- 1.15 The operating strategy agreed upon with the national authorities during the most recent programming mission (July 1997) consists of: i) promoting reforms in and streamlining of the federal government and the subnational governments; ii) assisting with liberalization of the economy; and the "Custo Brasil" initiative (the government's program to pare spending) by modernizing the sectors of production and finance and rehabilitating infrastructure; and iii) addressing the problems of social inequity and poverty, including action to make social spending more efficient. It also supports decentralization of social services and establishing closer ties between those services and the community and civil society. At the

same time, it seeks to place more emphasis on basic sanitation and the environment.

- 1.16 The health care strategy proposed by the Bank in the country paper now being prepared emphasizes the following courses of action: i) targeting of the low-income population; ii) incentives for more cost-effective public and private service delivery (both charity and profit-oriented), with emphasis on the provision of primary care by means of family health-care teams and/or community health agents and a substantial increase in PAB allocations; iii) effective recovery of costs from the population covered by private insurance policies; iv) the introduction of a demand-based financing model; v) the convergence of public, private and community institutions and sectors in activities designed to improve health; vi) compliance with the basic operating standards which govern the transfer of health care services to the municipalities, and the adaptation thereof to the needs of small and medium-sized municipalities; and vii) public health initiatives that focus on specific problems such as malaria, violence, traffic accidents, cardio-vascular disorders, and addiction to smoking, among others.
- 1.17 The proposed **program reflects** the Bank's strategy and is consistent with the current health care policy, thanks to: i) its **targeting** of the low-income population, emphasizing the need for community agents to see to the specific health care problems of **women and children** at risk; ii) the **channeling** of PAB resources to underprivileged communities through a private system of proven efficiency; iii) its contribution to **competition** between public and private health services; iv) the **autonomy** of the CMB and its hospital affiliates as agencies of civil society; and v) the proposed **integration** with actions in the areas of basic sanitation, housing and other sectors at the level of the participating communities.
- 1.18 On April 30, 1997, the Bank was approached by the Brazilian Agency for Technical Cooperation to fund this operation.

E. IDB experience in the health care sector

- 1.19 The Bank's experience in Brazil's health care sector - which is incipient - includes the project for extension and consolidation of the Maternal and Child Institute in Pernambuco (ATN/SF-4008-BR). The main lesson learned from that source is that the success of a project lies in proper selection of the executing agency and in the design of the proposal. The other recent experience stemmed from a health care sector reform program (REFORSUS, 951/OC-BR) approved in 1996. Slow execution thereof in the initial stages brought out the constraints inherent in the public sector's ability to manage external resources.

II. OBJECTIVE AND DESCRIPTION OF THE PROJECT

A. Objective

- 2.1 The goal of this project is to support the CMB network of charity hospitals in a process to improve mother and child health, extension services and community participation. Its aim in the first stage will be to strengthen promotional, preventive and rear-guard action by the five hospitals chosen as participants; and the integration thereof into national health care policies, introducing at these hospitals a new model of mother and child health care policies - to be replicated thereafter throughout the CMB System.

B. Specific Objectives

- 2.2 Specifically, the project seeks: a) to improve the coverage and quality of outpatient and in-hospital care of mothers and children, implanting in the CMB System strategies and models of comprehensive mother and child care that respond to local needs, through direct community work with health care agents; b) to strengthen five hospitals as regional referral units for mother and child care and training centers for a scheduled process that will replicate the care model in other units in the association. These objectives are predicated on three core strategies: i) the performance of community health care agents who serve as the backbone of community work; ii) an improvement in quality, focusing on its technical and human dimensions; and iii) the role to be played by the CMB in connection with other Santas Casas, functioning as a dissemination agent and catalyst in this pilot experiment.

C. Components and activities

- 2.3 To achieve the objectives described above, the project has been structured in three components which would be carried out in the five hospitals shown in Table I-1, and would include the participation of staff from other establishments in the CMB System.
- 2.4 The criteria used to select these five municipalities and the respective hospitals (Santas Casas) comply with the need to optimize their demonstration impact within the CMB System, based on: previous experience in extramural community work; the increasing role played by this group of communities in decisions on their health care services; the effective commitment to the community extension goals of the proposed program, on the part of the agencies selected for this purpose; the absolute and relative size of the needy population, and the relative importance of the agency in the SUS units, at both local and regional levels. Differences are apparent in the five hospitals (see Table I-1) in regard to their installed capacity, beneficiary population and community experience. By mirroring the spectrum of current

conditions in most of the country's charity hospitals, those differences should facilitate subsequent replication of the new community model of mother and child health care.

1. Instruction and training (US\$3.2 million)

- 2.5 This component will underwrite the training of community health care agents selected by the participating communities, as well as technical and managerial training of the multidisciplinary faculty teams and supervisors at the hospitals that take part in the program. Further details of the activities in this component are available in the technical files.

- a. Community health care agents: the duty of rural and urban perimeter community health care will be performed by the community agents employed by each hospital. Each of these agents will be responsible for roughly 300 families, with whom the agent will carry out basic activities in the home (such as sanitary education, mother and child care and reproductive health, surveillance of diet, control of diarrheal and acute respiratory infections, referral to outpatient and hospital centers). To that end, 146 community agents ^{6/} (see Table II-1) will be given the proper training (about 200 hours of theoretical and practical modules), annual refresher courses (40 hours) and frequent programmed supervision by the multidisciplinary teams in each hospital (pediatrics, obstetrics, nursing, psychology, phono-audiology, occupational therapy, and social aides) pursuant to the Ministry of Health regulations. The agents will be chosen from the candidates proposed by each community on the basis of their training, intellectual capability, vocation and aptitude for community work. Preference will be given to female candidates. The program will finance the selection, training and - on a gradually decreasing scale - the initial operating expenses of the community agents and the coordinating and supervisory teams. Each Santa Casa will reciprocate by assuming an increasing amount of the recurrent expenses of the trained staff.

^{6/} In addition, the Canindé Hospital will train and provide refresher courses for 186 agents serving the municipalities of Canindé, Caridade and Itatira.

Table II-1: Proposed community agents, listed by hospital

Hospital	No.
Anápolis	37
Barbacena	8
Canindé	24
Goiás Velho	40
Sobral	37
Total	146

- b. Formation of teams of trainers and supervisors and hospital mother and child care staff: the program will also finance the initial training and periodic refresher courses (48-hour modules, split between two annual events for each state) given to the coordination and supervisory teams described above (see paragraph 2.5, section a). These teams (which would comprise a total of 40 persons for five hospitals – i.e., 6 to 12 members for each hospital) would be responsible for the training activities scheduled (seminars and workshops) for the staff of each hospital providing mother and child care as well as for residents of the communities to be served and for the training of nursing aides. The various professionals thus trained would assume additional responsibilities (i.e. new types of care, education and promotion, surveillance and follow-up on the results of care, coordination of teams, participation in quality improvement activities, and similar tasks). In addition to strengthening the preventive and general care given to mothers and children, heightened attention would be directed at other aspects of reproductive health (e.g. early detection of uterine and breast cancer, control of sexually transmitted diseases, and family planning).

2. Physical and functional reconditioning of mother and child care facilities (US\$1.5 million)

- 2.6 This component would finance small-scale remodeling works and the necessary equipment to upgrade the outpatient and hospital facilities of the Santas Casas which offer secondary care for mothers and children referred by the community agents and outpatient centers. It will also support the improvement of the technical and human quality of the expanded physician and hospital

back-up services ^{7/} required due to the involvement of community health care agents. Special attention will be given to the promotion capability of the Santas Casas and to user participation and satisfaction. Also included are improvements in prenatal consultation and monitoring of the healthy child, lodging for expectant mothers on the verge of delivery ("Mothercare Homes"); rooms for parturient patients and deliveries, with provision made for handling the anticipated increase in normal parturients and high-risk cases referred to the hospital; upgrading of postpartum rooms where the normal newborn can be lodged with his mother; facilities for care of neonatal high-risk (UTI newborn) cases; conversion of private to semiprivate rooms (with four beds); and upgrading of the electromechanical systems, among others. Further details of the works and equipment to be financed are available in the technical files.

3. Coordination, monitoring, evaluation and dissemination
(US\$1,000,000)

- 2.7 Aside from continuous monitoring of the execution process, semiannual evaluation meetings will be held at each hospital, plus two joint seminars each year for evaluation of the teaching and supervisory teams at the five hospitals and a final evaluation. Process and impact indicators ^{8/} to be agreed upon with the Bank at the start of the execution period will be applied for these activities. The results and the lessons learned from this evaluation process will comprise the basic input for a progressive adjustment of the operating, teaching and training systems at the five hospitals during that period, as well as for the workshops, internships and additional dissemination activities scheduled to start as of the second year of execution (see paragraph 2.8).
- 2.8 The dissemination, promotion and support slated for replication of the new care model in the rest of the CMB system will be achieved by means of: i) 10 microregional workshops (one a year during the last two years of execution in each of the five areas); ii) internships and exchange visits for at least 135 professionals from other towns at all five of the hospitals - but mainly in

^{7/} Care during pregnancy, delivery and the period following childbirth for normal and at-risk cases; care of high-risk neonatal cases; lodging of normal newborn and children hospitalized with their mothers; maternal lactation; and child growth and development, so that the hospitals can receive accreditation from UNICEF and the Ministry of Health as "child-friendly" and "Safe Maternity" establishments.

^{8/} Impact will include changes in the incidence of complications during pregnancy and childbirth, perinatal mortality, maternal mortality in hospital, and the prevalence of malnutrition. Process will include coverage during prenatal period and childbirth and infant growth and development.

Canindé and Goiás Velho, due to their previous community experience in working with the children's pastoral program; iii) a national seminar with the participation of 40 representatives from the CMB state federations; iv) production and dissemination of a video, clips for television releases and the final project evaluation report, as well as other informative and promotional materials. A more detailed account of these activities is contained in the technical files.

D. Cost

- 2.9 It is estimated that the total cost of the program will be US\$5.71 million, broken down by component as shown in Table II-2. Of that amount US\$4.69 million would come from the Bank's contribution, to be financed by nonreimbursable resources in local currency from the Fund for Special Operations (FSO). The breakdown by hospital (Table II-3) illustrates the particular needs of each locale. Counterpart funding is estimated at US\$1 million, which covers the salaries of incremental staff (community health agents, instructors and supervisors). The remuneration item is for recurrent expenses for hiring new staff (community agents and members of the supervisory teams), outlays that would be gradually taken over by the budgets of each hospital during the project execution period (when the work thereon is 40%, 60% and 100% complete). The figures for travel and per diems cover of the 146 community agents and the five supervisory teams during their initial training and annual refresher courses. That same item for the third component corresponds to transportation for staff members from other hospitals in the CMB system to and from the workshops, seminars and internships that are scheduled.

Table II-2: CONSOLIDATED BUDGET
(in thousands of US\$)

BUDGETARY CATEGORY	IDB/FSO R\$	CMB	TOTAL	%
A. INSTRUCTION AND TRAINING				
1. Consulting services	121		121	2.1
2. Travel and per diems	354		354	6.2
3. Supplies and equipment	196		196	3.4
4. Courses	50		50	0.9
5. Remuneration	1,616	860	2,476	43.4
SUBTOTAL	2,337	860	3,197	56.0
B. PHYSICAL AND FUNCTIONAL RECONDITIONING OF MOTHER AND CHILD CARE FACILITIES				
1. Construction work	542		542	9.4
2. Equipment	909		909	15.9
3. Office equipment and furnishings	20		20	0.3
4. Supplies and equipment	53		53	0.9
SUBTOTAL	1,524		1,524	26.7
C. COORDINATION, MONITORING, EVALUATION AND PUBLICITY				
1. Consulting services	146	160	306	5.4
2. Travel and per diems	333		333	5.8
3. Equipment	3		3	0.0
4. Supplies and equipment	72		72	1.3
5. Publications	58		58	1.0
6. Contingencies	217		217	3.8
SUBTOTAL	829	160	989	17.3
TOTAL	4,690	1,020	5,710	
PERCENTAGE	82.1	17.9		100.0

Table II-3: BUDGET PER HOSPITAL (in thousands of US\$)

HOSPITAL	IDB/FSO	CMB	TOTAL	%
Anápolis	1,127	234	1,361	23.8
Barbacena	670	125	795	13.9
Canindé	893	149	1,042	18.2
Goiás Velho	610	80	690	12.1
Sobral	835	272	1,107	19.4
CMB Coordinator	555	160	715	12.6
TOTAL	4,690	1,020	5,710	100.0

III. EXECUTION

- 3.1 The program will be carried out over a three-year period under the responsibility of the CMB president's office, which will assign a coordinator and will engage full-time technical and support staff for promotion, coordination and central supervision: this will be a condition for the first disbursement. Components 1 and 2 will be executed directly by the five hospitals (paragraph 2.4). Multidisciplinary supervisory teams will be used for this purpose, assisted by the respective financial departments, working closely with the municipal health secretariat in each city. Training for the technical teams will take the form of specialized services, organized locally - with the participation of skilled professionals - under CMB coordination. The CMB central office will be responsible for execution of the monitoring, evaluation and dissemination component, using the logical framework to do so (Annex III-1).
- 3.2 The procurement procedures and processes will be examined in the course of regular supervision of the five projects and the Bank's coordinating unit, with pertinent measures being established in the event that any irregularities are noted (see Annex III-2). Purchases under US\$100,000 will be made on the basis of a minimum of three quotes. Purchases exceeding that amount will be made by invitation to submit bids to at least three suppliers selected from a prequalified list approved by the Bank.
- 3.3 The resources will be disbursed directly into a revolving fund managed by the CMB pursuant to the schedule shown below. Each advance of funds may amount to as much as 20% of the respective hospital's project cost. The CMB will be responsible for transferring the funds earmarked for each hospital, pursuant to agreements to be reached between the CMB and the co-executing hospitals. Accounting and auditing procedures must be compatible with the Bank's requirements. The corresponding documentation and records shall be made available to the Bank upon request. The counterpart funding, to be provided by the participating hospitals and the CMB, will be used mainly to pay the work teams (instructors, supervisors and community health agents) and staff hired specifically for the project activities.
- 3.4 Evaluation, monitoring and reports: The executing agency and co-executors will present semiannual progress reports and annual financial statements audited by external auditors acceptable to the Bank. In addition, the Bank's Country Office in Brazil will make regular supervisory visits to the executing agency and the co-executor hospitals. The periodic evaluations contemplated will be conducted by independent consultants engaged by the CMB.

Table III-1: DISBURSEMENT SCHEDULE (In thousands of US\$)

Component	Year 1		Year 2		Year 3	
	IDB	CMB	IDB	CMB	IDB	CMB
I. Instruction and training	1,039	0	765	338	533	522
II. Physical and functional reconditioning	1,005	0	519	0	0	0
III. Coordination, monitoring, evaluation and dissemination	227	20	236	20	366	120
Total	2,271	20	1,520	358	899	642

IV. SOCIAL IMPACT, ENVIRONMENTAL QUALITY AND JUSTIFICATION OF THE PROGRAM

- 4.1 Social and gender impact: This program has automatically been classified as a poverty targetted initiative since it will upgrade the comprehensive care given to mothers and children from 42,000 low-income families residing in the municipalities where the participating hospitals are located, as well as provide better specialized care to patient referrals from neighboring cities. It is therefore consistent with the objectives of equity and poverty reduction described in document AB-1704 of the Eighth Replenishment document (paragraphs 2.13 and 2.15).
- 4.2 The project is also expected to have a demonstration effect on the institutions in the association - more than 1,700 - by fostering innovative strategies and more efficient care models for the maternal and child bionome. It is anticipated that, thanks to this program, the five hospitals (and thereafter, all those that adopt the new model) may choose to be accredited by UNICEF as "Child-Friendly" and "Safe Child-Bearing" hospitals. The seminal role of the reproductive health services in each of the five projects optimizes the impact on low-income women who would be the principal beneficiaries, with due consideration as to gender.
- 4.3 Environmental impact: The program will have no adverse environmental impact, given the limited scope of the remodeling work envisaged - which in essence will improve the present environmental conditions in the mother and child care facilities of these five hospitals. Incorporation of the 146 community health agents into the headquarters municipalities and those of the surrounding area should in fact make a significant contribution to upgrading environmental sanitation in these communities, thus producing a positive impact on the environment.
- 4.4 The following safeguards will be incorporated into the program:
i) the hospitals must take the proper precautions in disposing of biological waste matter by separating it from ordinary solid waste and ensuring that the mode of disposal is environmentally safe;

ii) the infrastructure upgrading component will ensure adequate care in the installation of potentially dangerous equipment, along with proper training of the staff in charge; and iii) training in suitable management of hazardous materials and waste matter will be included.

- 4.5 Justification: Accordingly, financing of the proposed program is warranted because it calls for a change in the care model currently used in the CMB hospitals: from its passive therapeutic role as an SUS supplier to assumption of leadership states in the proactive supply of community mother and child care, aimed at the most disadvantaged population, by means of community health agents whose worth has been proven in Brazil through their ability to improve local health conditions. At the same time, the enhanced quality of mother and child hospital care would consolidate the role of the hospitals as microregional referral centers (in groups of neighboring municipalities with the same socioeconomic characteristics) for pregnant women and high-risk childbirth cases.

V. RISKS AND SPECIAL FACTORS

- 5.1 Experience and Institutional Capability of the CMB: Although the CMB has had no previous experience in working with multilateral organizations, it does have an established track record as a coordination agency for the Santas Casas system, with training and support programs for that group. It has had experience in dealing with bilateral aid entities in France and Canada through the Hospital Purchasing Group (GCH) established in 1997 as a result of the CMB's decision to achieve professional status for its bulk purchasing activities. Its recognized social commitment, rooted in religion, and the financially sound position of the majority of the associated charitable establishments minimize any risk that this initiative might be discontinued. The careful selection of the five hospitals, based on the expertise of their managerial teams and the existence of supplementary sources of income and previous experience in expansion projects minimize the risk at the co-executor level.
- 5.2 Sustainability, dependency on SUS resources and local ties with the municipal health secretariats: Another risk that might affect the program's sustainability is the dependency of the participating Santas Casas (and of the CMB system in general) on the resources channeled to them by the SUS through the respective municipal health secretariats. In practice, the five hospitals are the principal sources of care for the low-income population in their respective microregions and municipalities. As a result, they take part in the Municipal Health Council and maintain very close relations with the municipal health secretariats. The hospitals' SUS and PAB agreements with the secretariats include all of the

community services contemplated in the program as well as the hospital services reimbursed by SUS. All of these resources remain in the CMB hospital affiliates, thus allowing them to enjoy continuous growth and to provide their "clientele" with high-quality care and problem-solving capability through the integrated regional consortiums that are ranked according to the level of care they offer. In addition, the five hospitals now operate private local health care plans which supplement their income and permit internal cross-subsidies. Furthermore, early this year the CMB launched a nationwide health care plan (see paragraph 1.8) which is to become institutionalized, thus adding to the volume of supplementary resources. All of these factors ensure the program's sustainability by facilitating gradual absorption of the counterpart funding by each of the five hospitals as the Bank's share of financing declines during the life of the program.

- 5.3 Coordination with REFORSUS: On the one hand, the program is consistent with the policies agreed upon with the Minister of Health in regard to REFORSUS. In practice, this represents additional funding, since four of the five participating hospitals also receive REFORSUS resources. It has nevertheless been verified that the works financed by REFORSUS neither duplicate nor coincide with the investments proposed by the CMB. The works envisioned by REFORSUS include the reconditioning of emergency unit facilities at the Canindé hospital (R\$82,000); renewal of equipment at the Surgery Center at the Barbacena hospital (R\$100,000); outfitting of various units at the Anápolis hospital (R\$264,000); and restoration plus overall changes in the electrical, hydraulic and sanitary facilities at the Goiás Velho Hospital (R\$237,000). Since this proposal emphasizes replication of the experiment in extramural community care work, the benefits of REFORSUS will complement the program funds, and will thus make it easier for other Santas Casas that have already undergone physical upgrading to adopt the new model.
- 5.4 Another factor which should be noted in connection with execution of REFORSUS is the aforementioned (see paragraph 1.4) **inadequacy of the PAB**, accompanied by a declining use of the REFORSUS reimbursement tables as a result of the block transfers to a growing number of municipalities which are gradually achieving administrative autonomy: basic care (more than 3,300 at present) and municipal system (now 345). That is why plans call for negotiations with the Ministry of Health for a reformulation of the REFORSUS policy letter that would assure allocation of the necessary funding to the PAB, either from the SUS or from other sources (i.e. the CPMF).
- 5.5 Coordination with the program to reduce infant mortality (PRMI): The PRMI would support similar objectives in the public and privately contracted system, but - with the exception of Canindé, where the activities would be coordinated with the Municipal Health

Secretariat, thus avoiding any duplication — the municipalities envisaged as targets do not coincide.

BRASIL
LOGICAL FRAMEWORK FOR A MOTHER AND CHILD HEALTH CARE MODEL PROGRAM (TC-97-07-17-6)

SUMMARY OF OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
incorporation of the CMB charity work into national health policies and a new model of community child care.	Community mother and child care model in operation at the initial five hospitals and in 1,000 hospitals of the CMB network three years after completion of the project.	Annual evaluation reports plus another at the end of the program Inspections of the five hospitals and a sample of hospitals affiliated with the CMB which have begun to introduce the model	Successful implantation of the model at five initial hospitals Willingness of management bodies of hospitals in the CMB network to introduce new care model
level of mother and child care, and community participation in the quality and the preventive and rear-guard capability of the five hospitals and subsequent replication of the model in the CMB network.	In places where there are community health care agents: A 20% reduction of maternal and infant mortality rates A 40% reduction in immuno-preventable diseases and malnutrition A 30% reduction in complications in pregnancy, childbirth and post partum A 20% reduction in maternal mortality cases at the five hospitals Model in advanced stages of implantation at another 100 hospitals in the CMB network by the end of the project	Vital statistics Records of notifiable diseases Nutritional vigilance system Hospital statistics Reports of the CMB. Inspection visits	Deployment of community health agents for supervision and effective support of the model Effective allocation of budgetary resources to ensure continuity and sustainability of the model Effective coordination with and support from the municipal health secretariats and municipal health councils
COMPONENT 1: INSTRUCTION AND TRAINING			
coverage and quality of hospital care by implementing mother and child care models in local needs, through direct work with health agents.	140 community agents (ACS), trained, employed and providing service to a minimum of 300 families each An equivalent number of ACS positions created in the budget of the five hospitals Annual refresher courses for community agents	Reports on the semiannual, annual and final evaluations	Effective linkage with the municipal secretariats in the area of influence Effective coordination with the PRM Adequate selection of teaching and supervisory staff Sustainability and continuity of the teaching and supervisory teams

SUMMARY OF OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
of five hospitals as mother and s as regional referral and s for a process of replicating in the other units of the	<p>Multidisciplinary teaching and supervisory teams trained at the five participating hospitals</p> <p>All of the mother and child care staff at the five hospitals trained by teaching and supervisory teams, and are given new functions</p> <p>Systems for improvement and surveillance of technical and human quality, introduced and operating at the five hospitals</p> <p>Teaching and supervisory teams brought up-to-date with two annual sets of refresher courses (40 hours each)</p> <p>Orientation given to 50% of the communities' residents in educational events</p>	Semiannual, annual and final evaluation reports	<p>Acceptable selection of teaching and supervisory staff</p> <p>Sustainability and continuity of the and supervisory teams and trained</p>
COMPONENT: PHYSICAL AND FUNCTIONAL RECONDITIONING OF MOTHER AND CHILD CARE FACILITIES			
five hospitals as mother and onal referral units (by number of mothers and ed by community agents and	<p>Small-scale remodeling and outfitting of outpatient and hospital facilities completed in accordance with the projects presented by each hospital (prenatal consultation areas) well child control, "Mothercare Houses"; rooms for care prior to, during and following childbirth; care facilities for newborn infants at high risk; conversion of private rooms to semiprivate ones; improvements in the electromechanical systems.</p>	Evaluation reports: semiannual, annual and final	<p>Local availability of the necessary services</p> <p>Sustainable operation of the impro services</p>

SUMMARY OF OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
COORDINATION, MONITORING, EVALUATION AND DISSEMINATION COMPONENT			
<p>Effective coordination of the activities and establish an efficient monitoring and evaluation system of inputs, process and results</p> <p>Train hospitals as training units in a scheduled process to replicate the model at the remaining units in the region</p>	<p>Prompt completion of disbursements and timely presentation of reports</p> <p>The holding of semiannual evaluation meetings at each hospital</p> <p>Two joint annual seminars for evaluation of the training and supervisory teams at the hospitals held, followed by incorporation of the results thereof into the operating systems, training processes and dissemination activities</p> <p>Completion of activities to disseminate and help replicate the model:</p> <ul style="list-style-type: none"> a. 10 microregional workshops b. Internships and visits by 135 professionals from other towns c. A national seminar with 40 representatives of the CMB association d. A video, clips and promotional materials produced and ready for distribution <p>Final evaluation completed</p>	<p>Semiannual, annual and final evaluation reports</p> <p>Voluntary ex post special report three years after completion</p>	<p>Acceptable CMB coordination and management skills</p> <p>Satisfactory selection of the evaluation team</p>

PROCUREMENT PLAN

Major Items Provided by the Program	Financing in US\$000 % of total cost		Mode of Procurement	Date of SPN Estimated (quarter/year)
	IDB	NATIONAL		
1. CONSTRUCTION				
Anápolis	140,000		Presentation of three quotes up to US\$100,000	III/98
Barbacena	150,000			III/98
Canindé	117,000			III/98
Goiás Velha	93,000			III/98
Sobral	42,000			III/98
2. EQUIPMENT				
Anápolis	300,000		Invitation of three bidders on the prequalified list for contracts exceeding US\$100,000	IV/98
Barbacena	148,000			IV/98
Canindé	206,000			IV/98
Goiás Velha	173,000			IV/98
Sobral	102,000			IV/98
CMB	3,000			III/98
3. CONSULTING SERVICES				
Individual	267	160	Call for quotes from at least three suppliers	III/98
Corporate	0	0		

PROPOSED RESOLUTION

BRAZIL. NONREIMBURSABLE TECHNICAL COOPERATION FOR A
MOTHER-CHILD HEALTH CARE MODELS PROGRAM

The Board of Executive Directors

RESOLVES:

1. 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 agreements as may be necessary with the Confederação das Misericórdias do Brasil and to adopt such measures as may be pertinent for the execution of the plan of operations referred to in Document AT-_____, with respect to a nonreimbursable technical cooperation for a mother-child health care models program.
2. That up to the equivalent of US\$4,690,000, in reais, is authorized for the purposes of this resolution, chargeable to the net income of the Fund for Special Operations.
3. That the above-mentioned sum is to be provided on a nonreimbursable basis.