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BRAZIL

PROGRAM FOR THE EXPANSION AND STRENGTHENING OF SPECIALIZED HEALTH CARE IN THE STATE OF CEARÁ

(BR-L1177)

LOAN PROPOSAL

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ABBREVIATIONS

ANVISA	Agência Nacional de Vigilância Sanitária [National Health Surveillance Agency]
AWP	annual work plan
CERES/SESA	Células Regionais de Saúde [Regional Health Cells] of SESA
CNES	Cadastro Nacional de Estabelecimentos de Saude [National Cadastre of Health Facilities]
CONAMA	Conselho Nacional do Meio Ambiente [National Environmental Council]
CORAC/SESA	Coordenação de Regulação, Avaliação, Auditoria e Controle [Regulation, Evaluation, Auditing, and Control Coordination Office] of SESA
CRES-SUS	Central de Regulação Estadual [State Central Referral Unit of the Unified Public Health System]
DATASUS	Banco de dados do Sistema Único de Saúde [Databank of the Unified Public Health System]
DER	Departamento de Edificações e Rodovias [Buildings and Roads Division] of Ceará
ESF	Estratégia Saúde da Família [family health strategy] of the federal government
ESP-CE	Escola de Saúde Pública do Ceará [Ceará School of Public Health]
IBGE	Instituto Brasileiro de Geografía y Estatística [Brazilian Institute of Geography and Statistics]
ICAS	Institutional Capacity Assessment System
INCA	Instituto Nacional de Câncer [National Cancer Institute]
PMU	Program Management Unit
PGRSS	Plano de Gerenciamento de Resíduos do Serviço de Saúde [health-care services waste management plan]
RDC	Resolução da Diretoria Colegiada [Resolution of the Board of Directors] of ANVISA
SEINFRA	Secretaria da Infra-estrutura do Estado do Ceará [State of Ceará Infrastructure Department]
SEPLAG	Secretaria Estadual de Planejamento e Gestão [State of Ceará Planning and Management Department]
SESA	Secretaria de Estado da Saúde [State of Ceará Department of Health]
SIA-SUS	Sistema de Informações Ambulatoriais do SUS [ambulatory information system of the Unified Public Health System]
SIGP	Sistema de Gerenciamiento del Programa [program management system]
SIH-SUS	Sistema de Informação Hospitalar [hospital information system of the Unified Public Health System]
SIM	Sistema de Informação de Mortalidade [mortality information system] of the Ministry of Health

SINASC	Sistema de Informação sobre Nascidos Vivos [live birth information system] of the Ministry of Health
SUS	Sistema Único de Saúde [Unified Public Health System]
WHO	World Health Organization

PROJECT SUMMARY

BRAZIL
PROGRAM FOR THE EXPANSION AND STRENGTHENING OF SPECIALIZED HEALTH CARE IN THE STATE OF CEARÁ
(BR-L1177)

Financial Terms and Conditions			
Borrower:	State of Ceará	Amortization period:	25 years
Guarantor:	Federative Republic of Brazil	Grace period:	5 years
Executing agency:	The borrower through its Department of Health (SESA)	Disbursement period:	5 years
		Interest rate:	LIBOR
Source	**Amount (in US$)**	Inspection and supervision:	*
IDB (OC)	77,000,000	Credit fee:	*
Local	46,470,600		
Total	123,470,600	Currency:	U.S. dollars from the Single Currency Facility

Project at a glance

Project objective:

The general objective is to help improve the health status of the population of Ceará by expanding access to and enhancing the quality of specialized health care services and promoting integration among the different levels of care.

Special contractual conditions precedent to the first disbursement:

(i) Evidence that the program management unit has been formally established and its main members appointed in accordance with the Operating Regulations agreed on with the Bank; and (ii) entry into force of the Operating Regulations.

Special execution conditions:

(a) ***Precedent to awarding contracts for works:*** Presentation to the Bank of all the environmental and social licenses required under federal and state environmental legislation; (b) presentation of evidence, to the Bank's satisfaction, prior to disbursement of more than 25% of the financing for each dental clinic and polyclinic, (i) that the proper legal instruments have entered into force with the respective municipalities or social organizations, including the ways in which these health units will be cofinanced, and (ii) that the call for proposals for the selection of the health care professionals who will work in the new establishments has been published; (c) the expenses related to the works under the component will not exceed 58% of the loan proceeds; (d) prior to the disbursement of the Component 1 resources, presentation of evidence to the Bank that the agreement signed between SESA and the Buildings and Roads Division (DER), regarding the activities to prepare bidding documents and supervise the works under the component, has been formalized; (e) prior to disbursement of the Component 2 resources, presentation of evidence to the Bank that the agreement signed between SESA and the Ceará School of Public Health (ESP-CE), regarding the training activities under the component, has been formalized.

Exceptions to Bank policy:	None				
Project qualifies as:	SEQ[X]	PTI [X]	SECTOR [ ]	GEOGRAPHIC [X]	HEADCOUNT [ ]

* The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with the applicable provisions of the Bank's policy on lending rate methodology for Ordinary Capital loans. In no case will the credit fee exceed 0.75% or the inspection and supervision fee exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problems addressed, and rationale

1.1 The state of Ceará is situated in northeastern Brazil, covers 148,825,602 km^2, and has a population of 8.2 million. The services sector accounts for 56.1% of the state's GDP, followed by industry with 37.3%. Although the economy has grown in the last decade, Ceará is one of the poorest states in the country, with high inequality and exclusion indexes, and 36.77% of its population living in extreme poverty.[1] Estimates by the Agência Nacional de Saúde Suplementar [Private Health Insurance Regulatory Agency] indicate that 91% of the state's population only has access to the public health system.

1.2 Ceará stands out for its adoption of innovative health care policies and for being a pioneer in implementing a primary care model, the results of which have been used as parameters for the formulation and introduction of Brazil's national basic health care policy. This model is distinguished by the fact that it is centered on the work of community health agents and family health care teams,[2] which are present in all municípios and maintain population coverage of close to 90%, with the exception of the capital, Fortaleza.[3] With regard to the national oral health policy, it was one of the first states to establish dental services in the basic health care units, with coverage extending to 48.9% of the population.[4]

1.3 Consistent with the introduction and continuation of this model, Ceará's health care system continues to present steady improvements in some indicators as a result of the increase in coverage of basic health care services and a reduction in infectious and parasitic diseases. With regard to children's health, the infant mortality rate has fallen from 32 per 1,000 live births in 1996 to 17.9 in 2006 (78.5% of these infant deaths are related to perinatal causes). The percentage of live births among mothers who attend four or more prenatal checkups has risen to 90.4% today.

1.4 In the last two decades, the mortality profile of the population of Ceará has changed, with an increase in the number of deaths caused by nontransmissible diseases. Between 1997 and 2006, there was a substantial rise in the proportion of deaths attributed to diseases of the circulatory system, neoplasia, external causes, and respiratory diseases, which, taken together, account for 70% of deaths in the state.

1.5 The maternal mortality rate remained high over the last decade, with an average of 120 deaths per 100,000 live births (the WHO considers a rate of up to 20 deaths

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1 The national average for extreme poverty is 19.31%. People in that category have incomes of less than R$125 a month. Fundação Getúlio Vargas, 2007.

2 Introduced in 1987, the primary health care model in Ceará began with community health agents and currently focuses on the family health strategy (ESF), which is implemented through multidisciplinary teams that are responsible for about 3,000 people living in a predefined reference area (health territory).

3 Implementation of the ESF has begun recently in the capital, which is why its coverage is low, at 17%.

4 See the National Oral Health Policy Guidelines of the Ministry of Health, 2004, for more details.

acceptable), meaning that the problem requires the attention of public health managers in Ceará. The situation is even worse when data from parts of the interior of the state are analyzed, particularly in the Sobral macroregion, which includes three of the five municípios with the highest maternal mortality rates (average of 148 deaths per 100,000 population). In terms of cause of death in these cases, 80% were classified as avoidable, which points clearly to the need for better quality of prenatal care, integrated into a network of diagnostic support services to identify and monitor risks and improve care during deliveries.

1.6 Associated with this situation, neonatal mortality (deaths occurring between days 1 and 28 of life) from perinatal causes such as prematurity, obstetrical trauma, asphyxia during delivery, septicemia, and congenital malformations, has also risen over the same period, accounting for 53.5% of deaths among babies under 12 months of age in 2006. This high rate of neonatal deaths corroborates the shortfall in the supply of diagnostic support services and hospital services for childbirth, with guaranteed neonatal treatment effectiveness.

1.7 The situation in Ceará with regard to the number of hospitalizations and deaths from external causes is also of concern. In 2007, it ranked fifth among the states with the highest rates of hospital admissions for wounds from assaults (41 for every 100,000 population) and first in the number of hospitalizations as a result of traffic accidents, at nearly 128 per 100,000 population or almost double the national average. Also, mortality from traffic accidents has been rising in regions of the state outside the metropolitan area, from 10.5 per 100,000 in 1996 to 21.6 per 100,000 in 2006.

1.8 The change in the epidemiological profile of the state's population in recent decades and the resulting demand have not been accompanied by the investments needed to provide infrastructure and a health-care services management model to respond adequately to these challenges.

1.9 **Specialized health care**. Pursuant to national guidelines for the sector, the State Department of Health (SESA) has structured its state health system into microregions and macroregions for the purposes of organizing secondary and tertiary health care. The health care regions are responsible for providing more complex services in the basic clinics (pediatrics, clinical medicine, gynecology and obstetrics), urgent and emergency care, and diagnostic and therapeutic support services.

1.10 At present, the state of Ceará has a network offering services of medium and high complexity that clearly reflects the disparities in the distribution of the physical network, particularly in the macroregion of Fortaleza and the two macroregions outside the metropolitan area, Sobral and Cariri. The hospital network outside Fortaleza is composed of small hospitals, mostly under 30 beds, with low technological density and low treatment effectiveness at the primary level. As a result, people must travel to hospitals in Fortaleza, which has 62 of the state's 100 general public hospitals and all of the specialized, urgent, and emergency care

public hospitals in the state. Also, the medium complexity services in Ceará, as in most of the country, present structural deficiencies owing to the financing practices of the Unified Public Health System (SUS), which historically has spurred growth in the supply of high complexity services through economic incentives for contracting more expensive services and procedures with the private sector. This policy was a disincentive for the supply of medium complexity services, leaving a gap at this level in the system.[5]

Macroregion	Population	SUS beds	Beds per 1,000 pop.
Fortaleza	5,232,062	8,425	1.61
Sobral	1,498,505	906	0.60
Cariri	1,366,709	1,717	1.26

1.11 The shortfall in the supply of medium complexity services is even more serious in the macroregions of Sobral and Cariri. Taking the need for visits to specialists as a parameter, as established in Directive 1101 issued by the Ministry of Health,[6] these regions present a serious shortfall in the coverage of such services. Applying the calculations established in that directive and considering the network's current production, 147,000 more visits would be needed in Sobral and 507,000 in Cariri. Looking at the availability of medical equipment for diagnostic and therapeutic support in Ceará, the situation is very similar, revealing disparities among the three health macroregions. Fortaleza has nearly 70% of the state's medical equipment (such as mammography and tomography systems and ultrasound and digestive endoscopy equipment).

1.12 These shortfalls translate into limitations on early diagnosis and treatment of diseases that compromise the circulatory system and of neoplasias, which are accounting for a growing proportion of mortality in the state. Unless corrective action is taken, there is a risk that the incidence of these diseases will continue to rise.

1.13 Accordingly, despite the efforts to organize the system on the state level and to offer an extensive primary care system, the population of Ceará faces problems of access to specialized health care services (hospitals, polyclinics, dental clinics) to treat their new epidemiological profile, particularly in areas outside Fortaleza. This situation has pushed health care services in Fortaleza to the limit and has led to deaths en route to the capital, among other problems.[7]

B. Program rationale

1.14 The government of the state of Ceará has proposed to consolidate the progress made and the results obtained in health care in recent decades through: (i) the

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[5] See: Afonso JR. SUS pra valer: com saúde fiscal e federativa. Seminario Renovar Idéias. Belo Horizonte, 2006.

[6] Portaría Ministerial No. 1101/GM of 12/06/2002, which establishes the parameters for health care coverage in Brazil, based on SUS guidelines.

[7] Of deaths within 48 hours after admission to a hospital, 48% involve people from outside Fortaleza (Sobral and Cariri macroregions).

realignment of the state health care network by implementing new services that promote enhanced treatment effectiveness, quality, and equal access in all the state's health regions; (ii) integration and cohesion between the new services and the existing primary care and specialized networks through a system of efficient regulation; and (iii) redirection of small hospitals to provide support for the specialized hospitals, operating as exits for the latter, given that long-term stays in clinical beds in facilities with high technological density cannot be justified, on account of the costs.

1.15 The proposed program is consistent with the guidelines for reorganizing health services in Ceará established in the master plan for regionalization (PDR)-Ceará-2006, which promotes integration of the different levels of care through the use of linkage mechanisms such as the referral and counter-referral system. Since 2004, Ceará has had a State central referral unit in the SUS (CRES-SUS) that receives and channels intermunicipal referrals for specialized consultations and examinations, elective hospitalizations, and emergency admissions.

1.16 The program's guidelines also coincide with the Bank's strategy with Brazil (2004-2007), which steers support towards actions that promote the organization, financing, and operation of the SUS. The Bank also stresses actions with subnational institutions to strengthen decentralization and bring government closer to the population and its problems. With Bank support, the state of Ceará will be able to carry out a large part of its project to expand and strengthen specialized care, responding to the challenges of consolidating an integrated health care system.

C. Objectives, components and costs

1.17 The general objective of the program is to help improve the health status of the population of Ceará by expanding access to and enhancing the quality of specialized health care services, and promoting integration among the different levels of care.

1.18 The program includes the components described below.

1.19 **Component 1. Expansion of specialized health care services (US$66.07 million)**. This component is intended to increase the coverage of specialized health care services with treatment effectiveness and quality. Based on studies of demand and the needs of the microregions and macroregions, the following will be financed: (i) infrastructure for expanding the network of medium- and high-complexity referral services, including the construction of a northern regional hospital (Sobral), nine type-2 polyclinics, and eleven dental clinics; and (ii) medical and dental equipment and other equipment necessary for the operation of the aforementioned infrastructure. O**nly up to 58% of the proceeds from the Bank's loan will be used to cover expenses incurred in the works.**

1.20 The new services will directly benefit 100 municípios and cover about 3 million people in the Sobral and Cariri microregions and macroregions. The municipalities participating in the program or the social organizations will sign proper legal

instruments with the state government, and also assume the obligation to provide counterpart resources for the startup and operation of the ambulatory services (dental clinics and polyclinics).

1.21 **Component 2. Strengthening of management and improvement in service quality (US$6.25 million).** This component will build up the management capacity of the department and the new health care units to enable them to adopt the technical and managerial parameters established in the quality certification standards.

1.22 **Subcomponent 2a.** *Institutional strengthening of SESA's management.* This subcomponent is intended to build SESA's capacity, particularly for supervision of the health units. It will finance: (i) technical assistance and consulting services for the design and implementation of a supervision model for the program's health units (ii) design, implementation, and training in the use of an information system for the integrated management of the new services and their interfaces with SESA's regional and central levels and the State Central Referral Unit of the SUS; (iii) studies and evaluations on implementation of the innovative management models in the program's health units and of user satisfaction; and (iv) communications to disseminate program activities.

1.23 **Subcomponent 2b**. *Strengthening of management and continuous improvement in the quality of health care services*. This subcomponent will ensure good managerial performance by the new services, with quality parameters defined in terms of health care and management. Management courses will be offered for 300 professionals, including the managers of the new services and SESA directors. Quality certification of the new specialized hospital and ambulatory units will also be promoted. As part of this subcomponent, consulting and technical assistance services, training, educational materials, publications of standards, and procurement of specific software to manage the certification programs will be financed.

1.24 **Component 3. Program administration and auditing (US$4.67 million)**. The following will be financed to support program execution: (i) technical assistance and implementation of the program management system; (ii) independent audits of the program; (iii) supervision and quality control of the works; (iv) the midterm and final evaluations of the program; and (v) other specialized technical services to support management.

1.25 The program will cost a total of US$123,470,600 with US$77 million to be financed by the Bank. The remaining US$46,470,600 will be provided as the local counterpart. The funds are broken down by component, subcomponent, and origin in the following table.

Table 1. Program costs (in US$)

Category	Source of financing		Total	% of the total
	IDB	Local		
Percentage	62.36%	37.64%	100%	
1. Expansion of specialized health care services	66,067,764	39,877,977	105,945,741	85.80
2. Strengthening of management and improvement in the quality of health care services	6,253,960	3,774,841	10,028,801	8.1
2.a Institutional strengthening of SESA management	3,578,070	2,159,695	5,737,765	4.6
2.b Strengthening of management and sustained improvement in the quality of health care services	2,675,890	1,615,146	4,291,036	3.5
3. Program administration and auditing	4,678,276	2,817,782	7,496,058	6.1
Total	**77,000,000**	**46,470,600**	**123,470,600**	**100**

*The borrower will pay interest and other financial costs with own resources, outside the program's cost table.

D. Results framework with key indicators

1.26 The SUS information systems and the program management and monitoring system will provide data for monitoring the output, outcome, and impact indicators established in the program's results framework. The expected results are: (i) improvement in access to and the quality of specialized health care services, with an increase of 50% in the coverage of medical visits in the state and a reduction in waiting time; (ii) reduction in the maternal mortality rate from 64.2 per 100,000 live births to 48 per 100,000 over a six-year period; (iii) reduction in the neonatal mortality rate in the Sobral macroregion from 11.4 per 1,000 live births to 9.7 per 1,000 by the end of the program; (iv) reduction of 15% in stage III and IV breast cancer reported; (v) hospital and out-patient services operating up to quality certification parameters; (vi) increase in visits to specialists referred by the basic health care units; and (vii) improvement in SESA's management capacity to guarantee optimization of the services network and resulting integrated health care.

II. FINANCIAL STRUCTURE AND MAIN RISKS

A. Financing instruments

2.1 **Investment loan**. Considering the nature of the program, where a large percentage of the financing will be used for investments in infrastructure, it has been determined that the most suitable financing instrument for this operation is an investment loan. The disbursement period is five years and the term for beginning construction of the works is four years, counting from the date on which the loan contract enters into force.

2.2 Table 2 presents the disbursement schedule for program funds.

Table 2. Disbursement flow (in US$)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total
IDB	11,549,440	16,169,216	23,098,880	17,709,141	8,473,323	77,000,000
Local	6,971,150	9,759,610	13,942,300	10,689,097	5,108,444	46,471,600
Total	18,520,590	25,928,826	37,041,180	28,398,238	13,581,766	123,471,600
Annual %	15%	21%	30%	23%	11%	100%

B. Environmental and social safeguards, risks, and mitigation measures

2.3 The Environmental and Social Impact Review (ESR) Committee classified the program as a category B operation. The program may have potential negative impacts in the event that solid health-care waste[8] produced in the health units to be built is disposed of untreated directly into the environment (land or water) on account of its organic load and the presence of persistent pathogens or toxins. To avoid negative environmental impacts and ensure positive social ones, the loan proceeds will be used in accordance with the Bank's Environmental and Safeguards Compliance Policy (OP-703), its Operational Policy on Indigenous Peoples (OP-765), and Brazilian environmental and social regulations, including access for the disabled.

2.4 In Brazil, the National Health Surveillance Agency (ANVISA) and the National Environmental Council (CONAMA) are responsible for regulating internal and external management of health-care waste. In particular, Resolution RDC ANVISA 306/04 and CONAMA Resolution 358/05 require each generator to draw up and implement a health-care service waste management plan (PGRSS),[9] which needs to be approved by the state's Department of the Environment as a requirement for licensing.

2.5 For each health-care infrastructure work included in the program, the executing agency will prepare and implement a PGRSS following national technical criteria and procedures to identify, evaluate, prevent, and mitigate potential negative impact, with a view to complying with national environmental and social regulations. During the proposed program, the executing agency will comply with the obligation to provide all the information needed for environmental monitoring related to the comprehensive management of solid waste, among other conditions and as appropriate. Accordingly, management of solid health-care waste will conform to current legislation and the negative impacts are expected to be small,

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[8] In the definition of solid health-care waste, CONAMA Resolution 005/1993 also includes liquid health-care waste. See *Manual de gerenciamento de resíduos de serviços de saúde*, Ministry of Health, ANVISA, 2006 (page 19).

[9] The PGRSS is a document that identifies and describes actions related to solid waste management based on its nature and potential risks, including aspects related to generation, separation, packing, collection, storage, transport, treatment, and final disposal, as well as other actions to protect the health of users and workers and the environment. See *Manual de gerenciamento de resíduos de serviços de saúde*, Ministry of Health, ANVISA, 2006.

local, and temporary. **As a special execution condition, together with the report on the contracts awarded for the works, the borrower will present all the environmental and social licenses required under federal and state environmental legislation.**

C. Fiduciary risk

2.6 When the operation was being prepared, the Bank's Institutional Capacity Assessment System (ICAS) was applied to evaluate SESA's management capacity. The evaluation resulted in a general rating of 74.78%, which means that the operation has medium fiduciary risk.[10]

2.7 Specifically, the evaluation of SESA's financial administration subsystem recognizes previous experience in the administration of programs financed by multilateral agencies such as the World Bank. The general evaluation of the subsystem resulted in a rating of 74.29%, which indicates a medium level of development and a medium level of risk for program execution.

2.8 To minimize or completely eliminate the risks identified and thereby establish the minimum conditions for satisfactory program execution, an institutional strengthening plan has been drawn up that includes the following main activities: (i) training for the members of the program management unit (PMU) in the accounting, administrative (semiannual reports), and financial (disbursement requests) procedures required by the Bank; (ii) implementation of a program management system that includes a module on financial and accounting administration to ensure that the PMU's budgeting and financial functions comply with the Bank's accountability requirements; (iii) reinforcement of the structure and composition of the PMU, particularly in the areas of planning, programming, and procurement, following the plan presented in the program's Operating Regulations; (iv) development and implementation of a computerized management system to integrate data from the health units, CRES-SUS, and SESA's regional and central offices, in order to monitor and evaluate the management contracts; and (v) contracting of specialized consultants to control the quality of the infrastructure and medical equipment to be financed. With a view to building up the executing agency's capacity, the establishment of a central body, tentatively known as the "management quality monitoring center" was proposed, which will design and implement the model for supervision, monitoring, and evaluation of the new health units.

D. Other issues and risks

2.9 **Execution capacity**. Application of the ICAS methodology to SESA indicated that the planning system has been developed to a satisfactory level and that the administrative organization system is developed to a medium level. The general risk associated with programming and organization capacities is therefore medium.

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[10] See the consultants' midterm report "Análisis Institucional" available in the technical files of SCL/SPH.

2.10 With regard to execution capacity, which represents the ability to develop planning processes and determine responsibilities for resource administration, the personnel administration system was found to be sufficiently developed as is the goods and services administration system. A verification of SESA's internal and external control capacity and the consultant's analysis indicate that the risks associated with both systems are low.

2.11 **Financial feasibility and sustainability.** The state's budget approved by the state congress in the first 15 days of 2008 authorizes R$80 million, which ensures that financial resources will be available for the first year of the program. The program's financial impact was also evaluated from the standpoint of the operating costs of all the new health units, estimated to be R$195 million a year. It is estimated that the bill to regulate constitutional amendment EC-29, passed by the congress in June 2008, will provide between R$350 million and R$400 million in additional resources a year for the State of Ceará's health sector. Starting in 2009, the municipal health care budgets are expected to grow by a similar amount.[11]

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation arrangements

3.1 **Borrower, executing agency, and guarantor**. The borrower will be the State of Ceará and the executing agency will be its Department of Health (SESA), through a program management unit (PMU). The Federative Republic of Brazil will be the guarantor of the loan.

3.2 **Executing agency**. SESA will execute the program using its existing organizational structure, delegating operational and financial administration responsibilities to the PMU, which will report to the Office of the Secretary of SESA. The main functions of the PMU include: (i) planning and coordination of program execution, including preparation and implementation of the annual work plans (AWPs); (ii) monitoring of progress in the program and compliance with the preestablished guidelines and goals; (iii) administrative and financial management of the program; (iv) planning and monitoring of the procurement of goods, services, and works, ensuring that the processes conform to the procurement and contracting policies agreed on with the Bank; and (v) coordination with SESA's different line agencies with specific responsibilities in the areas to be supported by the program. The PMU will contract an independent company to supervise execution of the program infrastructure works. A management quality monitoring center, to be formally created within SESA's organizational structure, connected to the Office of the State Secretary of Health, will be responsible for designing and implementing a model for supporting and monitoring the management commitments made by the entities in charge of the new specialized services.

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[11] Campelli MGR, Calvo MCM. Cumprimento da Emenda Constitucional nº. 29 no Brasil. *Cad. Saúde Pública*, 2007, Vol. 23, No.7, pages 1613-1623.

3.3 With regard to the new health care services to be implemented under Component 1, the regional hospitals will be managed by a social organization to be qualified and contracted pursuant to local legislation. For the dental clinics and polyclinics, the intermunicipal consortia management model or the social organization model may be adopted, based on a political, technical, and financial feasibility analysis. The contractual relationship between SESA and the management entities will be governed by proper legal instruments.

3.4 **Management and cofinancing agreements**. The dental clinics and polyclinics to be built under the program will provide services for the population of a microregion that covers more than one município. Considering that financing of health care services is primarily a municipal responsibility, it has been decided that the operating costs of the dental clinics and polyclinics will be shared by the State and the beneficiary municipalities, which will be established in management agreements. This means that the management costs will be financed with the resources of those entities and that Bank financing will not be used. To ensure the viability of the startup of the new services, **as a special execution condition, the borrower will present to the Bank's satisfaction, prior to disbursement of more than 25% of the financing for each dental clinic and polyclinic, evidence that proper legal instruments have entered into force, including a plan for cofinancing these health units, and that the notice of a public competition to select the health care professionals who will work in the new establishments has been published.**

3.5 The training activities in Component 2 will be carried out by the State of Ceará's School of Public Health (ESP), a decentralized agency attached to SESA. It was created in 1993 and is responsible for the development and delivery of training and continuing education programs for health care professionals in the state. The relationship between SESA and the ESP will be established in an agreement, the model for which is contained in the Operating Regulations, and does not require transfers of financial resources from the executing agency to the ESP. In accordance with State Governor's Decree 29190 of 19 February 2008, the ESP will only be assigned budget credits, but responsibility for managing the funds, including payments, will remain with SESA. **Entry into force of the agreement between SESA and the Ceará School of Public Health (ESP-CE), regarding the training activities, will be a special execution condition precedent to the first disbursement under Component 2.**

3.6 The following agencies, in addition to SESA, will participate in the program: (i) the Office of the State Attorney General, responsible under state law for conducting the bid processes; and (ii) the Buildings and Highways Division (DER), associated with the Infrastructure Department (SEINFRA), which is responsible under state law for the preparation of basic and final project designs for bids on physical infrastructure and for subsequent supervision of the works. **Entry into force of the agreement between SESA and the Buildings and Roads Division (DER) will be a special execution condition precedent to the first disbursement under Component 1.**

3.7 The program will be executed according to the operating, technical, and financial requirements, standards, and procedures established in the loan contract. The program Operating Regulations will set out in greater detail the functions and responsibilities of the agents involved in program execution. **The entry into effect of the Operating Regulations is a special contractual condition precedent to the first disbursement.**

3.8 **Maintenance of the works**. The borrower will undertake to maintain and/or require the municipalities to maintain the program works up to generally acceptable technical standards and undertakes to send the Bank maintenance reports for a period of three years after each work has been completed, and during the program execution period.

B. Procurement

3.9 Procurements of goods, works, and consulting services for the program will be carried out in accordance with the "Policies for the procurement of works and goods financed by the IDB" (document GN-2349-7) and "Policies for the selection and contracting of consultants financed by the IDB" (document GN-2350-7) and as established in the loan contract and the program's procurement plan. Table 3 summarizes the applicable procedures for each type of procurement, depending on the amounts involved.

Table 3. Procurement procedures

Investment category	Ceiling (in US$ thousands)	Procurement procedure
Works	25,000 and over 500 and over but under 25,000 Under 500	International competitive bidding National competitive bidding Price comparison
Goods	5,000 and over 100 and over but under 5,000 Under 100	International competitive bidding National competitive bidding Price comparison
Consulting services	200 and over 1,000 and over Under 1,000	International notice Short list with wide geographic representation Short list may consist of national consultants

3.10 The Bank's supervision will be performed on an ex ante basis, as stipulated in Appendix I of documents GN-2349-7 and GN-2350-7, for the procurement of goods and works paid for from the loan proceeds during the first year of execution and for the first two consulting assignment contracting processes. Based on the ex ante reviews and once it has been demonstrated to the Bank's satisfaction that SESA has an adequate system to manage and control procurement, the Bank may decide to monitor the remaining contracts with consulting firms in amounts below US$200,000, with individual consultants in amounts below US$100,000, and for the procurement of goods in amounts below US$5 million on an ex post basis.

3.11 **Recognition of expenditures**. The Bank may recognize up to the equivalent of US$1.2 million from the loan and up to US$700,000 from the counterpart for expenses incurred on activities under Components 1 and 2 that have been subject requirements equivalent to those established in the loan contract, provided they have been incurred between the date on which the project entered into the Bank's pipeline and the date on which the loan is approved by the Bank's Board of Executive Directors, but no earlier than 18 months prior to the date of approval.

3.12 **Revolving fund**. The revolving fund will be equivalent to 10% of the total loan.

3.13 **External auditing**. An independent firm of public auditors contracted by the borrower on the basis of terms of reference approved in advance by the Bank will audit the program's annual financial statements following the stipulations contained in the General Conditions of the loan contract. The Ceará Auditor General's Office, via prior certification by the Bank, may undertake audits of the program. The cost of the audits will be financed by the program.

C. Summary of monitoring and evaluation arrangements

3.14 The semiannual program monitoring reports prepared by SESA will discuss overall program performance, the progress made in executing each of the components, and the development of the monitoring indicators selected in the results framework (Annex I).

3.15 In addition, two independent external evaluations will be performed. The first will be conducted halfway through the disbursement period or when 50% of the loan proceeds have been committed (whichever comes first). When 80% of the funds have been committed, the borrower will commission the final evaluation, which will examine: (i) the results achieved by the program, measured in terms of the targets reached and the performance indicators established in the results framework; (ii) the pertinence and effectiveness of processes and interventions; and (iii) management of the loan proceeds.

3.16 The borrower has indicated that it will not perform an ex post evaluation. However, the information compiled as part of the program evaluations could be used as a direct input for one. The borrower undertakes to compile the information needed for the Project Completion Report and make it available, in accordance with Bank policy OP-305.

D. Significant design activities after approval

3.17 Within 18 months after the program begins, counting from the date on which the loan contract enters into force, the definition of the following activities will be completed: (i) design and implementation of the integrated health care management system; (ii) the detailed review of the proposals for training courses for SESA managers and technical staff, including the production of educational materials; (iii) completion of data collection for the baseline; and (iv) review of the model for legal instruments adopted for the intermunicipal management agreements (social organizations or consortia). Within the first 12 months of the period in question, the

borrower undertakes to establish and deploy the management quality monitoring center.

RESULTS FRAMEWORK
MATRIX OF INDICATORS

Project objective	To help improve the health status of the population of Ceará by expanding access to and enhancing the quality of specialized health care services and promoting integration among the different levels of care.			
Outcome indicators	**Baseline 2007**	**Interim target 2010**	**Final target 2013**	**Comments**
1. Maternal mortality rate in Ceará	64.2	55.3	48.0	Number of deaths of women living in the state up to 42 days after delivery/100,000 live births among women living in the state. Source: SIM/SINASC
2. Neonatal mortality rate in the Sobral macroregion	11.4	10.3	9.7	Number of neonatal deaths in the Sobral macroregion of infants 0 to 27 days old x 1,000/total number of live births to mothers living in the Sobral macroregion. Source: SIM/SINASC
3. Average waiting time for specialized medical care at the Ceará polyclinics	*	3 (months)	1 (month)	Average number of days between the date on which an appointment is requested and the date on which it takes place in the polyclinics. Source: SESA/CRESUS/CORAC
4. Percentage of managed access to care in polyclinics and dental clinics	*	50	80	Number of managed accesses to polyclinics and dental centers/total number of accesses to polyclinics and dental clinics Source: SESA/CRESUS/CORAC
5. Percentage of stage III and IV breast cancer cases recorded	47.6	45.5	38	Number of cases of stage III and IV breast cancer/number of cases of breast cancer reported by stage x 100. Source: Cancer Hospital Records – National System – INCA

* SESA will be compiling data for the baseline through 2008.

Component 1: Expansion of specialized health care services	Baseline 2007	Year 1 2009	Year 2 2010	Year 3 2011	Year 4 2012	Year 5 2013	Comments
OUTPUTS							
6. Number of hospital beds provided under the program	0	0	0	190	235	254	Data source: CORAC/SESA/CNES
7. Number of polyclinics in operation provided under the program	0	2	4	7	9	9	Data source: CORAC/SESA/CNES
8. Number of dental clinics in operation provided under the program	0	4	6	9	11	11	Data source: CORAC/SESA/CNES
OUTCOMES							
9. Specialized coverage/person/year	0.2	0.21	0.22	0.26	0.28	0.30	Data source: SIA-SUS/CORAC/SESA + IBGE (pop.)
10. Coverage of specialized dental procedures	0.057	0.07	0.08	0.90	0.10	0.11	Data source: SIA-SUS/CORAC/SESA
11. Specific coverage of endodontic procedures	0.007	0.010	0.014	0.015	0.016	0.017	Data source: CRESUS/NUASB/CERES

Component 2: Institutional strengthening of SESA and health-care services management	Baseline 2007	Year1 2009	Year 2 2010	Year 3 2011	Year 4 2012	Year 5 2013	Comments
OUTPUTS							
12. Public hospital services certified	1	1	1	1	2	3	Data source: Certification agency SIGP
13. Number of polyclinics receiving coaching visits from the certifying agency	0	0	11	18	20	20	Data source: Certification agency SIGP
14. Number of polyclinics certified	0	0	2	6	8	10	Source: Certification agency SIGP
15. Number of dental clinics certified	0	0	8	14	16	16	Data source: SESA and SIGP
16. SESA trainers, technical staff, and managers trained	0	130	190	250	310	310	Data source: Ceará Public Health School (ESP/SESA)
OUTCOMES							
17. Management quality supervision center established and operating	0	1	1	1	1	1	Data source: SESA
18. Percentage of units with health care targets established in management contracts	0	30	50	70	80	90	Data source: SESA/Management quality supervision center
19. Percentage of units in operation that attain 80% of the agreed targets	0	0	20	50	70	80	Data source: SESA/Management quality supervision center

SUMMARY OF THE PROCUREMENT PLAN

Description	Estimated cost (US$)	Procurement method	Review	Source of financing and percentage		Prequalification (Yes/no)	Estimated dates of publication of the specific procurement notice/end of contract		Status
				IDB %	Local %				
1. Goods									
1. Medical and hospital equipment, surgical instruments, electronic equipment, and furniture for the Zona Norte Regional Hospital (HZN)	13,802,953.83	ICB	Ex ante	62.38	37.62	No	Nov./09	Oct./10	In preparation
2. Medical equipment, furniture, and instruments for type II polyclinic – Caucaia	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Sept./09	Feb./10	In preparation
3. Medical equipment, furniture, and instruments for type II polyclinic – Barbalha	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Dec./09	May/10	In preparation
4. Medical equipment, furniture, and instruments for type II polyclinic - Campos Sales	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Dec./09	May/10	In preparation
5. Medical equipment, furniture, and instruments for type II polyclinic – Crateús	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Sept./09	Feb./10	In preparation
6. Medical equipment, furniture, and instruments for type II polyclinic – Iguatu	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Feb./10	Jul./10	In preparation
7. Medical equipment, furniture, and instruments for type II polyclinic – Maracanaú	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Sept./09	Feb./10	In preparation
8. Medical equipment, furniture, and instruments for type II polyclinic – Quixadá	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Feb./10	Jul./10	In preparation
9. Medical equipment, furniture, and instruments for type II polyclinic – Sobral	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Dec./09	May/10	In preparation
10. Medical equipment, furniture, and instruments for type II polyclinic – Tianguá	1,963,488.16	NCB	Ex ante	62.38	37.62	No	Feb./10	Jul./10	In preparation
11. Dental equipment, furniture, and instruments for the dental clinic in Caucaia	298,365.70	NCB	Ex ante	62.38	37.62	No	Apr./09	Sept./09	In preparation
12. Dental equipment, furniture, and instruments for the dental clinic in Quixeramobim	298,365.70	NCB	Ex ante	62.38	37.62	No	Aug./09	Jan./10	In preparation
13. Dental equipment, furniture, and instruments for the dental clinic in Brejo Santo	298,365.70	NCB	Ex ante	62.38	37.62	No	Aug./09	Jan./10	In preparation
14. Dental equipment, furniture, and instruments for the dental clinic in Camocim	298,365.70	NCB	Ex ante	62.38	37.62	No	Aug./09	Jan./10	In preparation
15. Dental equipment, furniture, and instruments for the dental clinic in Limoeiro do Norte	298,365.70	NCB	Ex ante	62.38	37.62	No	Aug./09	Jan./10	In preparation
16. Dental equipment, furniture, and instruments for the dental clinic in Iço	298,365.70	NCB	Ex ante	62.38	37.62	No	Jun./09	Nov./09	In preparation
17. Dental equipment, furniture, and instruments for the dental clinic in Maracanaú	298,365.70	NCB	Ex ante	62.38	37.62	No	Apr./09	Sept./09	In preparation
18. Dental equipment, furniture, and instruments for the dental clinic in Cascavel	298,365.70	NCB	Ex ante	62.38	37.62	No	Apr./09	Sept./09	In preparation

Description	Estimated cost (US$)	Procurement method	Review	Source of financing and percentage		Prequalification (Yes/no)	Estimated dates of publication of the specific procurement notice/end of contract		Status
				IDB %	Local %				
19. Dental equipment, furniture, and instruments for the dental clinic in Itapipoca	298,365.70	NCB	Ex ante	62.38	37.62	No	Aug./09	Jan./10	In preparation
20. Dental equipment, furniture, and instruments for the dental clinic in Crateús	298,365.70	NCB	Ex ante	62.38	37.62	No	Jun./09	Nov./09	In preparation
21. Dental equipment, furniture, and instruments for the dental clinic in Canindé	298,365.70	NCB	Ex ante	62.38	37.62	No	Jun./09	Nov./09	In preparation

ICB: International competitive bidding; **LIB**: Limited international bidding; **NCB**: National competitive bidding; **PC**: Price comparison; **DC**: Direct contracting; **FA**: Force account; **PSA**: Procurement through specialized agencies; **PAs:** Procurement agents; **IA:** Inspection agents; **PLFI**: Procurement in loans to financial intermediaries; BOO/BOT/BOOT**:** Build, own, operate/build, operate, transfer/build, own, operate, transfer; **PBP**: Performance-based procurement; **PLGB:** Procurement under loans guaranteed by the Bank; **PCP**: Community participation procurement; **QCBS**: Quality- and cost-based selection; **QBS**: Quality-based selection **FBS**: Selection under a fixed budget; **LCS**: Least-cost selection; **CQS**: Selection based on the consultants' qualifications; **SSS:** Single-source selection.

Description	Estimated cost (US$)	Procurement method	Review	Source of financing and percentage		Prequalification (Yes/no)	Estimated dates of publication of the specific procurement notice/end of contract		Status
				IDB %	Local %				
2. Works									
1. Zona Norte Hospital – Sobral	39,534,883.72	ICB	Ex ante	62.38	37.62	No	Jan./09	Oct./10	Final project design in preparation
2. Polyclinic II – Caucaia	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Mar./09	Feb./10	Administrative process in the DER
3. Polyclinic II – Barbalha	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Jun./09	May/10	Awaiting documentation for the land
4. Polyclinic II – Campo Sales	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Jun./09	May/10	Awaiting documentation for the land
5. Polyclinic II – Crateus	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Mar./09	Feb./10	Administrative process in the DER
6. Polyclinic II – Iguatu	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Aug./09	Jul./10	Administrative process in the DER
7. Polyclinic II – Maracanau	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Mar./09	Feb./10	Documentation for the land
8. Polyclinic II – Quixadá	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Aug./09	Jul./10	Land under review by the DER
9. Polyclinic II – Sobral	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Jun./09	May/10	Land under review by the DER
10. Polyclinic II - Tianguá	2,899,709.30	NCB	Ex ante	62.38	37.62	No	Aug./09	Jul./10	Documentation for the land
11. Dental clinic – Caucaia	505,191.28	NCB	Ex ante	62.38	37.62	No	Jan./09	Sep./09	Documentation for the land
12. Dental clinic – Quixeramobim	505,191.28	NCB	Ex ante	62.38	37.62	No	May/09	Jan./10	Documentation for the land
13. Dental clinic – Brejo Santo	505,191.28	NCB	Ex ante	62.38	37.62	No	May/09	Jan./10	Documentation for the land
14. Dental clinic – Camocim	505,191.28	NCB	Ex ante	62.38	37.62	No	May/09	Jan./10	Documentation for the land
15. Dental clinic - Limoeiro do Norte	505,191.28	NCB	Ex ante	62.38	37.62	No	May/09	Jan./10	Documentation for the land
16. Dental clinic - Icó	505,191.28	NCB	Ex ante	62.38	37.62	No	Mar./09	Nov./09	Land regularization
17. Dental clinic - Maracanau	505,191.28	NCB	Ex ante	62.38	37.62	No	Jan./09	Sept./09	Land regularization
18. Dental clinic - Cascavel	505,191.28	NCB	Ex ante	62.38	37.62	No	Jan./09	Sept./09	Land regularization
19. Dental clinic - Itapipoca	505,191.28	NCB	Ex ante	62.38	37.62	No	May/09	Jan./10	Land regularization
20. Dental clinic - Crateús	505,191.28	NCB	Ex ante	62.38	37.62	No	Mar./09	Nov./09	Administrative process in the DER
21. Dental clinic - Canindé	505,191.28	NCB	Ex ante	62.38	37.62	No	Mar./09	Nov./09	Land use ceded by the Ministry of Health

US$1 = R$1.72 (September 2008)

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Description	Estimade cost (US$)	Procurement method	Review	Source and percentage of financing		Prequalification (Yes/no)	Estimated dates of publication of the specific procurement notice/end of contract		Status
				IDB %	Local %				
3. Consulting services									
Strengthening management and improving the quality of services and program administration									
Consulting services to design a model for supervising the health care units	493,784.00	QCBS	Ex ante	62.38	37.62	No	Jan./09	Dec./10	Pending
Preparation and implementation of the integrated health care management system	5,043,882.17		Ex ante	62.38	37.62	No	Jan./09	Dec./10	In preparation
Consulting services to prepare a model for dental clinic certification	100,000.00	QCBS	Ex ante	62.38	37.62	No	Jan./09	Dec./10	Pending
Dental clinic certification program	316,279.07	QCBS	Ex ante	62.38	37.62	No	Apr./10	May/12	Pending
Accreditation of hospitals and polyclinics	3,197,674.42	DC	Ex ante	62.38	37.62	No	Aug./10	Dec./12	Pending
Implementation, personalization, and technical assistance services for use of the program management system	350,000.00	QCBS	Ex ante	62.38	37.62	No	Jan./09	Dec./10	Pending
External auditing	617,230.00	SCC	Ex ante	62.38	37.62	No	Sept./09	Apr./13	Pending
Consulting services for the midterm and final evaluations	1,234,460.00	QCBS	Ex ante	62.38	37.62	No	Jun./09	Apr./13	Pending
Services to supervise and monitor works	1,266,485.49	QCBS	Ex ante	62.38	37.62	No	Jan./09	Dec./10	In preparation
Consulting services to evaluate user satisfaction with the health care units	100,000.00	QCBS	Ex ante	62.38	37.62	No	Apr./11	Feb./12	Pending
Consulting services to publicize program activities	100,000.00	QCBS	Ex ante	62.38	37.62	No	Oct./11	Apr./12	Pending
Contracts for other specialized services	123,394.60	QCBS	Ex ante	62.38	37.62	No	Jan./09	Dec./10	Pending

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DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE___/09

Brazil. Loan _____/OC-BR to the State of Ceará
Program for the Expansion and Strengthening of
Specialized Health Care in the State of Ceará

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the State of Ceará, as Borrower, and the Federative Republic of Brazil, as Guarantor, for the purpose of granting the former a financing aimed at cooperating in the execution of a program to expand and strengthen specialized health care in the State of Ceará. Such financing will be in the amount of up to US$77,000,000 from the resources of the Single Currency Facility of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

LEG/SGO/CSC/IDBDOCS# 1956393
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