

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

BRAZIL

PROGRAM FOR STRENGTHENING SOCIAL INCLUSION AND HEALTHCARE NETWORKS - PROREDES

(BR-L1378)

LOAN PROPOSAL

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ELECTRONIC LINKS	
REQUIRED	
1.	Annual work plan (plan of activities for the first disbursement and the first 18 months of implementation) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38014645
2.	Program monitoring and evaluation arrangements http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38014558
3.	Itemized procurement plan http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38014183
4.	Environmental and Social Management Report (ESMR) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38014166
OPTIONAL	
1.	Analysis of the mother-child healthcare network in the State of Sergipe (in Portuguese) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38012852
2.	Itemized program budget http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38012940
3.	Program economic analysis http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38026972 http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38027294
4.	Formation of healthcare networks in the State of Sergipe (in Portuguese) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38010145
5.	Organizational structure of the project management unit http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38013060
6.	The Unified Health Service (SUS) from A to Z http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38011908
7.	Map of extreme poverty in Sergipe http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38023483
8.	Medium complexity study http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38055040
9.	Consolidated financial report of the State of Sergipe http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38078891
10.	Environmental and Social Safeguards Screening Form for classification of projects (SSF) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38027326

ABBREVIATIONS

AWP	Annual work plan
CVA	Cerebrovascular accident
ESMP	Environmental and Social Management Plan
ESMR	Environmental and Social Management Report
GCI-9	Ninth General Increase in the Resources of the Bank
LACEN	Laboratório Central [Central Laboratory]
LIBOR	London Interbank Offered Rate
PMU	Program management unit
PPI	Programação Pactuada Integrada [Integrated Consensus-based Programming]
RAS	Rede de Atenção à Saúde [Healthcare network]
SEPLAG	Secretaria de Estado de Planejamento, Orçamento, e Gestão [State Planning, Budget, and Management Department]
SES/SE	Secretaria de Estado de Saúde de Sergipe [Sergipe State Health Department]
SUS	Sistema Único de Saúde [Unified Health System]
WHO	World Health Organization

PROJECT SUMMARY

BRAZIL

PROGRAM FOR STRENGTHENING SOCIAL INCLUSION AND HEALTHCARE NETWORKS - PROREDES (BR-L1378)

Financial Terms and Conditions			
Borrower: State of Sergipe Executing agency: State of Sergipe, through the State Health Department (SES/SE) Guarantor: Federative Republic of Brazil		Flexible Financing Facility*	
		Amortization period:	25 years
		Original weighted average life	15.25 years
		Disbursement period:	5 years
Source	Amount	Grace period:	5.5 years
IDB (Ordinary Capital)	US\$100,000,000	Inspection and supervision fee:	**
Local	US\$40,000,000	Interest rate:	LIBOR-based
Total	US\$140,000,000	Credit fee:	**
		Currency:	U.S. dollars from the Ordinary Capital
Project at a Glance			
Project objective: The program's main objective is to help improve the health of the population of Sergipe, particularly the most vulnerable groups, reducing regional inequities and ensuring access to quality services. To that end, it will endeavor to strengthen the management of the Unified Health System (SUS), expand the physical medium- and high-complexity network, and improve clinical practice.			
Special contractual clauses: Conditions precedent to the first disbursement: (i) evidence that the Program Management Unit (PMU) has been set up; (ii) evidence that PMU staff have been appointed; (iii) creation of the program's Special Bidding Committee; (iv) entry into force of the program Operating Regulations under the terms previously agreed on with the Bank; and (v) start of the bidding process for contracting the project management support firm (see paragraph 3.2). Execution conditions: (i) before the medical specialty centers enter into operation, the borrower will demonstrate the entry into force of the legal instruments to be signed by the SES/SE and the State Health Foundation (FUNESA) and the Município of Aracaju, under the terms previously agreed upon with the Bank; (ii) within six months from the date the project management support firm is hired, the borrower will implement the computerized project management and monitoring system, in keeping with the terms agreed on with the Bank; (iii) prior to the start of the works, the borrower will submit, through the executing agency, the final designs, the necessary permits, and the Environmental and Social Management Plan (ESMP), and present evidence of the holding of public consultations, in accordance with Bank policies; and (iv) fulfillment by the borrower, through the executing agency, of the programs, requirements, and guidelines established in the ESMP, the program Environmental Assessment Report, and the Environmental Control Plan during the program's original disbursement period and any extensions (see paragraph 3.3).			
Exceptions to Bank policies: None.			
Project consistent with country strategy:		Yes <input checked="" type="checkbox"/> [X]	No <input type="checkbox"/> []
Project qualifies as:		SEQ <input type="checkbox"/> []	PTI <input checked="" type="checkbox"/> [X] Sector <input type="checkbox"/> [] Geographic <input checked="" type="checkbox"/> [X] Headcount <input type="checkbox"/> []

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

(**) 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 applicable policies.

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problems addressed, and rationale

- 1.1 Located in the northeast of the country, Sergipe is Brazil's smallest state, with 2,068,031 inhabitants, of whom 73.5% live in urban areas, with 30% in the capital, Aracaju (Brazilian Institute of Geography and Statistics–IBGE, 2010). Between 2002 and 2010, the state's gross domestic product (GDP) grew 44.4%, at an average annual rate of 4.7%, surpassing the national average of 3.6%. Between 1991 and 2000, the state's Human Development Index (HDI) rose from 0.609 to 0.742, to become the second highest in the Northeast region. The improvement in these indicators was accompanied by rapid population growth of 15.9% over the last decade. Despite this progress, average family income in Sergipe is 62% of the level in Brazil as a whole (State Planning, Budget, and Management Department–SEPLAG). According to figures from the Ministry of Social Development, 16% of the state's population is living in extreme poverty, concentrated mostly in rural areas.
- 1.2 In recent years, Sergipe has implemented economic development policies aimed at improving the population's living conditions; and these have resulted, for example, in a 7.42% increase in formal job creation and 18.8% growth in university places, three times the average for the Northeast region, between 2009 and 2010. To make further progress along these lines, in 2011, SEPLAG produced the Sergipe Poverty Map,¹ with the aim of identifying the critical development problems facing the state's regions. This map was used to design the Plano Sergipe Mais Justo [Fairer Sergipe Plan] strategy, which is integrated and coordinated between the different government sectors and targeted on eradicating poverty and extreme poverty. This strategy is built on three pillars: (i) income transfer; (ii) productive inclusion; and (iii) access to public services. The last of these includes health strategies to expand access to services for the poorest population group.
- 1.3 **Public health challenges in Sergipe, risk factors, and epidemiological profile.** Sergipe displays positive trends in relation to chronic disease risk factors that are very similar to those of Brazil as a whole. Between 2006 and 2011, significant progress was made, such as a 2.9% reduction in tobacco consumption, a 14% increase in levels of physical activity, and 8.2% growth in the regular consumption of fruit and vegetables. Nonetheless, other risk factors worsened in the same period, such as levels of overweight and obesity, which rose from 40.2% to

¹ The Sergipe Poverty Map considers income, along with indicators including access to education, drinking water, energy, and health issues. The map has revealed degrees of poverty and extreme poverty in the different regions, identifying concentrations of poverty in regions far removed from the capital, such as Alto Sertão and Baixo São Francisco.

- 44.5%, and from 13.6% to 14.6%, respectively. Moreover, in 2011, 5.6% of the adult population had diabetes, and 23.3% high blood pressure.²
- 1.4 The State's epidemiological pattern is highly representative of pathologies associated with these risk factors, which can be addressed by improving the coverage and quality of primary healthcare, targeting the promotion of healthy habits and timely detection of diseases. The state's morbimortality profile shows that the main causes of death are related to circulatory diseases (25.6%),³ followed by external causes (14.9%), and neoplasias (12.2%), which in 2011 were together responsible for 56.72% of deaths among men and 51.99% among women.⁴ Associated with the heavy burden of chronic diseases, between 2008 and 2011 there was also a 48.84% increase in the number of lower-limb amputations resulting from diabetes complications, with an average of 12 per week in the last year. These acute patterns are eminently avoidable, since it is estimated that up to 80% of cardiac diseases, cerebrovascular accidents (CVAs), and cases of type-II diabetes are preventable,⁵ hence the importance of activating health promotion practices and patients adhering to their self-care plan.⁶
- 1.5 One of the consequences of the growing prevalence of circulatory diseases and external causes is an increase in permanent or temporary disabilities, particularly in adulthood. An estimated 40% of early retirements in the state are caused by CVAs, acute myocardial infarctions, and congestive cardiac insufficiency⁷ resulting from hypertension.
- 1.6 The incidence of cancer and its impact on the mortality rate in Sergipe has been rising strongly, mainly affecting working-age adults age 45 age and older.⁸ Neoplasias that are becoming more prevalent include prostate and lung cancer among men, and breast and cervical cancer among women, which, in 2011, accounted for 10.14 and 9.68 deaths per 100,000 inhabitants, respectively. For 2012 and 2013, there is an estimated incidence of 35 cases of breast cancer and 48.5 cases of prostate cancer per 100,000 inhabitants in Sergipe (National Cancer

² Vigilatel Brasil 2011 and 2006: *Vigilância de Fatores de Risco e Proteção para Doenças Crônicas por Inquérito Telefônico*. [Surveillance of risk factors and protection for chronic diseases, by telephone survey] Secretaria de Vigilância em Saúde [Health Surveillance Department]—Brasília: Ministry of Health, 2012 and 2007.

³ Ministry of Health (2011). Chronic diseases are responsible for 72% of all deaths in Brazil.

⁴ Op cit (idem 9).

⁵ World Health Organization (2008). Primary Health Care: Now More Than Ever.

⁶ Patients who are more active contribute to improving their health status. Bodenheimer et al, 2002; Hibbard and Geene, 2013.

⁷ SES/SE. Avaliação da Hipertensão, Diabetes Mellitus y AVC em Sergipe. [Evaluation of hypertension, diabetes mellitus, and CVA in Sergipe] Sergipe, 2013.

⁸ LIMA, C.A. Tendências de Incidências e de Mortalidade por Câncer no Município de Aracaju, Sergipe [Trends in cancer incidence and mortality in the município of Aracaju, Sergipe], PhD thesis, UFSE, Health Sciences, 2013.

Institute–INCA and Ministry of Health).⁹ According to the Sergipe State Health Department (SES/SE), in 2012 just one fifth of the target population that should have undergone mammogram examinations actually did so.¹⁰ This situation partly reflects the deficient coverage of early breast cancer detection services.

- 1.7 In terms of mother-child care, efforts made in recent years to reduce infant mortality in Sergipe have been successful, as confirmed by the drop in the infant mortality rate from 28.6 per 1,000 live births in 2002, to 16.1 in 2011, and its downward trend. Despite this progress, Sergipe still suffers from deficits in maternal and newborn health that are partly the result of difficult access to basic healthcare procedures, compounded by quality gaps in the services provided. Between 2000 and 2011, the maternal mortality rate fluctuated up and down without a clear trend. In 2011, there were 83 deaths per 100,000 live births, well above the national average of 63 per 100,000 live births, and far from the national target for fulfilling the Millennium Development Goals of 35 deaths per 100,000 live births in 2015. Direct obstetric causes¹¹ were responsible for 76% of maternal deaths in the state in 2011 (10 percentage points above the Brazilian average), resulting from obstetric complications during pregnancy, delivery, or the puerperium, caused by errors in procedures, incorrect treatments, omissions, or any of these associated factors. This reveals failings in basic care, particularly in prenatal care, when one would expect early detection and risk classification to prevent clinical conditions from worsening and to provide timely treatment. An example of this is the high incidence of congenital syphilis, which had risen to a level of 10.7 per 1,000 live births in 2012.¹² Deficient prenatal care¹³ affects both the mother and the child, primarily babies born up to 28 days prematurely, and accounts for 62% of infant fatalities.
- 1.8 **The organization of services in the Sergipe SUS.** Basic healthcare coverage is around 83% in the state,¹⁴ well above the national and northeastern averages of 58.06% and 69.70%, respectively. It is organized almost entirely under the Family

⁹ Estimates of cancer incidence are used to identify risk factors for a given population group and to quantify cancer's impact (op. cit, idem 7).

¹⁰ The Ministry of Health recommends that 60% of the target public (women ages 50 to 69) undergo the annual examination.

¹¹ The two main specific direct causes of maternal mortality in Brazil are hypertension and hemorrhagic shock, which in 2010 accounted for 19.7% and 10.9% of all maternal deaths, respectively. Other important direct obstetric causes are postpartum infection and miscarriage, which accounted respectively for 6.5% and 4.6% of total maternal deaths.

¹² In 2011, the national and regional averages were 3.3 and 3.6 cases per 1,000 live births, respectively.

¹³ In 2011, just 45.8% of expectant mothers attended the seven prenatal checkups recommended by the Ministry of Health, compared to a national average of 61.3%.

¹⁴ In Brazil, the population coverage of basic healthcare is measured at a ratio of 1 family health team per 3,000 inhabitants (minimum team: one doctor, one nurse, one nursing technician, and at least four community health agents) (National Basic Healthcare Policy).

Health Program (PSF)¹⁵ model. Nonetheless, such a high coverage rate poses challenges in terms of quality, such as the absence of referral and counter-referral protocols between basic healthcare and other pregnancy support services, particularly in the case of high-risk pregnancies. There is also a lack of rapid tests for human immunodeficiency virus (HIV) and syphilis for pregnant women, who have to wait an average of 60 days for the results of those tests.

- 1.9 In terms of medium-complexity care,¹⁶ Sergipe also displays significant shortcomings, particularly in areas away from the capital city, since 80% of services are concentrated in Aracaju.¹⁷ Although there is a specialized outpatient network, it is insufficient and fragmented and disconnected from the integrated logic of the healthcare system. For example, the average waiting time for specialist cardiology, endocrinology, and neurology appointments is six months (Oversight, Audit, Evaluation, and Regulation Unit–NUCAAR, 2013).¹⁸ The same is true of diagnostic and therapeutic services. Thus, apart from insufficient supply, medium-complexity services in Sergipe display low rates of compliance with the agreed-upon targets. On average, only 30% to 50% of programmed care involving specialized consultations and diagnostic examinations is actually provided. This is due to the fact that the municípios supplying these services are unable to perform the agreed-upon actions; and this is compounded by their limited operational capacity and service organization problems.
- 1.10 In the case of high-complexity care,¹⁹ 90% of procedures take place in the capital, while other areas of the state are served by six regional hospitals providing emergency care with few specialties. In some cases supply is insufficient to meet the growing demand. For example, oncology services have long waiting lists both for surgeries and for chemotherapy and radiation therapy.²⁰ This causes delays in treatment, jeopardizing the success of procedures and the potential for a cure.
- 1.11 **Health reform in Sergipe.** Since 2007, the state has been implementing a health and managerial reform project in the SUS,²¹ which, apart from aiming to guarantee

¹⁵ See Macinko J, et al., 2006 “*Evaluating the Impact of the Family Health Program on Infant Mortality in Brazil, 1990-2002*” and Macinko J, et al, 2007, “*Going to Scale with Community-based Primary Care: An Analysis of the Family Health Program and Infant Mortality in Brazil, 1999-2004.*”

¹⁶ Medium-complexity services in the SUS encompass consultations with medical and other specialists, as well as diagnostic and therapeutic support services.

¹⁷ See Sousa, David and Ana Santana, *Análise da Atenção Especializada de Média Complexidade em Sergipe* [Analysis of medium-complexity specialized care in Sergipe].

¹⁸ Oversight, Audit, Evaluation, and Regulation Unit (NUCAAR).

¹⁹ High-complexity services in the SUS consist of costly, high-technology procedures, as well as hospital care.

²⁰ On 20 August 2013, the Inter-Federative Universal Access Guarantee System (SIGAU) recorded a total of 333 patients on the waiting list for radiation therapy in the Oncology Unit of the Aracaju Emergency Hospital.

²¹ Law 6345 of 2008 defines the structure and functioning of the SUS in the State of Sergipe.

the rights enshrined in the 1988 National Constitution,²² proposes to improve the efficiency and efficacy of the delivery of health services. Consistent with SUS guidelines and the regulations governing its implementation,²³ the reform is focused on two technical-institutional pillars: (i) strengthening the state's role as policy driver and coordinator of the health system; and (ii) decentralizing the supply of services, organized into regions, thereby guaranteeing access and integrated care.

- 1.12 The changes brought about by the reform to support the aforementioned pillars have resulted in a redesign of the organizational and management framework for health services, as follows: (i) the organization of the SUS into healthcare networks (*redes de atenção à saúde – RASs*);²⁴ (ii) the creation of foundations²⁵ to provide health services and inputs in the regions, with the aim of creating an integrated and decentralized healthcare model; (iii) the introduction of management mechanisms for the planning and programming of actions and services at the different levels of complexity. To guarantee universal access to healthcare, concerted actions were also encouraged between the federative entities, based on the creation of regional inter-federative collegiate bodies (known as CIRs, comprising the municípios in each region) together with negotiating instruments and agreements. In Sergipe, the main vehicle for concerted action on the supply of and demand for medium- and high-complexity services between the municípios is the Integrated Consensus-based Programming model (*Programação Pactuada Integrada–PPI*). This is envisaged in the establishment of the SUS (Ministerial Regulation 1097/2006) and aims to guarantee balanced access to services, particularly the more complex ones, by better organizing the existing supply. For this purpose, the municípios enter into service delivery agreements and annually agree to provide specific services to the município(s), according to their interest and availability, receiving resource transfers in return. The state plays the role of intermediary, coordinator, and articulator of the PPI; and the Ministry of Health transfers the resources to finance the agreement.
- 1.13 **The organization of healthcare in RASs and their challenges in Sergipe.** The organization of health services in RASs aims to overcome fragmentation problems, rationalize the supply and use of health services, and avoid duplications, gaps in

²² Article 198 of the Federal Constitution of 1988: Public health actions and services form part of a regionalized and hierarchical network, constituting a unified system, organized on the basis of decentralization, integrated care, and community participation.

²³ Law 8080 – Organization of the Health Sector, 1990. Further information on the system can be found on the SUS portal.

²⁴ The RASs are organizational arrangements for health actions and services of different technological densities, which, integrated into technical, logistic, and management support systems, aim to guarantee comprehensive care. Ministry of Health, Brazil, 2010.

²⁵ The reform has created three foundations: the State Health Foundation (FUNESA); the Hospital Health Foundation (FHS); and the Parreira Horta Health Foundation (FSPH), which implement a wide range of health actions on behalf of the SUS in the state.

care and cost overruns caused by the avoidable aggravation of disease patterns.²⁶ International evidence shows that an integrated network can impact care quality through clinical protocols that define the most appropriate interventions for a given condition and who should execute them, and specify how patients transit through the service chain (Bodenheimer, 2008). In line with this evidence, in 2010 the Ministry of Health launched guidelines for the organization of the SUS healthcare networks for implementation of the strategy.²⁷

- 1.14 Since the health reform, Sergipe has been investing to consolidate the RAS model. In particular, it has plans of action and financing approved by the Ministry of Health for the mother-child and urgency and emergency networks. The 2012-2015 multiyear plan of action also envisages the construction of 102 family health clinics, to strengthen basic healthcare, which is seen as crucial to the effective functioning of the RASs. In addition, the plan provides for the expansion of hospital and emergency services, with the implementation of rapid care units in benchmark municípios.
- 1.15 Despite these advances, the organization of the RASs in the state continues to face major challenges, including: (i) regional gaps in the supply of healthcare; (ii) the absence of healthcare lines and protocols that organize patient care; (iii) the fragile role of the SES/SE in coordinating and monitoring service delivery agreements between municípios (PPIs) and in supervising contracts with the private sector; (iv) the weakness in logistics systems (mainly healthcare transportation) and information systems; and (v) high turnover rates among health professionals, particularly doctors, thereby generating discontinuity in patient care and low treatment persistence rates.²⁸
- 1.16 **Proposal for consolidating the RAS model in Sergipe.** In this context, the proposed program will finance the consolidation of the networks model, setting up five RASs to cover healthcare needs throughout the state. To define the five RASs, the SES/SE considered the following criteria: (i) population parameters; (ii) scale and economics; (iii) the epidemiological profile and health risk of the regions; (iv) access routes; and (v) the location of current and planned services.²⁹ These RASs seek to provide a pattern of high-quality comprehensive care in each region, taking account of the specifics of demand, local socioeconomic conditions, the supply of professional personnel, technologies and equipment, and the purchasing and financing power of the state and municípios.

²⁶ According to data from the World Health Organization (WHO), chronic diseases in Brazil currently absorb between 0.4% and 0.5% of GDP.

²⁷ Order (*Portaria*) 4279, Ministry of Health, 2010.

²⁸ Studies show that patients benefit from a stable health team. Atlas SJ, Grant RW, Ferris TG, Chang Y, Barry MJ. *Patient-Physician Connectedness and Quality of Primary Care. Annals of Internal Medicine.* 2009 Mar 3; 150(5): 325-35. PubMed PMID: 19258560. Pubmed Central PMCID: 2975389.

²⁹ See [Structure of the RASs](#)

- 1.17 **The Bank's strategy with the country and GCI-9.** The program is aligned with the Bank's country strategy with Brazil 2012-2014 (document GN-2662-1), particularly with the regional goal of stimulating social and productive inclusion by reorganizing the health system under a decentralized model. The activities to be financed will make a direct contribution to expanding the supply of chronic-degenerative disease prevention services; improving access to, and the coverage and quality of mother-child services; and reducing regional inequalities. The operation complements other Bank programs in Sergipe, such as PRODETUR (BR-L1256), since it will serve the poorest regions of the state. It is also aligned with the objectives of the Ninth General Increase in the Resources of the Inter-American Development Bank (GCI-9, document AB-2764) on poverty reduction and equity enhancement, particularly with the reduction of maternal and child mortality, and through the output "Increase in the number of individuals receiving health services," which correspond to the sector priority "Social policy for equity and productivity."
- 1.18 The proposed program innovates by seeking to help consolidate the RAS model in the country, based on the experience in Sergipe. Its design took account of knowledge generated in the technical discussions for preparation of program BR-L1376 (State of São Paulo) on the development of the RASs and healthcare lines. The knowledge gained through the two operations is expected to help produce evidence of the effectiveness of the RASs, which will serve as input for the national debate and future Bank operations.

B. Objectives, components, and cost

- 1.19 The program's main objective is to help improve the health of the population of Sergipe, particularly the most vulnerable groups, reducing regional inequalities and ensuring access to quality services. To that end, it will endeavor to strengthen state management of the Unified Health System (SUS), expand the physical medium- and high-complexity network, and improve clinical practice. The program will pursue these objectives through the following components:
- 1.20 **Component 1. Strengthening state management of the SUS (IDB: US\$29.3 million).** The objective of this component is to increase the management capacity of the SES/SE and Sergipe's municípios, and to develop and implement managerial tools targeting organization in RASs. It will finance, among other things: (i) the establishment of a strategic core; (ii) the development of an integrated health information system; and (iii) strengthening of the Central Única de Regulação (Unified Regulation Center).
- 1.21 **Subcomponent 1. Building the management capacity of the SES/SE.** This subcomponent aims to strengthen the strategic role of the SES/SE as coordinator, articulator, and driver of health policy in the state. The following will be financed: (i) creation of the SES/SE strategic core; (ii) reform and upgrading of the SES/SE's

main building;³⁰ (iii) development and implementation of the integrated information system; and (iv) the undertaking of studies³¹ that are crucial for making state management of the SUS more efficient.

- 1.22 **Subcomponent 2. Support for the RAS management model.** This subcomponent aims to build the capacity of the SUS professionals and coordinators in the municípios and state, and to organize access to services in the regions. The following activities will be financed for that purpose: (i) construction and implementation of the Unified Regulation Center³² to guarantee access and comprehensive care; (ii) construction of an SUS training and education center in Sergipe and procurement of equipment for it; and (iii) training for managers and technical staff of the municípios and state.
- 1.23 **Component 2. Structuring of the services in the RASs (IDB: US\$65.1 million; Local: US\$40 million).** The objective of this component is to strengthen the services infrastructure, by reorganizing and expanding the supply of services in the health regions and enhancing their quality by improving clinical practices. It is also expected to improve the coordination and integration of the different care levels in the RASs. The component is built on two main pillars:
- 1.24 **Subcomponent 1. Expansion and upgrading of the supply of medium- and high-complexity services, targeting regionalization of the services.** This subcomponent will promote equitable access to healthcare, guaranteeing comprehensive patient care, through the following activities: (i) reform, expansion, and procurement of equipment for the five medical speciality centers; (ii) procurement of equipment for the cancer hospital, in keeping with the functional physical profile agreed on with the Bank; (iii) quality accreditation of the cancer hospital; (iv) procurement of equipment for a Specialized Rehabilitation Center (CER IV) in Aracaju; (v) construction of the Sergipe Central Laboratory (LACEN) headquarters and procurement of equipment; (vi) LACEN quality accreditation; (vii) procurement of equipment for the Women's Comprehensive Health Care Center (CAISM); and (viii) procurement of vehicles for health service patient transportation in the health regions.
- 1.25 **Subcomponent 2. Improvement of clinical management by structuring and implementing healthcare lines.** This subcomponent aims to enhance the quality of care by reorganizing clinical processes and practices and instituting mother-child, oncology, chronic disease, and disabled persons care lines, which respond to

³⁰ The physical condition of the SES/SE building is precarious, which impacts its operating capacity and results. In all 3.7% of the loan will be devoted to this.

³¹ Studies on the following topics: Modeling of regional networks; strategies for attracting and retaining human resources in the health sector outside of the state capital; quality and efficiency in health spending, targeting medium- and high-complexity services and the development of mechanisms for managing the services; optional health transportation; study on cost and effectiveness in laboratories; contracting instruments and regulation between the state and municípios; study to model the Unified Regulation Center; and household survey of disabled persons.

³² See the definition of the regulation in *SUS de A a Z* [the SUS from A to Z], p. 199.

prevailing health conditions or those that are priorities for the state. Financing will be provided for the design, validation, and implementation of clinical protocols and the development of healthcare lines,³³ through studies, consultancies, training events and the preparation and printing of clinical guides and handbooks.

- 1.26 **Component 3. Program management, monitoring, and evaluation (IDB: US\$5.6 million).** The aim is to help the SES/SE execute, monitor, and support the agreed outcomes for the program. The following activities will be financed: (i) cost of contracting consultants for the PMU; (ii) the contracting of an activities monitoring system; (iii) midterm evaluation and impact studies; and (iv) the program audit.
- 1.27 **Costs and financing.** The total cost of the program will be US\$140 million, of which US\$100 million (72%) will be funded by the IDB loan, and US\$40 million (28%) will be financed by the State of Sergipe. The operation has a program request approved by the Brazilian government's External Financing Commission (COFIEX), through Recommendation 1340 of 5 October 2012.
- 1.28 Table 1.1 shows the breakdown of costs by component and source of financing:

Table 1.1: Costs of the Operation (US\$)

Description	IDB	Local	Total
Component 1. Strengthening state management of the SUS	29,281,421	0	29,281,421
Component 2. Structuring of the services in the RASs	65,085,391	40,000,000	105,085,391
Component 3. Program management, monitoring, and evaluation	5,633,188	0	5,633,188
Total	100,000,000	40,000,000	140,000,000

C. Key indicators of the Results Matrix

- 1.29 The indicators selected for the Results Matrix aim to reflect the changes expected in the health status of the population of Sergipe, as a result of the activities financed by the program. In particular, it was decided to choose the impact indicators that best represent the trend of the five priority health conditions: (i) rate of maternal mortality from direct obstetric causes; (ii) cervical-uterine cancer mortality; (iii) premature mortality as a result of diabetes mellitus in persons under 60; (iv) premature mortality caused by CVAs in persons under 60; and (v) rates of hospitalization for basic care. An intermediate indicator is the percentage of women ages 50 to 69 who undergo an annual mammogram; and, as final outcomes, the percentage of pregnant women attending the seven minimum prenatal checkups,

³³ Healthcare lines consist of a set of knowledge, technologies, and resources needed to address specific health risks or conditions. They are supplied in a coordinated way by the SUS, organized in flows, and based on clinical protocols/technical manuals (São Paulo Health Department).

and the percentage of persons registered in the basic health units with diabetes and hypertension who receive monitoring.

- 1.30 These indicators will be tracked using the various databanks that comprise DATASUS, Brazil's official health data system managed by the Ministry of Health. DATASUS compiles national data by federative unit (states and municípios), with a breakdown to the service level (production and performance). The system represents the main source of public health data, given its vast stock of information, long time series, and the reliability of its data.
- 1.31 The economic analysis performed for this operation focused on investments aimed at strengthening medium-complexity healthcare, by building specialty centers in the five RASs in Sergipe. Nine key healthcare procedures were selected, specifically those expected to be in the greatest demand, in view of prevailing pathologies and the treatments prescribed today. Demand for the services was estimated using national and international healthcare parameters, which are being adopted by the state.³⁴ Effective supply was also verified (parameter year 2012), and this was used to identify shortfalls in supply for each of the nine procedures. Lastly, the analysis compared the cost of providing these missing services in the public sector, as against outsourcing them to the private sector. Profitability indicators show that the benefits of the program's investments exceed the investment and operating costs entailed in project implementation. The net present value (NPV) at a 12% discount rate gives a value of US\$38,298,538, with an internal rate of return (IRR) of 28.95%. The sensitivity analysis shows that the point of indifference between investing in and operating the specialty centers, compared to overcoming the shortfall by purchasing the services, occurs when the investment has a standard deviation of 116%, a situation that is not likely to occur.
- 1.32 In relation to the sustainability of the proposed investments, [financial analyses](#) show that Sergipe has a technical reserve available for operating new services, equivalent to about 50% of the resources currently assigned by the Ministry of Health to medium- and high-complexity care. This ensures that the new units will have the resources needed to operate on a permanent basis.

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

- 2.1 The Bank financing for this operation will be processed as an investment loan under the Flexible Financing Facility (document FN-655-1). The planned disbursement period is five years.

³⁴ The services programmed in the Sergipe PPI are based on parameters of need, pursuant to Ministry of Health and WHO protocols.

B. Environmental and social risks

- 2.2 This was rated a “Category B” operation under the Bank’s Environment and Safeguards Compliance Policy (OP-703). To comply with the provisions of OP-703, during preparation of the operation, a program Environmental Assessment Report was produced by the state government through its project preparation unit. This identified the main potential socioenvironmental impacts and risks, highlighting the interventions of Component 2 (Structuring of the services in the RASs), as well as prevention and mitigation measures and the environmental control of the corresponding impacts. Pursuant to the Bank’s Access to Information Policy (OP-102), the program has been disseminated through the SES institutional website <http://www.saude.se.gov.br>; on the portal of state’s news agency, Agência Sergipe de Notícias (ASN): <http://www.agencia.se.gov.br/>; and on the SEPLAG web portal <http://www.seplag.se.gov.br>. In addition, the Environmental Assessment Report was posted on the SES website for public consultation and contributions, and it will be presented and discussed at a public meeting to be organized by the executing agency.
- 2.3 The program’s positive impacts relate to improvements in the population’s health status, particularly among the most vulnerable groups. The program forms part of the social priorities identified in the Sergipe extreme poverty map, which has been used to develop the Plano Sergipe Mais Justo [Fairer Sergipe Plan]. The impacts will be felt throughout the state, with less inequality in access to health services between the regions. The negative impacts that will arise during the works will be temporary and on a small scale. Potential adverse impacts arising during the operation of the services involve the management of waste material, liquid effluents, and gas emissions.
- 2.4 The precautions and measures to be adopted to control, prevent, and mitigate the potential adverse impacts are described in the Environmental and Social Management Plan (ESMP) included in the Environmental and Social Management Report (ESMR) annexed to this document. The [ESMR](#) prescribes procedures, actions, and responsibilities for proper socioenvironmental management of the program.

C. Fiduciary risks

- 2.5 The capacity of the SES/SE to organize, implement, and control the program was evaluated through an institutional capacity assessment system (ICAS) analysis. The results show that the SES has medium institutional capacity for program management, and a medium level of institutional risk. On fiduciary issues, the assessment identified a lack of experience among its technical staff in executing externally funded projects, and lack of knowledge of the Bank’s regulations/policies, which could hinder program implementation. This risk will be mitigated by: (i) creating a PMU attached directly to the SES/SE, to be staffed by full-time specialists and serve as the direct interlocutor between the SES/SE and the Bank; (ii) hiring a specialized firm to support program management; (iii) creating and instituting a Special Bidding Committee consisting of staff seconded from the

SES/SE to take charge of procurement and contracting processes involving the loan proceeds, pursuant to Bank policies; (iv) upgrading the current financial system, or else incorporating a program management system authorized by the Bank, to include a financial and accounting management module that ensures accountability requirements are fulfilled; (v) preparing Operating Regulations that describe the detailed flow of fiduciary processes in detail; and (vi) holding training and capacity-building events led by the Bank's fiduciary team for all personnel involved in implementing the program.

D. Other risks

- 2.6 Two main risks to program implementation were identified, both linked to the characteristics of SUS management. Firstly, there is a possibility that the annual PPI may prove to be an inadequate tool for the RAS management model which the program aims to consolidate. The current PPI generates fragile commitments among health sector managers towards healthcare supply targets, owing to problems in clarifying objectives. Moreover, the SES/SE has limited capacity to coordinate and mediate the corresponding agreements. To mitigate this risk, studies will be undertaken and technical support provided to design new mechanisms for operating agreements between municípios.
- 2.7 Secondly, a risk was identified in terms of a potentially inadequate supply of healthcare personnel, particularly doctors, for the services to be implemented outside the state capital. This could compromise the fulfillment of program targets, since the equipment financed will require specialized staff to operate it according to SUS guidelines. The Ministry of Health is seeking different solutions to support the states in this problem, including creation of the “Mais Médicos” [More doctors] program,³⁵ in recruiting and selecting doctors both from Brazil and from some other selected countries to work in social priority areas, including Sergipe. Other ongoing strategies promoted by the SES/SE include: (i) an increase in the number of places offered by university medical courses, the expansion of medical residency programs, and the creation of a university hospital—all in the interior of the state; and (ii) the implementation of permanent distance training and education programs. These include the family medicine specialization program, for recently graduated doctors, to encourage professionals to join the Family Health Program in areas outside the state capital. In particular, this program will support the SES/SE through a number of strategic actions in line with the foregoing, such as building the SUS/SE training center, studies to support a long-term comprehensive strategy, and attracting and retaining health personnel in more remote areas.

³⁵ For further details, see <http://portalsaude.saude.gov.br>.

III. IMPLEMENTATION AND PLAN OF ACTION

A. Summary of implementation arrangements

- 3.1 The borrower will be the State of Sergipe, and the Federative Republic of Brazil will guarantee the borrower's financial obligations arising from the loan contract. The executing agency will be the SES/SE, which will be responsible for program management, supervision, and evaluation. A PMU will be set up to fulfill these functions, with a suitable structure of posts and responsibilities. The PMU will report directly to the office of the SES/SE and will be created by an appropriate legal instrument. It will consist of a team of SES/SE permanent staff working full-time with support from a project management firm. The following [structure](#) is envisaged: (i) a general coordinator; (ii) a technical coordinator; (iii) a planning, budget, and management coordinator; and (iv) a works coordinator. The PMU will also be supported by the Special Bidding Committee mentioned in paragraph 2.5. A management firm will support the PMU on technical, administrative, and financial matters, and in the supervision of program implementation, including the works.
- 3.2 **The following will be special contractual conditions precedent to the first disbursement: (i) evidence that the Program Management Unit (PMU) has been set up; (ii) evidence that PMU staff have been appointed; (iii) creation of the program's Special Bidding Committee; (iv) entry into force of the program Operating Regulations under the terms previously agreed on with the Bank; and (v) start of the bidding process for contracting the project management support firm.**
- 3.3 **Execution conditions:** (i) before the medical specialty centers enter into operation, the borrower will demonstrate the entry into force of the legal instruments to be signed by the SES/SE and the State Health Foundation (FUNESA) and the Município of Aracaju, under the terms previously agreed upon with the Bank; (ii) within six months from the date the project management support firm is hired, the borrower will implement the computerized project management and monitoring system, in keeping with the terms agreed on with the Bank; (iii) prior to the start of the works, the borrower will submit, through the executing agency, the final designs, the necessary permits, and the Environmental and Social Management Plan (ESMP), and present evidence of the holding of public consultations, in accordance with Bank policies; and (iv) fulfillment by the borrower, through the executing agency, of the programs, requirements, and guidelines established in the ESMP, the program Environmental Assessment Report, and the Environmental Control Plan during the program's original disbursement period and any extensions.
- 3.4 **Program Operating Regulations.** Program implementation will be governed by the Operating Regulations that define rules and procedures for the executing agency on programming, financial-accounting management, procurement, audits, and program monitoring and evaluation.

- 3.5 **Procurement.** Goods procurement and the contracting of works and consulting services will abide by the relevant Bank policies (documents GN-2349-9, Policies for the procurement of goods and works financed by the Inter-American Development Bank, and GN-2350-9, Policies for the selection and contracting of consultants financed by the Inter-American Development Bank). In view of the analysis made of the executing agency's capacity, the procurement processes indicated in the procurement plan, financed in whole or in part by the Bank, will be reviewed ex ante, as will all procurements with an estimated cost above the thresholds for international competitive bidding.
- 3.6 **Disbursements.** Disbursements will be released under the advance of funds modality, based on the project's actual liquidity needs for a period of up to six months. Disbursements will be made to a special bank account in the name of the project, for the exclusive use of the loan proceeds, as specified in document OP-273-2, Financial Management Policy for IDB-financed Projects.
- 3.7 **Audit.** The project's financial statements will be audited annually by an independent private firm of auditors, contracted by the executing agency and eligible for the Bank, pursuant to document OP-273-2, Financial Management Policy for IDB-financed projects. The audited financial statements will be submitted to the Bank no later than 120 days after the end of the entity's fiscal year, pursuant to the procedures and terms of reference agreed upon with the Bank. The audit will include the review of procurement processes, in addition to the Bank's own actions and reviews.
- 3.8 **Retroactive financing.** In accordance with the policy on retroactive financing (OP-507), as a charge against the loan proceeds, the Bank may retroactively finance up to US\$5 million (5% of the proposed loan amount) and recognize against the local contribution up to US\$8 million (20% of the estimated local contribution), in eligible expenses incurred by the borrower before the loan approval date, for final, architectural, and complementary designs and to procure program goods and works. To be eligible, such expenses will have fulfilled requirements substantially similar to those specified in the loan contract; will have been incurred no earlier than 14 June 2013, the project profile approval date; and in no circumstances will include expenses incurred more than 18 months before the loan approval date.
- 3.9 The executing agency will prepare semiannual progress reports on the fulfillment of the objectives and the results agreed upon in each annual work plan (AWP), and in the program monitoring report (PMR), which includes the monitoring of risks and activities to mitigate them. The executing agency will also monitor: (i) the execution status and situation of the procurement plan; (ii) fulfillment of contractual clauses; and (iii) the execution status of the program budget. The report in the second half of the year will include: (i) the AWP for the following year; (ii) the updated procurement plan; and, when appropriate, (iii) the actions envisaged to implement the audit recommendations. The executing agency will also have a monitoring and evaluation subcoordination unit responsible for implementing the [Monitoring and Evaluation Plan](#).

B. Design activities post approval

- 3.10 Once the operation has been approved, and prior to contract signing, the program execution plan will be prepared to support the implementation of program activities. In addition, during program preparation, a number of key activities will be identified to ensure proper start-up of the operation. Taking advantage of the technical cooperation program (ATN/FI-13262-BR),³⁶ which the Bank is currently implementing with the State of Sergipe and which has a balance of funds available, consultants will be hired to model the SES strategic unit, as envisaged in Component 1. Prior definition of their role, technical profiles and responsibilities will be essential to ensure fulfillment of the planned activities.

³⁶ Although the Strategic Unit is foreseen in Component 1, this technical cooperation program will support the pre-implementation phase, since its objective is to help several states in northeastern Brazil to strengthen the SUS.

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)	Individuals receiving a basic package of health services.			
2. Country Strategy Development Objectives		Aligned		
Country Strategy Results Matrix	GN-2662-1	i) Expand the supply of chronic degenerative disease prevention services, and ii) Improving the access, coverage, and quality of mother-child services and reduce regional inequalities.		
Country Program Results Matrix	GN-2756	The intervention is included in the 2014 Country Program Document.		
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
		9.0		10
3. Evidence-based Assessment & Solution		8.4	33.33%	10
3.1 Program Diagnosis		3.0		
3.2 Proposed Interventions or Solutions		2.4		
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		8.5	33.33%	10
5.1 Monitoring Mechanisms		2.5		
5.2 Evaluation Plan		6.0		
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: i) Budget, ii) Treasury, iii) Accounting and Reporting, iv) External Control, and v) Internal Audit. Procurement: i) Information System, ii) Shopping Method, iii) Contracting Individual Consultant, and iv) National Public Bidding.		
Non-Fiduciary	Yes	i) Strategic Planning National System; ii) Monitoring and Evaluation National System; and iii) Statistics National System.		
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:				
Gender Equality				
Labor				
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	Yes	Funds from ATN-FI-13262 were used to finance two diagnostic studies that were strategic in the design of this program. These are: Analise da Rede de Maternal and Child Atenção do Estado de Sergipe and Analise da Specialized Media Atenção Complexidade em Sergipe.		
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 indicators of interest for this evaluation strategy can be expressed as a functional relationship between individual characteristics and service offerings. The evaluation is expected to yield results that demonstrate the degree of effectiveness of the supply side intervention considering different population profiles and behaviors.		

The Program for Strengthening the Social Inclusion Network and Health Care - PROREDES - aims to improve the health of the population in Sergipe, especially the most vulnerable. To achieve this objective, the program supports strengthening of the management of the Unified Health System (SUS), the expansion of the physical network of medium and high complexity, and improving clinical practices.

The project proposal includes the diagnosis of main problems, a description of the target population, and a proposal of respective solutions. The logical framework presented in the POD is consistent, covering inputs, outputs, outcomes and impacts, including final indicators of the health of the population of Sergipe. Similarly, the results matrix includes indicators for major outputs, outcomes and impacts of the program. The indicators in the results matrix meet SMART criteria and include baseline values and targets.

The project has an economic cost-benefit analysis that supports the economic viability of the proposed activities. The results monitoring and evaluation will be undertaken by the Program Management Unit (UGP) that will be established in the Ministry of Health of the State of Sergipe. The monitoring and evaluation activities have been planned. The primary data source for monitoring indicators is DATASUS, the official system health information system for the country.

The impact assessment is quasi-experimental, using a difference in difference and instrumental variables strategy to measure the causal effects of the program on the health of the population.

RESULTS MATRIX

Project objective	The program's main objective is to help improve the health of the population of Sergipe, particularly the most vulnerable groups, reducing regional inequities and ensuring access to quality services. To that end, it will endeavor to strengthen the management of the Unified Health System (SUS), expand the physical medium- and high-complexity network, and improve clinical practice.
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Impact indicators ¹	Baseline	Target (Year 5)	Source	Calculation method
Premature deaths from diabetes mellitus (DM) (age 30 to 69)	Total: 290 Men: 146 Women: 144 Year 2011	Total: 249 Men: 125 Women: 124	Databank of the Unified Health System (DATASUS)	No. of premature deaths (ages 30 to 69) from DM / Resident population x 100,000. Diabetes: Categories E10-E14 of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).
Premature deaths from cerebrovascular accident (CVA) (ages 30 to 69)	Total: 118 Men: 64 Women: 54 Year 2011	Total: 101 Men: 55 Women: 46	DATASUS	No. of premature deaths (ages 30 to 69) from CVA / Resident population x 100,000. CVA: Category I-64 of ICD-10.
Rate of hospitalization for basic care	Total: 569.43 / 100,000 Year 2012	Total: 565 / 100,000 ²	DATASUS	No. of hospitalizations for basic care ³ / Resident population x 100,000.
Rate of maternal mortality from direct obstetric causes	62.99 / 100,000 live births (LB) Year: 2011	50 / 100,000 LB	DATASUS	No. of maternal deaths from direct obstetric causes / No. of live births x 100,000.
Mortality from cervical-uterine cancer	11.81 / 100,000 Year: 2011	9.33 / 100,000	DATASUS	No. of deaths from cervical-uterine cancer / Female population age 12 to 69 x 100,000.

¹ For a detailed description of the indicators see the descriptive annex.

² The historical series for this indicator does not show significant differences between the male and female group, so it was decided not to provide a gender breakdown.

³ See the causes in the annex describing the indicators.

Final outcome indicators	Baseline	Target (Year 5)	Source	Calculation method
Percentage of pregnant women classified as high-risk who attend prenatal checkups in their region of domicile	50.35% Year 2012	80%	DATASUS / Pregnancy healthcare system (SISPRENATAL)	No. of pregnant women classified as high-risk who attend prenatal checkups in their region of domicile / No. of pregnant women classified as high-risk who attend prenatal checkups throughout the state x 100.
Percentage of pregnant women diagnosed with syphilis who receive treatment in the first trimester of pregnancy	20.41% Year 2012	40%	DATASUS	No. of pregnant women diagnosed in the first trimester of pregnancy who receive treatment / Total No. of pregnant women diagnosed with syphilis during pregnancy.
Percentage of women diagnosed with breast cancer and cervical-uterine cancer who start treatment within 60 days in Sergipe	0	30%	DATASUS / Female cancer care system (SISCAN) / Cervical cancer care system (SISCOLO)	There is currently no way to calculate the baseline for this indicator, because the system will be only implemented in the fourth quarter of 2013.
Percentage of women completing a minimum of seven prenatal checkups	45.75% Year 2011	52%	DATASUS	No. of live births to mothers completing seven prenatal checkups / No. of live births x 100.
Percentage of persons recorded as suffering from diabetes and hypertension in basic health units who receive monitoring	92.65% ⁴ Year 2011	93%	DATASUS	No. of persons with diabetes and hypertension being monitored by the health team / Total No. of persons with diabetes and hypertension registered in basic health units x 100.
Percentage of women ages 50 to 69 undergoing an annual mammogram	10.20% Year 2012	18%	DATASUS	No. of mammograms performed on women ages 50 to 69 / Female population ages 50 to 69 x 100.
Percentage of women (ages 25 to 69) who undergo an annual cytopathological test for cervical-uterine cancer	14.61% Year 2011	20%	DATASUS / SISCOLO Brazilian Institute of Geography and Statistics (IBGE)	No. of cytopathological cervicovaginal tests performed in the group ages 25 to 69 / Female population ages 25 to 69 x 100.

⁴ There are thought to be inconsistencies in the information compiled for the baseline from the DATASUS Basic Care System (SIAB). As the indicator is crucial for monitoring improvements in the clinical management of noncommunicable chronic diseases (NCDs), the program will provide support for an investigation of the data, so the baseline may be amended.

OUTPUT INDICATORS

Component 1	Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Comments
Integrated information system with logical project concluded, tested, and validated	#	0 (2013)	0	1	0	0	0	1	
No. of healthcare networks with the system operating in their services and trained teams	#	0 (2013)	0	0	1	2	2	5	
Strategic core of the SES/SE structured and operating		0 (2013)		1	0	0	0	1	
Consulting services and strategic studies for the SES/SE	#	0 (2013)	3	3	2	0	0	8	Year 1: (i) Modeling of the RASs; (ii) Preparation of human resource strategy; (iii) Cost-effectiveness of laboratory services. Year 2: (iv) Quality and efficiency of health expenditure; (v) Modeling of the Regulation Center; (vi) Upgrading of management instruments. Year 3: (vii) Health transportation; and (viii) Household survey of disabled persons.
Regulation center constructed and implemented		0	0	0	1	0	0	1	
SUS / SE Professional Training and Skills Development Center constructed and operating		0	0	0	0	1	0	1	
SUS personnel trained	#	0	230	670	70	240	0	1,210	

Component 2		Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Comments
Medical specialty centers remodeled, expanded, and operating	#	0	0	1	1	1	2	5	
Central Laboratory (LACEN) constructed and operating	#	0	0	0	1	0	0	1	
LACEN accredited for quality	#	0	0	0	0	1	0	1	
Sergipe Oncology Hospital accredited for quality	#	0	0	0	0	0	1	1	
Mother-child healthcare line developed and validated	#	0	1	0	0	0	0	1	Development of the healthcare line envisages the creation / adoption of clinical protocols and care flows. Validation takes place in the Bipartite Intermanagement Commission.
Child healthcare line (ages 0 to 3) developed and validated	#	0	1	0	0	0	0	1	Idem previous comment.
Oncology healthcare line (including: breast, cervical-uterine, and prostate cancer, cancer of the oral cavity) developed and validated	#	0	0	0	1	0	0	1	Idem previous comment..
Chronic disease healthcare line (diabetes and cardiovascular) developed and validated	#	0	0	1	0	0	0	1	Idem previous comment.
Disabled persons healthcare line developed and validated		0	0	1	0	0	0	1	Idem previous comment.

NARRATIVE SUMMARY OF THE INDICATORS INCLUDED IN THE RESULTS MATRIX⁵

Impact indicators		
INDICATORS	CALCULATION METHOD	COMMENTS
Premature deaths from diabetes mellitus (DM) (under age 60)	Numerator: No. of deaths (ages 30 to 69) from DM registered in Codes E10-E14 of ICD-10. Denominator: Resident population (ages 30 to 69) x 100,000.	Target based on the “Pacto pela Saúde” [Covenant for Health] Directive 5, Objective 5.1, Universal Indicator 30 – SISPACTO / COAP 2013-2015 Used the national benchmark parameter: 2% reduction per year. Source: Health Surveillance Department (SVS/MS).
Premature deaths from CVA	Numerator: No. of deaths (ages 30 to 69) from CVA registered in the Codes I 64 of ICD-10. Denominator: Resident population (ages 30 to 69) x 100,000.	Target based on the “Pacto pela Saúde” [Covenant for Health] Directive 5, Objective 5.1, Universal Indicator 30 – SISPACTO / COAP 2013-2015 Used the national benchmark parameter: 2% reduction per year. Source: SVS/MS.
INDICATORS	CALCULATION METHOD	COMMENTS
Rate of hospitalization for conditions susceptible to basic care (<i>internações por condições sensíveis à atenção básica</i> – ICSAB)	Numerator: No. of hospitalizations ICD-10 (ICSAB list). Denominator: Resident population x 100,000. ICSAB List: A00-A09; A15-A19; A33-A37; A46; A50; A51-A53; A95; B26; B05-B06; B16; B50-B54; B77; D50; E10-E14; E40-E46; E50-E64; E86; G00.0; G40-G41; G45-G46; H66; I00-I02; I10-I11; I20; I50; I63-I67; I69; J00-J06; J13-J14; J15.3-J15.4; J15.8-J15.9; J18.1; J20-J21; J31; J40-J47; J81; K25-K28; K92.0; K92.1-K92.2; L01-L04; L08; N10-N12; N30; N34; N39.0; N70-N76; O23; P35.0	
Rate of maternal mortality from direct obstetric causes	Numerator: No. of maternal deaths from direct obstetric causes: ICD-10 Codes 00 to O08.9, O11 to O23.9, O24.4, and O26.0 to O92.7. Denominator: 100,000 LB.	
Mortality from cervical-uterine cancer	Numerator: No. of deaths from cervical-uterine cancer. Denominator: Female population ages 12 to 69 x 100,000. ICD-10 Codes: C53, C53.0, C53.1, C53.8, and C53.9.	As a result of the interventions and other ongoing actions, a reduction of 1.87% per year is expected.

⁵ For a more detailed description of the indicators and the calculation formula, see the annex.

INDICATORS	CALCULATION METHOD	COMMENTS
Final outcome indicators		
Percentage of pregnant women classified as high-risk who attend prenatal checkups in their region of domicile	Numerator: No. of pregnant women classified as high-risk attending prenatal checkups in their region of domicile. Denominator: No. of pregnant women classified as high-risk attending prenatal checkups in the state x 100.	Prenatal: Set of care procedures for pregnant women to ensure their health and that of the child, which involves clinical monitoring throughout pregnancy and the puerperium (40 days after delivery) following protocols based on their risk classification.
Percentage of pregnant women diagnosed with syphilis who receive treatment in the first trimester of pregnancy	Numerator: No. pregnant women diagnosed in the first trimester of pregnancy who receive treatment. Denominator: Total No. of pregnant women diagnosed with syphilis during pregnancy x 100.	Targets defined in the State plan to combat congenital syphilis.
Percentage of women diagnosed with breast cancer and cervical-uterine cancer who start treatment within 60 days in Sergipe	Numerator: No. of women diagnosed with breast cancer and cervical cancer who start treatment within 60 days. Denominator: No. of women with confirmed diagnosis for breast and cervical cancer.	This indicator aims to monitor compliance with Federal Law 12.732 / 2012, which requires the SUS to start providing cancer treatment within 60 days of a diagnosis being confirmed. SISCAN, the system that will be used to monitor patients diagnosed with cancer is in the implementation phase. Nonetheless it is a potential source of information for the program, which will include investments in early cancer detection services and implementation of the Sergipe Oncology Hospital.
Percentage of women completing at least seven prenatal checkups	Numerator: No. of live births to mothers who completed seven prenatal checkups . Denominator: No of live births X 100.	Target based on the “Pacto pela Saúde” [Covenant for Health] Directive 3, Objective 3.2, Universal Indicator 21 – SISPACTO / COAP 2013-2015.
Percentage of persons recorded in basic health units as suffering from diabetes and hypertension who receive monitoring	Numerator: No. of persons with diabetes and hypertension being monitored by the primary care health team. Denominator: Total No. of persons with diabetes and hypertension registered in basic health units x 100.	
Percentage of women ages 50 to 69 undergoing an annual mammogram	Numerator: No. of bilateral screening mammograms performed on women ages 50 to 69. Denominator: Female population ages 50 to 69 x 100.	Target based on the “Pacto Pela Saúde” [Covenant for Health] Directive 3, Objective 3.1, Universal Indicator 19 – SISPACTO / COAP 2013-2015.

INDICATORS	CALCULATION METHOD	COMMENTS
Percentage of women (ages 25 to 69) who undergo an annual cytopathological test for cervical-uterine cancer	Numerator: No. of cervical/vaginal cytopathological examinations performed on women ages 25 to 69. Denominator: Female population ages 25 to 69 x 100.	Target based on the “Pacto pela Saúde” [Covenant for Health] Directive 3, Objective 3.1, Universal Indicator 19 – SISPACTO / COAP 2013-2015.

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country: Brazil

Project number: BR-L1378

Name: Program for Strengthening Social Inclusion and Healthcare Networks (PROREDES)

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I. EXECUTIVE SUMMARY

- 1.1 The institutional evaluation for the project's fiduciary management was based on: (i) the country's fiduciary context; (ii) the results of the fiduciary risk evaluation; (iii) the institutional capacity of the State of Sergipe Health Department (SES/SE); and (iv) meetings held with the team. As a result, agreements applicable for project execution have been prepared for both procurement and financial management.

II. THE COUNTRY'S FIDUCIARY CONTEXT

- 2.1 Brazil has a solid and transparent regulatory and institutional framework, with robust country fiduciary systems that allow for adequate management of administrative, financial, internal control, and procurement processes, fulfilling the principles of transparency, economy, and efficiency. These systems need continuous fine-tuning and strengthening, however, to adapt still further to the new fiduciary requirements. In this regard, the Bank's fiduciary strategy for Brazil aims at making progressive, sustainable use of the country's fiduciary systems.
- 2.2 In 2011, the State of Sergipe (SE) implemented an integrated public sector management system (IGESP) that is operated by the State Finance Department (SEFAZ/SE). Use of the system is mandatory for all departments, public enterprises, and foundations in Sergipe. It contains an agreements administration module.
- 2.3 For the planning and organization of program actions, the entities use and abide by the following national management support instruments: (i) the multiyear plan, which sets the guidelines, objectives, and targets of the public administration; (ii) the annual Budgetary Procedures Law (LDO), which sets out the government's budgetary guidelines; (iii) the Annual Budget Law which estimates and specifies the expenses of the public administration for the current fiscal year; (iv) the Fiscal Responsibility Law, which sets limits on public administration

- expenses; and (v) the information systems (planning, accounting, financial management) that support management.
- 2.4 Procurement and contracting processes follow the National Tendering Law (8.666/93). Procurements of off-the-shelf goods and services use the federal government's online procurement system, COMPRASNET, which has been evaluated and accepted by the Bank.
- 2.5 Public sector entities in Brazil are controlled by State Audit Departments (Tribunais de Contas Estaduais–TCEs), and also by the Federal Audit Department (Tribunal de Contas da União–TCU) when federal funds are involved. Although control audits are performed annually, these audit bodies continuously monitor the financial transactions and processes of the entities by tracking the integrated financial management systems on a daily basis. Internal control audits are also performed by SEFAZ/SE.

III. THE EXECUTING AGENCY'S FIDUCIARY CONTEXT

- 3.1 The executing agency is the State of Sergipe Health Department (SES/SE), which is responsible for formulating state health policy and its directives, in accordance with the principles of the Unified Health System (SUS). The SES/SE will be assisted by a Program Management Unit (PMU), to be created through an appropriate legal instrument, and by a Special Bidding Committee (SBC) to execute program resources. As an exception, procurements using the reverse auction method will be implemented by the auctioneer team in the State Planning Department (SEPLAG).
- 3.2 The PMU will consist of a general coordinator, together with technical; planning, budget, and administration; and works coordination units.
- 3.3 As the SES/SE has no experience with the Bank's procedures, or with the number and scale of the interventions, particularly the works that are envisaged, a program management support and works supervision firm will be contracted to provide technical support with additional specialized staff.

IV. FIDUCIARY RISK EVALUATION AND MITIGATION ACTIONS

- 4.1 The capacity of the SES/SE to program, organize, execute, and control the operation was evaluated using the institutional capacity assessment system (ICAS). The results show that the Department has MEDIUM institutional capacity for program management and a MEDIUM level of institutional risk. On fiduciary issues, it was found that the technical staff of the SES lack experience in executing externally funded projects, and have no knowledge of the Bank's rules/policies. As this risk could hinder adequate and efficient program execution, it will be mitigated by: (i) creating a PMU, consisting of full-time staff and consultants, which will serve as the direct interlocutor between the SES and the Bank; (ii) contracting a program management support and works supervision

firm; (iii) creating and instituting an SBC to implement procurement and contracting processes financed from the loan proceeds, which will be implemented following the Bank's policies; (iv) upgrading the current financial system, or otherwise incorporating a program management system authorized by the Bank, which would include a financial and accounting management module to ensure that the financial functions fulfill the Bank's accountability requirements; (v) preparing Operating Regulations describing the flow of fiduciary processes in detail; and (vi) holding training and capacity-building events by the Bank's fiduciary team, for all personnel involved in program implementation.

V. CONSIDERATIONS FOR THE SPECIAL PROVISIONS OF THE CONTRACT

- 5.1 Program management will fulfill the Bank's rules on reporting and financial statements, and will provide any other information requested by it.
- 5.2 **Conditions precedent to the first disbursement:** (i) evidence that the Program Management Unit (PMU) has been set up; (ii) evidence that PMU staff have been appointed; (iii) creation of the program's Special Bidding Committee; (iv) entry into force of the program Operating Regulations under the terms previously agreed on with the Bank; and (v) start of the bidding process for contracting the project management support firm.
- 5.3 **Audited financial statements:** An independent external audit firm eligible for the Bank will be contracted to perform the annual audit of the program's financial statements and expenses, pursuant to Bank procedures. The documentation in support of expenses incurred will be reviewed ex post by the external auditors.
- 5.4 **Exchange rate to be used:** The choice will be defined during the negotiation.

VI. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

- 1. **Execution of procurement and contracting processes**
 - 6.1 The fiduciary agreements and requirements in relation to procurement specify the provisions to be applied and observed in all procurement and contracting processes provided for under the program.
 - a. **Procurement of works, goods, and nonconsulting services**
 - 6.2 Works, goods, and services, financed in whole or in part with IDB loan proceeds, will be procured or contracted pursuant to the Policies for the procurement of goods and works financed by the Inter-American Development Bank (document GN-2349-9, of March 2011).
 - 6.3 The Bank may recognize the modalities provided for in Law 10.520/2002, the Online Auction Law, in processes with an estimated cost per contract below the threshold set for international competitive bidding (ICB), provided the requirements specified in the Bank's procurement policies are respected, particularly in relation to: (i) the origin of the goods; (ii) the nationality of the

suppliers; (iii) changes to purchase orders; (iv) the prohibition of price bands; and (v) advertising in a national newspaper.

- 6.4 Application of the provisions of Law 10.520/2002 will be subject to the following thresholds: (i) electronic auction, using the COMPRASNET system for the procurement of off-the-shelf goods and services with an estimated cost of no more than US\$5 million; (ii) price list for the procurement of off-the-shelf goods with an estimated cost equal to or less than US\$5 million, with prior Bank authorization of such list; and (iii) in-person auction, for the procurement of off-the-shelf goods and services with an estimated cost equal to or less than US\$100,000. The Bank may cancel the use of one or more of the modalities described in this paragraph at any time during project implementation.

b. Selection and contracting of consulting services

- 6.5 Consulting services for the program, financed in whole or in part with IDB loan proceeds, will be selected and contracted pursuant to the Policies for the selection and contracting of consulting services financed by the Inter-American Development Bank (document GN-2350-9 of March 2011).
- 6.6 Consulting firms will be selected and contracted using the methods specified in Sections II (quality- and cost-based selection–QCBS) and III (Other selection methods) of document GN-2350-9, with the processes being structured on the basis of the directives and standards described in Section II (quality- and cost-based selection–QCBS)
- 6.7 To proceed with contracting processes, the executing agency will form shortlists of six selected firms that have met the technical requirements specified in the Call for Expressions of Interest.
- 6.8 Irrespective of the selection method used, when the estimated cost of the contract is US\$200,000 or more, per contract, the Call for Expressions of Interest will be published in UNDB online (international advertising).
- 6.9 Individual consultants, financed in whole or in part with proceeds from the Bank's loan, will be selected and contracted in accordance with Section V (Selection of Individual Consultants) of document GN-2350-9.

c. Retroactive financing.

- 6.10 As a charge against the loan proceeds, the Bank may retroactively finance up to US\$5 million (5% of the proposed loan amount) and recognize against the local contribution up to US\$8 million (20% of the estimated local contribution), in eligible expenses incurred by the borrower before the loan approval date, for final, architectural, and complementary designs and to procure program goods and works. To be eligible, such expenses will have fulfilled requirements substantially similar to those specified in the loan contract; will have been incurred no earlier than 14 June 2013, the project profile approval date; and in no circumstances will include expenses incurred more than 18 months before the loan approval date.

d. Recognition of expenditures. Not applicable.

e. Domestic preference. No domestic preference margins will apply.

2. Thresholds for Brazil (in US\$)

- 6.11 The threshold triggering the use of ICB will be made known to the borrower or executing agency, as the case may be, online at www.iadb.org/procurement. For procurements in amounts below the threshold, the selection method will depend on the complexity and characteristics of the procurement or contract in question, and the decision will be indicated in the procurement plan approved by the Bank. The threshold for including international consultants on the shortlist will also be indicated on the same website. Below that threshold, the shortlist may consist entirely of national consultants.

3. Main procurement processes

Activity	Type of bidding	Estimated date	Estimated amount (US\$)
Consulting services			
Contracting of consulting services for the SES/SE integrated information system	Quality- and cost-based selection (QCBS)	Jan-2015	2,500,000
Contracting of program management support	QCBS	Jan-2014	4,585,153
Goods and services			
Procurement of medical-hospital equipment for the Sergipe Oncology Hospital (HOSE)	Auction	Apr-2016	13,203,154 (various)
Procurement of computer hardware for the Aracaju Medical Specialty Center (Augusto Franco district)	Auction	Oct-2017	2,180,546
Works			
Execution of works of the SUS Permanent Education Center	National competitive bidding (NCB)	Apr-2014	11,301,943
Execution of works at the Central Laboratory (LACEN)	NCB	Dec-2014	5,478,878

4. Procurement supervision

- 6.12 It was agreed with the team that procurement processes (as identified in the procurement plan) financed in whole or in part by the Bank, as well as all procurement processes with an estimated cost above the ICB thresholds and all direct contracting, would be reviewed ex ante.

5. Special provisions

- Procurement plan: The executing agency will submit updates to the procurement plan covering the following 18 months, for review and approval by the Bank, annually or as needed.
- For the procurement of goods and nonconsulting services based on Law 10.520/2002—the Online Auction Law, the processes will be implemented in the COMPRASNET system.

6. Records and files

6.13 Program records and files will satisfy the following conditions at a minimum:

- a. The records/processes will contain original documentation, filed in chronological order.
- b. The records/files will be stored in a suitable environment intended for such purpose, with restricted access and preventive security measures, such as a smoking ban, access limited to authorized individuals, etc.;
- c. A record will be kept of all documentation on file.

VII. FINANCIAL MANAGEMENT AGREEMENTS AND REQUIREMENTS

1. Programming and budget

- 7.1 The SES/SE uses planning instruments such as the multiyear plan and the Annual Budget Law. The budget for program activities forms part of that Law.
- 7.2 For program execution, the budgetary resources will be recorded in the year of execution as an external source in the State of Sergipe's Integrated Financial Management System (IGESP), and all operations and resource management will be handled through this system.
- 7.3 The SES/SE team will ensure that the budgetary resources for the program, both the Bank's contribution and the local counterpart, are duly budgeted and secured for annual execution, in accordance with the operation's programming. Project resources will be used in executing the entity's budget.

2. Accounting and information system

- 7.4 The SES/SE operates the IGESP, and all SES/SE accounting, including for the project, will be recorded in this system. The IGESP allows for the extraction of accounting data to different environments, and it contains an exclusive agreements module. Nonetheless, it currently cannot identify program transactions with the characteristics required by the Bank (by source of financing, in dollars, and by investment category).
- 7.5 Accordingly, the SES/SE will develop a reporting system that makes it possible to extract the minimum financial information required from the project, pursuant to the Bank's requirements; this will be included in the operating manual, and the Bank will verify that it has been done. Otherwise, the SES/SE will procure a financial system that makes it possible to present this information in a reliable, timely manner.

3. Disbursements and cash flow

- 7.6 The program will use the State treasury system. Expenses will be subject to the budgetary and financial execution process and will be recorded in the IGESP.

- 7.7 The program will operate with funds advanced by the Bank to satisfy the project's actual liquidity needs for the following 180 days. To obtain an advance of funds, it will be necessary to submit a disbursement request accompanied by a financial plan reflecting funding requirements (cash flow) for a 180-day period.
- 7.8 The SES/SE will file an initial project financial plan with the Bank, indicating the annual schedule of disbursements for the program execution period. This initial plan will be used to prepare a more detailed one for the first year of execution, based on which the first advance of funds will be planned. For future advances of funds, at least 80% of resources previously advanced will need to be accounted for.
- 7.9 Documentation in support of expenses incurred will be reviewed ex post at the time of the annual audits or whenever the Bank so requests. The ex post review will be duly documented in a report structured according to the Bank's auditing requirements.
- 7.10 Expenditures deemed ineligible will be reimbursed from the local counterpart or other resources, at the Bank's discretion, depending on the nature of the ineligibility.

4. Internal control and internal audit

- 7.11 The environment and procedures for internal control, communication, information, and monitoring of the activities of the executing agency abide by Brazilian state and federal regulations.
- 7.12 Internal control of the SES/SE is performed by the SEFAZ/SE through the following two mechanisms: 1. Through a permanent internal control unit located in the SES/SE, which performs prior reviews of the financial transactions and processes generated in the SES/SE; and 2. Through the tracking and monitoring of the IGESP (all financial transactions are recorded in this system), in which the auditors have direct online access to control the financial activities of state departments.

5. External control and reporting

- 7.13 The external control of state departments is performed by Sergipe's TCEs and by the TCU, with control audits being performed annually, pursuant to the annual external audit plans. These audit departments continuously monitor the financial transactions and processes of the entities by tracking the IGESP.
- 7.14 At the present time, the TCE/SE is not eligible with the Bank to audit the financial statements of Bank-funded projects, so the SES/SE will hire a firm of external auditors eligible with the Bank. The project's audited financial statements will be presented annually no later than 120 days after the end of the fiscal year, pursuant to the provisions contained in document "OP-273-2-Financial Management Policy for IDB-financed Projects." The contents of the reports and opinions to be issued will abide by the terms of reference prepared by the executing agency and accepted by the Bank, in accordance with current international audit standards and

other norms, and with the procedures observed by the Bank. The audit services will be financed from the loan proceeds.

6. Supervision plan

7.15 The supervision plan is designed for a low-risk operation. It may be altered during project implementation, according to the risk circumstances prevailing, or to satisfy additional control needs decided upon by the Bank.

Supervision activity	Supervision plan			
	Nature-scope	Frequency	Entity responsible	
			Bank	Executing agency
PROCUREMENTS	Review of procurement processes and the contracting of works and consulting services	As indicated in the procurement plan	Sector and procurement specialist	Executing agency
	Review of processes above the ICB and direct contracting thresholds	Throughout implementation period	Sector and procurement specialist	Executing agency
	Supervision visit	Annual	Sector specialist and fiduciary team	
FINANCIAL	Ex post review of disbursements and procurements	Annual	Fiduciary team	Executing agency
		Annual	Fiduciary team	External auditors
	Annual audit	Periodic	Fiduciary team	
	Review of disbursement request			
	Supervision visit	Annual	Sector specialist and fiduciary team	External auditors
ELIGIBILITY AND COMPLIANCE WITH CONTRACTUAL CLAUSES	Budgetary forecast	Annual	Sector specialist and fiduciary team	Executing agency
	Presentation of audited financial statements	Annual	Sector specialist and fiduciary team	Executing agency and independent auditors
	Conditions precedent to the first disbursement	180 days from signing	Sector specialist and fiduciary team	Executing agency