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BRAZIL

CITY OF SÃO PAULO HEALTH CARE NETWORKS RESTRUCTURING AND QUALITY CERTIFICATION PROJECT – AVANÇA SAÚDE SP

(BR-L1429)

LOAN PROPOSAL

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LINKS

REQUIRED

1. Project execution plan and annual work plan
2. Monitoring and evaluation plan
3. Environmental and social management report
4. Procurement plan

OPTIONAL

1. Project economic analysis
2. Climate change
3. Project works – basic designs
4. Safeguard policy filter and safeguard screening form
5. Draft Operating Regulations

ABBREVIATIONS

AWP	Annual work plan
CGM	Controladoria Geral do Município de São Paulo [Office of the Controller General of São Paulo]
CNES	Cadastro Nacional de Estabelecimentos de Saúde [National Register of Health Care Facilities]
DATASUS	Departamento de Informática do Sistema Único de Saúde [Information Technology Department of the Unified Health System]
ESMP	Environmental and Social Management Plan
HDI	Human Development Index
ICB	International competitive bidding
LOA	Lei Orçamentária Anual [Annual Budget Law]
NCB	National competitive bidding
PCU	Project coordination unit
PGM	Procuradoria Geral do Município [Attorney General of the Município]
QCBs	Quality- and cost-based selection
RUE	Rede de urgência e emergência [urgent and emergency care network]
SEADE	Sistema Estadual de Análise de Dados [state data analysis system]
SIA	Sistema de Informações Ambulatoriais [outpatient information system]
SIH	Sistema de Informações Hospitalares [hospital information system]
SINASC	Sistema de Informações sobre Nascidos Vivos [live births information system
SIURB	Secretaria Municipal de Infraestrutura Urbana e Obras [Municipal Urban Infrastructure and Works Department]
SMS	Secretaria Municipal de Saúde [Municipal Health Department]
SOF	Sistema de Presupuesto y Finanzas [Budget and Finance System]
SUS	Sistema Único de Saúde [Unified Health System]

PROJECT SUMMARY

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<table>
<tr><th colspan="6">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="2">Borrower: Município of São Paulo</td><td colspan="2">Flexible Financing Facility[a]</td><td></td></tr>
<tr><td>Amortization period:</td><td>17 years</td></tr>
<tr><td colspan="3" rowspan="2">Guarantor: Federative Republic of Brazil</td><td>Disbursement period:</td><td>5 years</td></tr>
<tr><td rowspan="2">Grace period:</td><td>7.5 years[b]</td></tr>
<tr><td colspan="3">Executing Agency: Município of São Paulo, through the Municipal Health Department</td><td></td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Interest rate:</td><td>LIBOR-based</td></tr>
<tr><td rowspan="2">IDB (Ordinary Capital):</td><td rowspan="2">100,000,000</td><td rowspan="2">50</td><td>Credit fee:</td><td>[c]</td></tr>
<tr><td>Inspection and supervision fee:</td><td>[c]</td></tr>
<tr><td>Local:</td><td>100,000,000</td><td>50</td><td>Weighted average life:</td><td>12.25 years [d]</td></tr>
<tr><td>Total:</td><td>200,000,000</td><td>100</td><td>Approval currency:</td><td>U.S. dollar (from the Ordinary Capital)</td></tr>
<tr><th colspan="6">Project at a Glance</th></tr>
<tr><td colspan="6">Project objective/description: The project's objective is to contribute to improving the health conditions of the Município of São Paulo's population, by enhancing service access and quality and improving system performance, through consolidation of the health care networks approach.</td></tr>
<tr><td colspan="6">Special contractual conditions precedent to the first disbursement of the loan: The following will be special contractual conditions precedent to the first disbursement of the loan proceeds: (i) approval and entry into force of the project Operating Regulations, under the terms previously agreed upon with the Bank; (ii) establishment of the project coordination unit and appointment of its members; and (iii) signature and entry into force of the cooperation agreement between the Municipal Urban Infrastructure and Works Department and the Municipal Health Department, under the terms previously agreed upon with the Bank (paragraph 3.4).</td></tr>
<tr><td colspan="6">Special contractual conditions for execution: See Annex III, Fiduciary Agreements and Requirements. In addition, the borrower will comply with the special contractual conditions for execution set out in the environmental and social management report – Annex B.</td></tr>
<tr><td colspan="6">Exceptions to Bank policies: none</td></tr>
<tr><th colspan="6">Strategic Alignment</th></tr>
<tr><td colspan="2">Challenges:[e]</td><td colspan="2">SI ☑</td><td>PI ☐</td><td>EI ☐</td></tr>
<tr><td colspan="2">Crosscutting issues:[f]</td><td colspan="2">GD ☑</td><td>CC ☑</td><td>IC ☐</td></tr>
</table>

(a) Under the Flexible Financing Facility (FFF) (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule as well as currency and interest rate conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

(b) Under the flexible reimbursement options provided by the FFF, changes in the grace period are possible provided that the original weighted average life of the loan and the last payment date, as documented in the loan contract, are not exceeded.

(c) 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.

(d) The original average weighted life may be shorter, based on the effective date of signature of the loan contract.

(e) SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration). The original weighted average life may be shorter depending on the effective signature date of the loan contract.

(f) GD (Gender Equality and Diversity); CC (Climate Change and Environmental Sustainability); and IC (Institutional Capacity and Rule of Law).

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, and rationale

1.1 The Município of São Paulo displays some of the characteristics inherent in a metropolis: high population density, enormous intraregional inequalities, and increased aging of the population that is uneven among the regions. As the main economic capital of South America, its 12 million inhabitants face challenges that are typical of urban agglomerations: tension from the pace of everyday life, pressure from situations and risk of violence, and complications from poor mobility, which cause ongoing stress and, by extension, multiple variants of physical and psychological disorders and diseases.[1] These are determining factors in community health conditions, requiring services that adapt constantly and have the capacity to respond quickly and efficiently. As life expectancy rises, health care demands become more complicated. São Paulo is seeking to implement a new framework for public action to address the changing health care demands specific to each territory.

1.2 **Health challenges.** São Paulo's morbidity and mortality profile reflects the significant socioeconomic and historical disparities between regions. In some areas of the city, chronic, noncommunicable diseases are the prevailing health conditions. In others, however, the rate of infectious diseases and maternal and child mortality reflect the lags common to developing countries. For example, the mortality rate from diseases of the circulatory system is 27.78 in Campo Belo, a region in southern São Paulo, while it is 9.34 in Anhangüera, which is in the northern part of the município. Conversely, the infant mortality rate is 8.24 in Campo Belo and 15.14 in Anhangüera (2015, SINASC/SMS), reflecting the pronounced epidemiological differences between regions. These differences are also corroborated in life expectancy at birth, which varies significantly among the city's neighborhoods. It ranges from 53.85 to 79.67 years of age between less and more developed areas.

1.3 **The Unified Health System (SUS).** Brazil instituted the SUS In the 1988 Federal Constitution and the rules governing the system were issued in 1990. Its core principle is universal and equitable access to health promotion, protection, and recovery services, within regionally-based, hierarchical service delivery networks. Responsibility for the networks and financing are shared among the federal, state, and municipal levels of government, and supplemented by private sector involvement. The Ministry of Health steers policy and establishes the SUS's guidelines, while the states promote the integration of services among regions and provide supplemental health care. In turn, the municípios provide services directly to the population and are exclusively responsible for basic health care.

1.4 **The SUS in São Paulo.** Health care services in the município only began to be reorganized and expanded in accordance with SUS guidelines in 2001. As a result of this delay in implementing the SUS,[2] development of the system's planning and

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[1] Psychiatric epidemiology classifies these stress-causing environmental situations as life events, which, in contexts of significant urban growth, can become chronic, unleashing a series of negative impacts on individuals' health. See: Margis et al. *Relação entre estressores, estresse e ansiedade*. *Revista Psiquiátrica RS*, V.5, 25, 65-74, April 2003.

[2] Most Brazilian municípios, particularly the capitals, had already begun this process at the start of the 1990s.

organization processes and the structuring of services lagged significantly. These organizational weaknesses, compounded by São Paulo's sociodemographic complexity, resulted in the implementation of a system reacting to urgent demands while lacking integration and efficiency.[3] Moreover, in many cases, this gradual expansion of care structures was not aligned with the health care needs of each territory, generating a disconnect between supply and demand. A heterogeneous network was set up in which various services with different names, clinical guidelines, and management methods covering identical or similar demands coexist. Today São Paulo has an enormous public network of 947 health service facilities, including 453 basic units, 19 hospitals, 48 urgent and emergency centers, and 47 medium-complexity centers. There are also 26 state hospitals under its management and approximately 150 private facilities under contract.[4] Adding to this complicated picture, the município is the regional and national referral hub for highly complex services: almost 40% of the network's high-complexity supply is used by patients from the rest of the state and other regions of the country.

1.5 **Infrastructure deficiencies and quality issues.** Despite the magnitude of its physical network, the city of São Paulo's services are insufficient and some lack adequate structures, especially in the historically more underserved regions. Hospital care reflects these significant inequalities. For example, the district of Jardim Paulista, with a high Human Development Index (HDI)[5] of 0.96, has 35.5 beds per 1,000 inhabitants, while in districts in the extreme southern region and in the northern region (with HDIs of 0.75 and 0.78, respectively), the number of hospital beds per 1,000 population is only 0.32 and 1.08, respectively. Half the districts in these regions lack hospital beds. These health care service gaps in regions with high levels of social vulnerability, where the population relies on SUS services exclusively, deepen the inequities between social groups. As a result, inhabitants are forced to seek access to services in other regions of the city, causing difficulties in their treatment. Moreover, lack of timely care can lead to severe complications or even death. Currently, close to 90% of high-complexity hospitalizations and 30% of medium-complexity ones involving residents of the northern region[6] take place outside the area, against the principles of the regionally-based service organization,[7] which will be discussed more thoroughly below.

1.6 Another important factor affecting hospital efficiency and, therefore, that of the health care system in general, involves the long-term hospitalization of subacute

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[3] Studies using Data Envelopment Analysis show that the Município of São Paulo is less efficient than other municípios in its metropolitan region. See: Varela et al. *Desempenho dos municípios paulistas: uma avaliação da eficiência da atenção básica à saúde*. *Revista de Administração*, v.47, n.4. In addition, according to the SUS Development Index (IDS-SUS), São Paulo's results are worse than those of Vitoria and Belo Horizonte, capitals in the same region of the country.

[4] The contracts are concentrated in the areas of diagnostic and therapeutic support and high-complexity services.

[5] HDI – United Nations Development Programme, 2010.

[6] São Paulo's northern region has close to 2.5 million inhabitants in an area of some 350 square kilometers.

[7]. SUS services should be organized on a regional basis in the municípios, in accordance with the following: Article 198 of the Federal Constitution, Law 8,080/90, and Basic Operational Standard 01/93, among others. In the municípios, services should be organized in districts that comprise health regions, forming a comprehensive and hierarchical network to serve their reference population groups.

patients[8] who need more complex and prolonged care and, often, are socially vulnerable. In 2017, the average public network hospital stay in São Paulo due to cardiovascular diseases and trauma was 116 and 31 days,[9] respectively.[10] This has negative effects because such stays "block"[11] significant and costly hospital resources. The health of patients is also affected, given that their needs require a different care model that would enable them to begin rehabilitation in a timely manner, thereby reducing the risk of sequelae and deteriorating health.[12] Given the growing burden of chronic, noncommunicable diseases and the increase in the elderly population, chronic patient demand, generally with functional dependency, will rise. Such patients will require continuing care, rehabilitation, or palliative care, with a multidisciplinary approach, strong interaction with the family, and psychosocial support.

1.7 Related to the preceding topic, urgent and emergency care units also represent critical points for the SUS in São Paulo. The prevalence of diabetes mellitus and systemic arterial hypertension in São Paulo's adult population is rising, from 4.7% (2003) to 7.7% (2015) and from 17% (2003) to 23.2%, respectively.[13] In 2016, 26% of deaths were caused by acute myocardial infarction, stroke, and traumas (mainly traffic accidents).[14] This situation demands the organization of a network of urgent and emergency facilities that is regionally-based and hierarchical, with a high degree of capillarity and the capacity to respond to the needs of the territories in a flexible manner. This does not currently describe São Paulo's urgent and emergency care network (RUE), however. In most of the health districts there are gaps in terms of access to pre-hospital services,[15] which are the RUEs' first point of care. According to the population parameters established by the Ministry of Health,[16] to homogenize supply and organize the Município of São Paulo's demand for urgent and emergency care, new urgent care units are needed in all six regions, especially the (historically underserved) northern, western, and eastern regions and the recently established central region, in which the service networks are still being organized. In addition, a significant portion of RUE infrastructure consists of old buildings in poor condition that do not comply with current health

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8 According to the American Health Care Association, the Joint Commission on Accreditation of Healthcare Organizations, and the Association of Hospital-based Skilled Nursing Facilities, a subacute care patient is one who experienced a recent acute illness (e.g. heart attack or stroke), an injury (trauma), or exacerbation of a chronic process.

9. According to clinical guidelines, patients with hospital stays of two to six weeks could be eligible for intermediate-care, outside a hospital setting. See: Intermediate Care – Halfway Home, Department of Health, London, 2009.

10 DATASUS. Hospital Information System.

11 Long hospital stays result in "bed-blocking" in high-cost hospitals, with negative consequences for patient health and system efficiency. National Health Service, 2015.

12 Mac Arthur, 2017. "The 'Intermediate Care Hospital': Facility Bed-based Rehabilitation for Elderly Patients." SPH/IDB.

13 Source: DATASUS/SMS.

14 Source: São Paulo Municipal Health Department (SMS), DATASUS Mortality Information System.

15 The urgent care units represent the RUEs' pre-hospital component and are the first level of service in the hierarchical organization of urgent and emergency care.

16 According to Directive GM/MS10/2017. The population parameters for urgent care units are: (i) urgent care unit size I: from 50,000 to 100,000 inhabitants; (ii) urgent care unit size II: from 101,000 to 200,000 inhabitants; and (iii) urgent care unit size III: 201,000 to 300,000 inhabitants.

standards and limit the capacity to provide quality services to the population. This is reflected in the overcrowding of existing urgent care facilities[17] and the population's search for urgent care in highly specialized hospitals, which generates disruptions and inefficiency.[18] These problems in the RUEs have significant consequences for the residents of São Paulo and are reflected in the health outcomes. In 2016, 50% of deaths from acute coronary disease occurred in pre-hospital units, which shows that a significant number of these deaths could be avoided through timely and effective care.

1.8 Primary care coverage in the Município of São Paulo has gradually been increasing since 2010. In 2017, average primary care coverage in the município was 61.1%. According to the 2017-2020 Municipal Targets Plan, this figure should reach 70% in 2020, giving priority to the areas with the lowest coverage: center, west, southeast, and east.[19] Despite these coverage successes, some indicators show significant margins for improvement in service quality. In 2015, avoidable hospitalizations in São Paulo accounted for almost 25% of the total, with 50% involving the exacerbation of circulatory and respiratory diseases. This reflects significant quality gaps in early detection and prevention,[20] which should be addressed through the provision of services at the basic level and timely referral to the other levels of care. There was also an increase in the incidence of congenital syphilis in the município: the rate rose from 2 per 1,000 live births in 2007 to 6.6 per 1,000 live births in 2017[21] (DATASUS). Such data corroborates the existence of shortcomings in the quality of prenatal care, provided both at the primary care level and by diagnostic and therapeutic support services.

1.9 **Complexity of health management.** The Municipal Health Department is the managing agency responsible for the direct and indirect delivery of services and for coordination with the state and federal health care units in its territory. This triple role—providing health care services, controlling the service network of other spheres, and acting as supreme health authority in the município—assumes a set of competencies to efficiently exercise full command of the system. The Municipal Health Department currently faces a number of challenges to fully succeed in its role as lead agency. Some of the main constraints it faces are:

a. **Substandard information systems.** There are currently 14 proprietary information systems in the Municipal Health Department that compile data from the health care, epidemiological, administrative-financial, regulatory, and other areas, comprising an enormous mass of data. This information is not integrated, however, nor is it associated with an analytical capacity that would

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17 All the regions in São Paulo have overcrowded urgent and emergency care services: 80% in the central region, 60% in the western region, 90% in the northern region, 50% in the eastern region, 60% in the southeastern region, and 60% in the southern region. Source: Urgent and Emergency Coordination Office, São Paulo's Municipal Health Department (SMS), 2017.

18 In 2017, 80% of urgent care provided in the Município of São Paulo's large hospitals involved low complexity issues, which should have been dealt with in the pre-hospital urgent care units.

19 See *Plan de Reestructuración de las Redes Asistenciales*, page 20; *Diagnóstico das Redes Assistenciais*, page 20-21.

20 Pereira et al., 2015. "*Perfil das Internações por Condições Sensíveis à Atenção Primária subsidiando ações de saúde nas regiões brasileiras.*"

21 This reflects the national trend. Over the same period, this rate ranged between 2 per 1,000 live births and 6.8 per 1,000 live births. Source: *Boletim Epidemiológico – Sífilis*, Ministry of Health, Brazil, 2017.

generate health intelligence, inform decision-making at various levels (clinical, managerial, and strategic), and promote efficiency in the use of resources. Moreover, a significant gap in individualized clinical information is in evidence in the município, given that only 30% of basic health care units have electronic patient records in operation, resulting in tenuous monitoring of users, care overlaps, and system inefficiency.

b. **Weak management tools for services under contract.** São Paulo provides health care services for its 12 million inhabitants directly and through a broad network of private, philanthropic, and nongovernmental service providers, financed with public funds from the SUS. Close to 55% of the Municipal Health Department's health care budget is managed by health care social organizations[22] that provide hospital, medium-complexity, and primary care services. This complex network of providers requires the commensurate capacity for planning, monitoring, and evaluating hundreds of contracts and for making appropriate adjustments, in order to ensure resource optimization, the integration of care among the various providers, and commitment to the needs of the territories. Currently this network's management systems exhibit such weaknesses as incomplete information, a lack of automated data entry, and the absence of analytical functionalities needed to help identify areas of inefficiency and thereby improve spending performance.

c. **Difficulty with setting parameters for services and their costs in the logistics of inputs.** São Paulo's health network is currently very fragmented and heterogeneous in terms of services and clinical practices, resulting in suboptimal levels of quality and efficiency. A variety of services are provided to address the same medical conditions, with no clear standards, making it difficult to standardize and contain costs. Moreover, there are important challenges in managing the supply chain. The current system used for planning, distribution, monitoring, and control of the consumption of drugs and medical-hospital supplies is obsolete. Significant improvements are required in the areas of process automation and integration with other management systems, since this heading represents close to 6% of total spending on health care.

1.10 **More demand for health care services in a context of fewer resources: the change and transformation imperative.** The Municipal Health Department decided to undertake an extensive reorganization of the health sector, to address demographic and epidemiological challenges, citizens' multiple and growing needs, and significant fiscal constraints, both current and future. In 2017, the Município of São Paulo's Health Care Networks Restructuring Program, based on the principles of organizing services into local, integrated networks, was launched.

1.11 **São Paulo's proposal for the reform of its health sector.** In order to implement this policy framework, the Municipal Health Department identified seven lines of action for its health care restructuring plan: (i) the lynchpin: reorganization of services into local integrated health care networks—microsystems focused on a reference population group—to strengthen the delivery of health care in a

[22] Health care social organizations are nonprofit, private-sector institutions that complement the state. The latter provides the infrastructure, while the health care social organizations are responsible for managing the services. In São Paulo, health care social organizations are governed by Law 14,132 of 24 January 2006.

coordinated, comprehensive manner, in which all levels of care have clear roles, sharing responsibility for the health care and outcomes of this population; (ii) strengthening of basic care, as the principal component of care and focus of local networks' operation; (iii) standardization of services, streamlining structures, and unifying the different types of services, with the objective of strengthening network organization and management and user guidance; (iv) reorganization and expansion of the pre-hospital RUE, to address the needs of the new organization of local networks, while prioritizing demand and making more efficient use of hospital resources; (v) reorganization of the hospital network, taking territorial needs and economies of scale into account, redefining hospital profiles and classifying them into three types (from highest to lowest level of complexity): structural, strategic, and support; (vi) integration and expansion of health information systems, improvement of clinical and managerial performance, resource optimization, and expansion of data mass and quality; and (vii) strengthening of health care management, creation and enhancement of management capacity in the Municipal Health Department, and improvement of clinical management. In addition, the Município of São Paulo seeks to step up the quality of its infrastructure, including health care facilities, through a certification program created by the Municipal Urban Infrastructure and Works Department (SIURB), pursuant to the criteria established in the Manual de Sustentabilidade para Edificações Públicas ["manual for public building sustainability"].

1.12 In the context of the São Paulo Health Care Networks Restructuring Plan and the 2017-2020 Targets Plan, the government of the Município of São Paulo requested support from the Bank to promote its health sector reform. Against a backdrop of growing prevalence of chronic, noncommunicable diseases, there is ample literature[23] that supports the integrated network approach as an efficient strategy to guarantee accessible, equitable, comprehensive, and continuing care, promoting services more suited to the needs of the communities and with greater emphasis on primary care, prevention, and control of risk factors. The plan's guidelines are also in line with other health care reform and reorganization proposals in the international arena[24] addressing similar challenges.

1.13 To advance the implementation of the new organization of local, integrated health networks in São Paulo, which began in 2017, this operation will provide strategic support to: (i) consolidate service access and quality where there are still gaps that prevent the networks from operating effectively; and (ii) strengthen the Municipal Health Department's management capacities, including the development of management systems and tools, the improvement and integration of information systems, and the promotion of technological innovation to bolster service quality

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[23] Pan American Health Organization, 2010. Redes Integradas de Servicios de Salud: Conceptos, Opciones de Política y Hoja de Ruta para su Implementación en las Américas. PAHO/WHO. Washington, D.C.; Vilaça Mendes 2013, "Las Redes de Atención de Salud," Brasilia, Federal District. National Council of State Ministers of Health (CONASS); Pelote et al., 2013 "How to Achieve Optimal Organization of Primary Care Service Delivery at System Level: Lessons from Europe." International Journal for Quality in Health Care 25(4)".

[24] http://www.healthcareimprovementscotland.org/; Ministry of Health. 2017. Statement of Strategic Intentions 2017 to 2021. Wellington: Ministry of Health; https://www.health.govt.nz/system/files/documents/publications/statement-of-strategic-intentions-2017-to-2021-ministry-of-health.pdf; *País Vasco: Transformando el Sistema de Salud – 2009-2012*. https://www.osakidetza.euskadi.eus/contenidos/informacion/estrategia_cronicidad/es_cronicos/adjuntos/transformando_sistema_salud.pdf.

and agility. In addition, to further consolidate the model, network professionals and managers will need to be provided with new capacities and competencies to entrench new practices and work methods.

1.14 To expand primary care access and coverage, basic health care units will be built, renovated, and expanded in underserved territories in the northern, central, western, southern, southeastern, and eastern regions,[25] expanding coverage through the Family Health Strategy.[26] Moreover, this operation will support a substantive improvement in primary health care quality and response capability, by certifying services and strengthening the primary level for its dual role as organizer of care and as the level responsible for managing most of the health problems of the population, with a view to preventing complications and making the system more cost-effective.

1.15 With regard to hospital care, the Brasilândia Strategic Hospital will be built with local counterpart funding. It will provide maternal and child, pediatric, and general clinical services, with 300 beds to meet high-complexity demand in the northern region. It will be this region's reference strategic hospital for the local networks.

1.16 In the context of the RUE, new urgent care units will be needed to comply with the population parameters established by the Ministry of Health and consolidate the urgent and emergency referrals for the new local networks. In addition, already existing services in the northern, central, western, and eastern regions will have to be renovated and expanded,[27] comprising comprehensive standardized networks in these regions. The management of these units will also be strengthened through computerized risk classification and regulation systems for hospitals, resulting in greater efficiency, control of demand, and interaction with the patient's clinical history.

1.17 Lastly, to consolidate the organization of local networks, one integrated care center will be built in each region of the city. These care centers will operate as service pilots, with the objective of addressing prolonged care needs and supporting timely and safe hospital discharges and the transition to home care, in coordination with primary care. The município will be developing this integrated care center model in alignment with national policy,[28] and taking into account domestic and international experiences.[29]

1.18 The challenges of this stage call for significant efforts to propel the deep changes required by the transition to the integrated network model of care. To speed up this

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[25] See: diagnostic assessment of the Restructuring Plan, page 17, and *Diagnóstico de Redes Assistenciais*, pages 20-21.

[26] Evidence shows that the Family Health Strategy is the most efficient for primary care in Brazil. Macinko J., et al., 2006. "Evaluation of 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."

[27] See *Diagnóstico de Redes Assistenciais*, page 16.

[28] Directive GM/MS 2,809, 7/12/2013, which contains regulations on backup beds.

[29] Generalitat de Catalunya, 2004. Barcelona *Els serveis sociosanitaris i l'atenció geriátrica*. Department of Health and Social Security; Bengoa, R. 2011. A Strategy to Tackle the Challenge of Chronicity in the Basque Country. Alava: Basque Government; Dahl, U., Steinsbekk, A., Jenssen, S., and Johnsen, R. 2014.; Hospital Discharge of Elderly Patients to Primary Health Care, with and without an Intermediate Care Hospital: a Qualitative Study of Health Professionals' Experiences. International Journal of Integrated Care. 14: 1-11.

reform process, this operation will promote a series of management measures and strategies to make health spending more efficient, thereby guaranteeing the system's sustainability.

1.19 For purposes of strengthening macro management capacity, the project will support improvements in supply chain planning, monitoring, and control systems (drugs and medical/hospital supplies). The Municipal Health Department already has a private provider that centralizes warehousing and distribution. However, weaknesses have been identified in the department's exercise of its role as lead agency. Support will also be provided for the development of a cost system and intelligent systems for contract management, to improve system performance and spending efficiency.

1.20 It will be vital to restructure the governance system, moving some of the leadership functions to the direct managers of the services and the regional coordinators, while at the same time strengthening the Municipal Health Department's role of regulating and steering the Município of São Paulo's health policy. Training will therefore be provided for network managers and professionals. Support will also be provided for clinical management, through the implementation of clinical protocols organized along lines of care[30] for prevailing conditions (diabetes, hypertension, chronic respiratory diseases, and maternal and child health care), which will strengthen the integration of care and of the networked services.

1.21 In alignment with these efforts, the project will support the macro strategy "Connected Health," which provides for the integration of all health information systems in the município. Thus, individual clinical data will be organized and standardized, efforts that are essential for monitoring patients and for consolidating the network model, which will help to avoid unnecessary repetition of tests and improve the quality of care. An enormous repository of data will be generated, for which data analysis functionalities will be developed to increase the Municipal Health Department's management capacity. In terms of this strategy, support will be provided for the implementation of electronic patient records in 100% of the basic health care units.[31] This is one of the most strategic aspects of network management and the strengthening of Municipal Health Department health intelligence.

1.22 **Lessons learned and related operations.** This project will join a portfolio of five ongoing health sector operations in Brazil (loans 3051/OC-BR, 3262/OC-BR, 3703/OC-BR, 2586/OC-BR, and 3400/OC-BR). Two additional operations are being prepared simultaneously (BR-L1519 in Belo Horizonte and BR-L1518 in Paraíba). All these projects, together with two recently concluded ones (loan 2586/OC-BR in São Bernardo do Campo and loan 2137/OC-BR in Ceará), have design elements in common and contribute several lessons reflected in the project: (i) an approach of (re)organization of the services into integrated networks from primary to tertiary care makes it possible to gain efficiency and improve continuity in patient treatment in a context of limited resources; (ii) the strengthening of service network management helps ensure the optimal functionality of the

[30] According to evidence in the context of the SUS, health care services are more efficient when they are coordinated along lines of care. Magalhães, J. R., M. Gariglio, and Teixeira et al., 2002.

[31] The project will promote the national strategy for implementation of electronic records in São Paulo, in line with the Ministry of Health's Basic Health Units Information Technology Program.

renovated and reorganized infrastructure;[32] (iii) the new managerial models for service contracting and financing, logistics management, planning, and procurement of critical inputs entail benefits in terms of quality and savings in time and resources; (iv) the development and application of lines of care and clinical protocols raise quality levels and avoid the wasting of resources by standardizing processes in accordance with the best evidence of international practice; and (v) although information technologies in the health sector, particularly clinical records systems, can ensure better patient flow in the network of services and reduce the need to repeat data gathering and diagnostic testing, solid and flexible user-oriented plans are required for these investments in information and communications technology to be successful.

1.23 **Strategic alignment.** The project is aligned with the Update to the Institutional Strategy 2010-2020 (document AB-3008), in particular with the challenge of social inclusion and equality, through human capital development based on improving health care services. It also addresses the crosscutting areas of gender equality and diversity (document GN-2800-8), given that it includes protocols for maternal and child health care and chronic disease treatment that will address biological differences and gender roles for combatting chronic, noncommunicable diseases, which will address differences in access to and use of health care services by men and women, as well as different behaviors with respect to self-care. These matters affect both the incidence and manifestations of chronic, noncommunicable diseases and their consequences.[33] In the mother and child line of care, Ministry of Health guidelines[34] will be reinforced that promote men's active participation in prenatal, partum, and postpartum care, so they share in the rights and responsibilities along with the mothers. The impact evaluation will make it possible to identify gender differences in chronic patient health indicators. The project is also aligned with the crosscutting area of climate change and environmental sustainability. Approximately 42.69% of the project's resources will be invested in climate change mitigation activities, pursuant to the joint methodology of the multilateral development banks for tracking climate change adaptation finance. These resources are related to energy efficiency and water savings measures incorporated into infrastructure. They contribute to the IDB Group target of increasing financing for projects related to climate change to 30% of all approved operations by the end of 2020. It is important to highlight that 100% of the project's new works and alterations financed with loan proceeds will be certified under the sustainability seal created by the SIURB. Moreover, the project is expected to

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32 Lessons I and II were reflected in the design of Component 1; lessons III and IV were taken into account in the design of Component 2; and lesson V was considered for the design of Component 3, given that the guidelines for its proposals were anchored in previous Bank experience with similar operations (2137/OC-BR, 3051/OC-BR, and 2586/OC-BR).

33 WHO, 2009. "Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks;" Schramm, J. et al.; Gender Inequalities in Noncommunicable Disease Mortality in Brazil. Stevens A. et al. *Ciência & Saúde Coletiva*, 2012, Vol.17(10), p. 2627. Barker, Gary, Ricardo, Christine and Nascimento, Marcos. 2007. Engaging Men and Boys in Changing Gender-based Inequity in Health: Evidence from Programme Interventions. WHO, Geneva, 2007; Pathania, V. S. Women and the Smoking Epidemic: Turning the Tide. 2011. Bulletin of the World Health Organization 89:162-162. DeVon H. A., et al. Symptoms Across the Continuum of Acute Coronary Syndromes: Differences between Women and Men. 2008. American Journal of Critical Care.

34 http://dab.saude.gov.br/portaldab/ape_redecegonha.php.

contribute to the 2016-2019 Corporate Results Framework (document GN-2727-6) by increasing the number of beneficiaries receiving health care services. The operation is included in the Update of Annex III of the 2018 Operational Report (document GN-2915-2).

1.24 In addition, the operation is consistent with the IDB's Health and Nutrition Sector Framework (document GN-2735-7) in that it contributes to improving health care infrastructure and technology and strengthens institutional capacity for better system governance. The operation is aligned with the Sustainable Infrastructure for Competitiveness and Inclusive Growth Strategy (document GN-2710-5), given that it will finance infrastructure for quality health care services that promote sustainable and inclusive growth. Lastly, the project is consistent with the Bank's Country Strategy with Brazil 2016-2018 (document GN-2850) in that it contributes to the expansion and improvement of the primary care network and to the reduction of indicators such as the hospitalization rate for conditions treatable at the primary care level or for diabetes mellitus and its complications.

B. Objectives, components, and cost

1.25 The project's objective is to contribute to improving the health conditions of the Município of São Paulo's population, by enhancing service access and quality and improving system performance, through consolidation of the health care networks approach. The operation is structured in four components:

1.26 **Component 1. Support for the restructuring, reorganization, and integration of local health care networks (IDB: US$63.8 million; Local: US$98.3 million).** The objective of this component is to reorganize and expand the Município of São Paulo's local health care networks. The following activities will be financed, *inter alia*: (i) technical consulting services to implement the proposal for the restructuring, streamlining, integration, and governance of local health care networks; (ii) architectural and detailed plans for the works;[35] (iii) construction of roughly nine basic health care units and procurement of equipment; (iv) renovation and expansion of roughly 14 basic health care units and procurement of equipment; (v) construction of roughly 12 urgent care units and procurement of equipment; (vi) renovation and expansion of roughly 10 urgent care units and procurement of equipment; (vii) construction of the Brasilândia Hospital and procurement of equipment for the Brasilândia and Parelheiros hospitals; and (viii) construction of up to six integrated care centers and procurement of equipment. Priority will be given to the regions with the worst social and health care indicators, as reflected in the diagnostic assessments of São Paulo's Health Care Networks Restructuring Plan.

1.27 **Component 2. Improvement of health system efficiency and quality (IDB: US$22.3 million; Local: US$1.7 million).** This component will enhance the performance of the Municipal Health Department by expanding its institutional, strategic, and managerial capacities. The following will be financed, *inter alia*:

[35] The Município of São Paulo holds clear tile to the land on which the works will be built. Basic designs for these works are available since the urgent care units and basic health care units must follow a national model provided by the Ministry of Health. The integrated care centers have a similar architectural reference. See optional link 3. The detailed designs for the first year's works will be prepared while awaiting signature of the loan contract.

1.28 **Subcomponent 2.A. Instruments for expanding the Municipal Health Department's institutional capacities (IDB: US$12.8 million).** This subcomponent will finance: (i) implementation of analytical tools to strengthen service delivery contract management; (ii) cost management system methodology development, procurement, and implementation; (iii) implementation of the strategic procurement system for drugs and medical/hospital inputs; (iv) studies and consulting assignments on improving the drug distribution model; (v) implementation of intelligent planning, execution, and monitoring systems for warehousing, distribution, and consumption of drugs and medical/hospital supplies throughout the network; (vi) studies, consulting services, and tools to support implementation of the Municipal Health Department's Strategic Core;[36] and (vii) training for network managers and professionals.

1.29 **Subcomponent 2.B. Ongoing improvement of the health sector's internal productivity and quality (IDB: US$9.5 million; Local: US$1.7 million).** This subcomponent will finance: (i) the roll out of lines of care for prevailing conditions; (ii) procurement of the computerized risk classification and regulation system for urgent care units and other urgent and emergency services; (iii) integration of the regulation centers of the Mobile Urgent Care System[37] and urgent and emergency care into the primary care management system; and (iv) certification of the response capacity and quality of roughly 340 basic health care units, as a core element of the integrated health care networks model based on the Family Health Strategy.

1.30 **Component 3. Strengthening of information management as well as promotion of innovation and the use of new health care technologies (IDB: US$7.4 million).** This component will strengthen and integrate health care information systems, expand the Municipal Health Department's management and decision-making capacities, and promote innovation processes in the sector. The following, *inter alia*, will be financed: (i) integrated system for electronic registration in health care;[38] (ii) implementation of electronic patient records in 100% of the primary care network; and (iii) consulting assignments and studies for the development of the integrated care center health care model; and (iv) consulting assignments and studies for the identification and implementation of new health care technologies (particularly digital technologies such as telemedicine).

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[36] The Municipal Health Department's Strategic Core will be directly connected to the Secretary's cabinet and will perform analytical functions based on the integration of a broad health care database. It will be responsible for guiding and supporting the planning, monitoring, and evaluation of the Municipal Health Department's technical areas (and territories) and informing upper management's decisions. Its scope of action will take into account: health situation (epidemiological, demographic, and socioeconomic data), status of service costs and production, supply chain, and contracts with various providers.

[37] Mobile Urgent Care System. The urgent and emergency care regulation centers classify and manage the município's urgent care demands, referring patients to services based on their risk and profile. São Paulo currently has two RUE regulation centers that act separately: one for mobile pre-hospital services and the other for fixed pre-hospital and hospital services (urgent care units and hospitals). The integration of both centers is important to improving system organization.

[38] Information technology solutions will be acquired for the integration of the Municipal Health Department's (and the Health Ministry's) current systems and for the development of a centralized and shared repository of citizens' clinical data and tools to enable analysis of this database in accordance with the needs of health care professionals, managers, and users.

1.31 **Component 4. Project administration and evaluation (IDB: US$6.5 million).** This component will support the Municipal Health Department in project execution and monitoring of anticipated outcomes. It will finance, *inter alia*: (i) support services for project management; (ii) specialized technical services; (iii) independent audits; and (iv) midterm and final reviews of the project to evaluate its impact.

C. Key results indicators

1.32 The impact indicators for this operation involve chronic, noncommunicable disease-related morbidity and mortality—especially the premature death rate (under age 60) from complications due to diabetes mellitus and strokes—as well as avoidable hospitalizations, stemming from network strengthening. The intermediate outcome indicators include estimated primary health care coverage. Final outcome indicators will include the annual rate of hospitalizations due to diabetes mellitus and its complications in the population aged 30 to 59 living in São Paulo. In addition, the framework of corporate outcomes included the sector indicator for the "number of people receiving health care services."

1.33 **Economic analysis.** The strategies promoted in this operation are based on evidence of the effectiveness of the integrated health care networks' care model. On the basis of specific evidence for Brazil, the economic analysis quantified the incremental benefits flowing from project investments, including: (i) savings in hospital spending from a reduction in avoidable admissions; (ii) productivity gains from the reduction in morbidity and mortality associated with the care model adopted; and (iii) gains from implementation of lines of care. The analysis quantifies disability-adjusted life years that can be saved by implementing investments in a context of integrated networks, considering the increase in effective coverage and the time it takes for results to materialize. In the base scenario, with conservative assumptions in terms of the effectiveness of the interventions, over a horizon of five years and using a discount rate of 1.6,[39] the benefit/cost ratio ranges between 0.79 and 3.00. The sensitivity analyses also show that the benefit/cost ratio is greater than 1 even in the less favorable scenarios.

II. Financing Structure and Main Risks

A. Financing instruments

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

[39] As discussed in optional link 1, the 3% discount rate for health care projects is the one recommended by the World Health Organization.

Table II.1. Summary of project costs (US$ million)

Component	IDB	Local	% IDB	Total
1. Support for the restructuring, reorganization, and integration of local health care networks	**63.8**	**98.3**	**39**	**162.1**
2. Improvement of health system efficiency and quality	**22.3**	**1.7**	**93**	**24.0**
Subcomponent 2. A. Instruments for expanding the Municipal Health Department's institutional capacities	12.8	-	100	12.8
Subcomponent 2. B. Ongoing improvement of the health sector's internal productivity and quality	9.5	1.7	100	11.2
3. Strengthening of information management and promotion of innovation and the use of new health care technologies	**7.4**	**-**	100	7.4
4. Project administration and evaluation	**6.5**	**-**	**100**	**6.5**
TOTAL	**100.0**	**100.0**	**50**	**200.0**

Table II.2 Projected disbursements (US$ million)

Financing	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total
IDB (Ordinary Capital)	-	33.4	39.7	15.1	7.8	4.0	100
Municipal Health Department (local counterpart)	11.9	30.2	37.1	3.6	9.8	7.4	100
Total	**11.9**	**63.6**	**76.8**	**18.7**	**17.6**	**11.4**	**200**

2.2 **Financial analysis.** According to the financial evaluation of municípios performed by the Brazilian federal government, the Município of São Paulo is eligible to contract this loan with the Bank, in that it complies with the indexes established in the Fiscal Responsibility Act. For its part, the National Treasury Department classified the Município of São Paulo under category "B," based on its low level of debt and suitable level of current spending and financial obligations (May 2018). However, to authorize the signature of the loan contract, the federal government will again analyze the Município of São Paulo's fiscal situation prior to granting final approval.

B. Environmental and social risks

2.3 Pursuant to the Bank's Environment and Safeguards Compliance Policy (Operational Policy OP-703), the operation has been classified under category "B," since the social and environmental risks and impacts during the construction phase and operation of the health units will be localized and temporary, with effective mitigation measures in place that are known in the health sector. The main adverse social and environmental risks and impacts of the operation—whose infrastructure activities involve remodeling and new construction of small health care units—are as follows: (i) in the construction phase, the generation of debris and rubble from the demolitions and construction; and (ii) in the operation phase, the generation of hospital wastewater and hospital solid waste as well as patients', workers', and visitors' exposure to infections; these risks and impacts will be mitigated through the implementation of the mitigation measures set out in the environmental and social management plan (ESMP).

2.4 Considering that none of the works will be exposed to the risk of significant natural disasters, in accordance with Operational Policy OP-704, the operation's type 1

disaster risk has been classified as low; the type 2 risk does not apply to the project. Similarly, on 13 May 2018, pursuant to Operational Policy OP-102, the project's environmental and social analysis (ESA) and the ESMP were posted on the IDB's website.[40] None of the works will result in the involuntary resettlement of people or in the expropriation of land. The ESA/ESMP has confirmed that all the works will take place in facilities and on lots that are public property. The gender issue has been addressed in the project's studies, including the participation of vulnerable groups in project benefits, the lack of restrictions on women's participation in the works during the execution and operation of each type of works, and the freedom of women to participate in the consultations on the project's works, in compliance with applicable legislation.

C. Fiduciary risks

2.5 An Institutional Capacity Analysis Platform workshop was conducted, which classified the risk as medium. The risk identified involved possible delays in execution because of lack of knowledge about and experience with the Bank's procurement and financial management policies on the part of the Municipal Health Department, SIURB, and Municipal Attorney General (PGM) teams.

2.6 The following actions will be taken to mitigate this risk: (i) establishment of the project coordination unit (PCU), with a full-time focus on the project; (ii) the hiring of a project management support firm; (iii) creation of a Special Procurement Committee to support the preparation and implementation of procurement processes in accordance with Bank and/or country policies; (iv) assignment of agents to address project demands; (v) procurement of the project's physical-financial management system; (vi) IDB-provided training for all personnel involved in execution (SMS, SIURB, and PGM); and (vii) the signature of a cooperation agreement between the SIURB and the Municipal Health Department.

D. Other risks and key topics

2.7 Two risks involving public management and governance were identified, both of which are medium-level risks. The first concerns the change in government resulting from the 2020 municipal elections, which could also result in changes in the PCU and, therefore, lack of continuity in execution. To mitigate these risks, the preparation and implementation of a project information communication and dissemination plan is proposed, as well as planning for execution that takes this context into account. The second risk identified is that the project will not be prioritized among Municipal Health Department activities since the department does not currently have a team that could devote itself full-time to its execution. To mitigate this risk, the PCU will be set up and a project management support firm will be hired.

2.8 **Sustainability.** The Município of São Paulo has a good fiscal situation and all the new services provided for in the context of the project will be enshrined in the government planning instruments.[41] Prior to issuing any infrastructure tenders, the Municipal Health Department will be required to report the financial impacts

[40] https://www.iadb.org/Document.cfm?id=EZSHARE-1663712947-16.

[41] The investments are included in the 2017-2020 Targets Plan, the government's multiyear plan, and the Municipal Health Plan. The latter two will be published in the second half of 2018. These forecasts incorporate buildings and equipment maintenance costs.

of investment-associated current spending to the Department of Finance, for prior authorization.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 **Executing agency.** The borrower will be the Município of São Paulo and the Federative Republic of Brazil will be the guarantor of the borrower's financial obligations stemming from the loan contract. The executing agency will be the Município of São Paulo, through the Municipal Health Department—or another institution with similar functions that assumes the executing agency role, provided that the Bank's no objection is secured. The Municipal Health Department will set up the PCU.

3.2 The executing agency, through the PCU, directly attached to the Office of the Municipal Secretary of Health, will be responsible for: (i) project planning and administrative and fiduciary execution; and (ii) project monitoring and evaluation. At a minimum, this unit will have a general coordination subunit, a technical coordination subunit, a planning coordination subunit (which includes project management), a finance coordination subunit, an accounting coordination subunit, a procurement coordination subunit, an information and communication technology coordination subunit, and a works coordination subunit. The Municipal Health Department will be responsible for the PCU's technical management, since the coordinators will be on its staff. A project management support firm is expected to be contracted,[42] which will provide support to the Municipal Health Department, including consultants under the supervision of the coordinators, for jobs with profiles that do not match those of Municipal Health Department staff. In addition, the firm will bolster expertise in project management, with the transfer of such knowledge to the Municipal Health Department. The SIURB (or another institution with similar functions that assumes the executing agency role, provided that the Bank's no objection is secured) will be responsible for issuing calls for bids and contracting the project's detailed designs and works, as provided for in Decree 58,171/2018, as the agency responsible for these functions in the Município of São Paulo. The Municipal Health Department's Engineering Department and the PCU will assist the SIURB with works execution. In addition, an agreement between the Municipal Health Department and the SIURB will be drafted to bolster institutional cooperation in the context of the project. A Special Procurement Committee will be set up, connected to the PCU, which will exclusively manage project procurement processes—except those related to the project's detailed designs and works. The PCU will have legal support from the PGM, which will designate point persons for project-related legal matters.

3.3 Project execution will be governed by the project Operating Regulations, the terms of which will be negotiated and approved by the Bank. These Regulations will cover environmental matters and will establish guidelines and procedures for the executing agency in the areas of programming, accounting-financial management, procurement, audits, and monitoring and evaluation. In addition, the project

[42] A performance contract is anticipated, to be organized in modules so that the support is adjusted to the project's rate of execution (winding down beginning in year three).

Operating Regulations will set out the project's institutional and execution arrangement, specifying the functions of the PCU, the responsibilities of each actor, and the respective flows.

3.4 **The following will be special contractual conditions precedent to the first disbursement of the loan proceeds: (i) approval and entry into force of the project Operating Regulations, under the terms previously agreed upon with the Bank; (ii) establishment of the PCU and appointment of its members; and (iii) signature and entry into force of the cooperation agreement between the SIURB and the Municipal Health Department, under the terms previously agreed upon with the Bank.** The first condition is justified since the project Operating Regulations are needed to ensure that the project is executed effectively. The second condition is considered essential to provide assurances to the Bank that the executing agency will have a suitable team ready to begin project execution. The third condition is justified by virtue of the importance of formalizing the SIURB's commitments and authority vis-à-vis the executing agency with regard to the execution of project works.

3.5 **Procurement.** The procurement of goods, works, and consulting services will be conducted in accordance with the Bank's policies (documents GN-2349-9, Policies for the Procurement of Works and Goods Financed by the IDB, and GN-2350-9, Policies for the Selection and Contracting of Consultants Financed by the IDB). Based on the institutional capacity analysis of the executing agency, the procurement processes to be financed in whole or in part by the Bank will be subject to ex post review, except in such cases in which ex ante supervision is warranted and in the case of direct contracting, as indicated in the procurement plan. For procurement processes executed under the country system, supervision will also be carried out through that system.

3.6 **Disbursement.** Disbursements will be made under the advance of funds modality, based on the project's actual liquidity needs for a maximum period of six months. Disbursements will be deposited into a special bank account opened in the name of the project exclusively for the loan proceeds, as established in document OP-273-6, "Financial management guidelines for IDB-financed projects."

3.7 **Audits.** The project's financial statements will be audited annually by an independent external auditing firm acceptable to the Bank, to be hired by the executing agency. The audited financial statements will be delivered to the Bank no later than 120 days after the close of each fiscal year of the entity, in accordance with procedures and terms of reference previously agreed upon with the Bank. The audit will include an ex post review of disbursement and procurement processes, in addition to the Bank's own actions and reviews.

3.8 **Retroactive financing and recognition of expenditures.** The Bank may finance retroactively, as a charge against the loan proceeds, up to US$20 million (20% of the proposed amount of the loan), and it may recognize, as a charge against the local contribution, up to US$25 million (25% of the estimated amount of the local contribution) in eligible expenditures incurred by the borrower before the loan approval date for contracts involving the detailed designs of project works, and expenditures for construction of the Brasilândia Hospital and the urgent care units and the procurement of equipment therefor, provided requirements substantially similar to those established in the loan contract have been met. These

expenditures must have been incurred on or after 4 April 2018 (project profile approval date), but under no circumstances will expenses incurred more than 18 months prior to the loan approval date be included.

B. Summary of results monitoring arrangements

3.9 Through the PCU, the executing agency will deliver semiannual reports to the Bank on: (i) progress towards fulfillment of the objectives and outcomes agreed upon in each annual work plan (AWP) and in the project's monitoring report, including analysis and monitoring of risks and related mitigation measures; (ii) status of the procurement plan and its execution; (iii) fulfillment of contractual clauses; and (iv) status of financial execution. In addition, the report for the second half of each calendar year through 30 November will include: (i) the AWP and project execution plan for the following year; (ii) the updated procurement plan; and (iii) where applicable, the actions planned to implement the audit recommendations. The PCU will also be supported by consulting services responsible for implementing the project's monitoring and evaluation plan. The indicators included in the results matrix will be monitored using the data generated by the Municipal Health Department and reported in DATASUS.

3.10 The impact evaluation will use the synthetic controls methodology and will compare the final outcome indicators of the results matrix in the Município of São Paulo with another group of municípios with more than 500,000 inhabitants, where the project will not be implemented. For each indicator, e.g. the premature mortality rate from strokes, a synthetic control will be constructed. By construction, that synthetic control will present the same trends as the Município of São Paulo in the years prior to the intervention, and consequently its future behavior will serve as a counterfactual for what would happen in the absence of the project. The data needed to prepare the evaluation come from DATASUS and, more specifically, from the Mortality Data Reporting System and the Hospital Data Reporting System of the SUS, which compile such information on a routine basis. The baseline is expected to be determined in year 1 and the final report will be drafted in year 5. A midterm evaluation of project implementation will be performed[43] and presented up to 90 days after 50% of the loan proceeds have been disbursed or 36 months after the contract has entered into effect, whichever occurs first. A final evaluation will be presented to the Bank 90 days after the final disbursement. All evaluations are included in the project budget.

C. Post-approval design activities

3.11 During the period between loan approval and contract signature, joint work with the Municipal Health Department will follow up on: (i) progress of the bidding process involving the project management support firm; (ii) the contracting of detailed designs for the project's initial works; (iii) the drafting of terms of reference for contracting the project's physical-financial management system; and (iv) the drafting of the project Operating Regulations.

[43] Not compulsory, from the Bank's perspective.

Development Effectiveness Matrix		
Summary		
I. Corporate and Country Priorities		
1. IDB Development Objectives	Yes	
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity -Climate Change and Environmental Sustainability	
Country Development Results Indicators	-Maternal mortality ratio (number of maternal deaths per 100,000 live births) -Beneficiaries receiving health services (#)*	
2. Country Development Objectives	Yes	
Country Strategy Results Matrix	GN-2850	Expanded access to and improved quality of primary health care services.
Country Program Results Matrix	GN-2915-2	The intervention is included in the 2018 Operational Program.
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		Evaluable
3. Evidence-based Assessment & Solution	10.0	
3.1 Program Diagnosis	3.0	
3.2 Proposed Interventions or Solutions	4.0	
3.3 Results Matrix Quality	3.0	
4. Ex ante Economic Analysis	10.0	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	3.0	
4.2 Identified and Quantified Benefits and Costs	3.0	
4.3 Reasonable Assumptions	1.0	
4.4 Sensitivity Analysis	2.0	
4.5 Consistency with results matrix	1.0	
5. Monitoring and Evaluation	9.3	
5.1 Monitoring Mechanisms	2.5	
5.2 Evaluation Plan	6.8	
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/FMP Criteria)	Yes	Financial Management: Budget, Treasury, External Control. Procurement: Information System, Comparison, Contracting Individual Consultant, National Public Bidding.
Non-Fiduciary	Yes	Strategic Planning National System, Monitoring and Evaluation National System, Statistics National System.
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
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		

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

The objective of the program is to contribute to the improvement of the health conditions of the population of the Municipality of Sao Paulo by increasing access and quality of services, improving the performance of the system, and consolidating the focus of health networks. To achieve these objectives, the program supports the restructuring, reorganization and integration of local health care networks, improving the efficiency and quality of the health system, and the strengthening of information management and promotion of innovation and use of health technologies. The project presents a cost-benefit analysis that supports the economic viability of the proposed activities, with a benefit / cost ratio of 1.60. The vertical logic presented in the POD is consistent with the indicators presented in the results matrix, and includes indicators for the main outputs, outcomes and impacts. Indicators meet SMART criteria and include baseline and target values as well as the sources and means of verification that will be used to measure them. The final impact indicators are premature mortality rate due to cerebrovascular accident, premature mortality due to diabetes mellitus, premature mortality due to coronary disease, and the rate of ambulatory case sensitive hospitalizations, disaggregated by gender. The Project Coordination Unit, directly linked to the Cabinet of the Municipal Secretary of Health, will be in charge of the monitoring and evaluation of the program. The indicators of the results matrix will be reported using administrative information sources including SMS and DATASUS. The project includes an impact evaluation that will use a synthetic control methodology, comparing the evolution of the final outcome indicators of the results matrix in the Municipality of Sao Paulo with another set of municipalities of more than half a million inhabitants that do not implement the project.

RESULTS MATRIX

Project objective:	The project's objective is to contribute to improving the health conditions of the Município of São Paulo's population, by enhancing service access and quality and improving system performance, through consolidation of the health care networks approach.

EXPECTED IMPACT

Indicators	Unit of measure	Baseline	Baseline year	Final target Year 5	Means of Verification	Comment[1]
IMPACT						
Premature death rate from stroke among women	per 100,000 population	19.2	2016	18.3	Information Technology Department of the Unified Health System (DATASUS)	
Premature death rate from stroke among men	per 100,000 population	28.3	2016	26.9		
Hospitalization rate for conditions treatable at the primary care level for women	per 10,000 population	39.4	2017	34.5		
Hospitalization rate for conditions treatable at the primary care level for men	per 10,000 population	45.3	2017	39.0		
Premature death rate from diabetes mellitus among women	per 100,000 population	5.9	2016	5.6		
Premature death rate from diabetes mellitus among men	per 100,000 population	9.6	2016	9.1		
Premature death rate from coronary disease among women	per 100,000 population	23.6	2016	22.4		
Premature death rate from coronary disease among men	per 100,000 population	61.8	2016	58.7		

[1] All comments can be found in the full version of the monitoring and evaluation plan.

EXPECTED OUTCOMES

Indicators	Unit of measure	Baseline	Baseline year	Year 5	Final target	Means of verification	Comments
Final outcome indicators							
Average length of stay of users due to sequelae of cerebrovascular disease and external causes[2] in Unified Health System (SUS) general hospitals	day	51	2017	48	48	Hospital Information System (SIH)-SUS	
Average hospital stay in SUS network general hospitals of the city of São Paulo	day	5.9	2017	5.0	5.0		
Proportion of admissions of an urgent nature in strategic hospitals	%	87.6	2017	74.5	74.5		
Hospitalization rate for diabetes mellitus and its complications	per 1,000 population	3.9	2017	3.7	3.7	SIH-SUS / State Data Analysis System (SEADE)	
Percentage of pregnant women diagnosed with and treated for syphilis in the first trimester of pregnancy	%	28.5	2017	27	27	Municipal Health Department Monitoring System	
Intermediate outcome indicators							
Number of people receiving health care services	person	7,343,286	2017	7,996,838	7,996,838	DATASUS	
Rate of urgent and emergency care classified by risk in RUE services	%	47	2017	90	90		
Annual ratio of basic medical appointments scheduled/population	per 100 population	82	2017	90	90	Outpatient Information System (SIA)-SUS / SEADE	
Percentage of patients residing in the northern region treated in hospitals[3] in that same region (medium complexity)	%	69.6	2015	80	80	SIH-SUS / SEADE	
Estimated primary care coverage	%	61.2	2017	70	70	National Register of Health Care Facilities (CNES) / SEADE	
Percentage of new works and renovations, financed with Bank resources, certified by the Buildings Bureau (EDIF)[4]	%	0	2017	100	100	Certificates issued	
Rate of drug and input shortages	%	30	2016	15	15	Municipal Health Department Monitoring System	

[2] International Statistical Classification of Diseases and Related Health Problems, Tenth revision (ICD-10): I69 T90 to T98.

[3] The region's municipal and state hospitals will be taken into account.

[4] Certification seal for works sustainability, created and managed by the Buildings Bureau of the Municipal Department of Works and Services (SIURB) of the Município of São Paulo.

OUTPUTS

Outputs	Unit of measure	Baseline	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	Final target	Means of verification	Comments
Component 1. Support for the restructuring, reorganization, and integration of local health care networks											
Consulting assignment plan for implementation of networks model approved[5]	phase	0	2018	2	2				4	Approval documents signed by the Secretary of Health	
Architectural and detailed designs for the works	design	0	2018	20	11				31	Municipal Health Department Monitoring System	
Brasilândia Hospital built and equipped	unit	0	2018	0	1	0	0	0	1	CNES/Ministry of Health	CNES/Ministry of Health
Parelheiros Hospital equipped	unit	0	2018	1	0	0	0	0	1		
Basic health care units built and equipped	basic health care unit	453	2018	0	0	4	5	0	462		
Basic health care units renovated and equipped	basic health care unit	0	2018	0	4	6	4	0	14		
Urgent care units built and equipped	urgent care unit	3	2018	0	11	0	0	1	15		
Urgent care units renovated and equipped	urgent care unit	0	2018	0	6	2	0	2	10		
Integrated health centers built and equipped	integrated health center	0	2018	0	2	4	0	0	6		
Building of the Northern Regional Coordination Office renovated and equipped	Coord. Office	0	2018	1	0	0	0	0	1	SIURB reports	
Buildings of the Central and Western Coordination Offices equipped	Coord. Office equipped	0	2018	2	0	0	0	0	2		
Component 2.A. Instruments for expanding the Municipal Health Department's institutional capacities											
"Analytics" system for the services contracts system implemented	system	0	2018	0	1	0	0	0	1	Municipal Health Department Monitoring System	
Cost management system implemented	system	0	2018	0	0	0	1	0	1		

[5] The consulting assignment is divided into four macro phases: (i) conceptual overview model; (ii) diagnostic assessment; (iii) preparation of regionalized model; and (iv) action plan implementation and communication.

Strategic procurement system implemented	system	0	2018	1	0	0	0	0	1	Municipal Health Department Monitoring System	
Planning, execution, and monitoring systems for warehousing, distribution, and consumption of drugs and medical/hospital supplies	system	0	2018	0	1	0	0	0	1		
Study for the new drug distribution model prepared	study	0	2018	0	1	0	0	0	1		
Strategic Core of the Municipal Health Department implemented	Strategic Core	0	2018	0	1	0	0	0	1		
Lead network managers trained	manager	0	2018	25	25	25	25	25	125	Certificates	
Network professionals trained	professional	0	2018	700	700	700	700	700	3,500		
Component 2.B. Ongoing improvement of the health sector's internal productivity and quality											
Quality certification of basic health units	unit	0	2018	0	85	85	85	85	340	Municipal Health Department Monitoring System	
Urgent and emergency regulation centers integrated	phase	0	2018	1	0	0	0	0	1		
Urgent care units and urgent and emergency services with management and risk classification system implemented	unit	0	2018	45	12	0	0	0	57	Ambulatory information system SIA DATASUS	
Component 3. Strengthening of information management and promotion of innovation and the use of new health care technologies											
Consulting assignments and studies performed	report	0	2018	1	1	0	0	0	2	Municipal Health Department Monitoring System	
Basic health care units with electronic records implemented	units	0	2018	200	262	0	0	0	462	Ministry of Health report	
Clinical data integration system implemented	phase	0	2018	2	2	1	1	1	7	Assisted harmonization reports	
Component 4. Program administration and evaluation											
Audit reports	report	0	2018	0	1	1	1	2	5	Audited financial statements	
Impact evaluation reports	report	0	2018	1	0	0	0	1	2	Municipal Health Department Monitoring System	
Midterm and final evaluation report	report	0	2018	0	0	1	0	1	2		

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Brazil
Project number:	BR-L1429
Name:	City of São Paulo Health Services Networks Restructuring and Quality Certification Project – Avança Saúde SP
Executing agency:	Município of São Paulo, through the São Paulo Municipal Health Department
Fiduciary team:	Leíse Estevanato and Marília Santos (VPC/FMP)

I. EXECUTIVE SUMMARY

1.1 The institutional evaluation for the program's fiduciary management was based on: (i) the country's current fiduciary context; (ii) the findings of the risk assessment; (iii) the Institutional Capacity Assessment Platform analysis; (iv) prior experience under other Social Protection and Health Division health care programs in Brazil; and (v) working meetings with the IDB Project Team and the São Paulo Municipal Health Department. Brazil has robust country fiduciary systems that enable sound management of administrative, financial, oversight, and procurement processes, in accordance with the principles of transparency, economy, and efficiency. The executing agency's systems related to its planning and organization, execution, and control capacity have a medium level of development and represent a medium risk.

1.2 The São Paulo Municipal Health Department is a consolidated department. It has a stable, high-level technical staff, though its numbers are insufficient for program execution. Nor does it have recent experience with programs financed by international agencies, or trained staff with knowledge of the Bank's procurement and financial management policies.

1.3 For purposes of program execution, the São Paulo Municipal Health Department will set up a program coordination unit (PCU) directly attached to the Office of the Secretary of Health.

II. EXECUTING AGENCY FIDUCIARY CONTEXT

2.1 The structure of the São Paulo Municipal Health Department/PCU will comprise: (i) a general coordinator; (ii) a technical and planning coordinator, specializing in public health; (iii) a coordinator of finance and accounting, with knowledge of financial planning and management processes; (iv) a procurement coordinator; (v) an information technology coordinator, with knowledge of the information technology topics and solutions anticipated under the project; and (vi) a works coordinator.

2.2 The Municipal Urban Infrastructure and Works Department (SIURB) will contract and execute the works, as established in Municipal Decree 58,171 of March 2018. To this end, the SIURB will sign an agreement with the São Paulo Municipal Health Department, confirming its responsibility vis-à-vis the program, including the need to comply with the Bank's policies. The SIURB will have two point persons who will act as the liaison under the program in the dialogue with the São Paulo Municipal Health Department. They will be trained by the Bank on its procurement policies. The SIURB will also be responsible for works supervision and monitoring, pursuant to its legal powers.

2.3 Since the São Paulo Municipal Health Department does not have a large staff with experience and training in the execution of programs financed by international agencies, a support firm is expected to be contracted for management of the actions planned under the program.

2.4 The executing agency is subject to internal control by the Office of the Comptroller General of the Município and the Office of the Attorney General of the Município (PGM). External control will be performed by an independent external auditing firm acceptable to the Bank, to be hired by the executing agency in accordance with the IDB's relevant procedures and policy.

III. Institutional Capacity Assessment, Fiduciary Risk, and Mitigation Measures

3.1 The institutional capacity assessment and its validation with staff of the São Paulo Municipal Health Department and the SIURB found that the executing agency has a medium level of institutional capacity.

3.2 The following medium-level fiduciary risk was identified: possible delays in execution because of lack of knowledge about and experience with the Bank's procurement and financial management policies among the São Paulo Municipal Health Department, SIURB, and PGM teams.

3.3 The following actions will be taken to mitigate this risk: (i) establishment of the PCU, with a full-time focus on the program; (ii) the hiring of a program management support firm; (iii) creation of a special procurement committee to support the preparation and processing of procurement in accordance with Bank and/or country policies; (iv) assignment of agents to address project demands; (v) procurement of the program's physical-financial management system; and (vi) IDB-provided training for all personnel involved in execution (São Paulo Municipal Health Department, SIURB, and PGM).

IV. Considerations for the Special Provisions of the Loan Contract

4.1 **Special contractual condition for execution:** The borrower will provide evidence that the program's computerized physical-financial management system has been implemented and is in operation up to six months from the signature of the loan contract. **Rationale**: In line with the provisions of Operational Policy OP-273-6, implementation of the program's physical-financial management and accounting system is critical for budgeting, recording, accounting, making payments, and preparing supporting documentation in a timely and reliable manner. By fulfilling

this condition, the risk of delays in program execution resulting from errors or inconsistencies in the financial reports will be mitigated.

V. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

5.1 The fiduciary agreements for procurement establish the provisions applicable to execution of all planned procurement for the program.

A. Procurement execution

5.2 **Procurement of works, goods, and nonconsulting services**. The contracts will be subject to international competitive bidding (ICB) and will be executed using the standard bidding documents issued by the Bank. Bidding processes subject to national competitive bidding (NCB) will be executed using the country bidding documents agreed upon with the Bank. The selection and contracting of works, goods, and nonconsulting services will be carried out in accordance with the Policies for the Procurement of Works and Goods Financed by the IDB (document GN-2349-9).

5.3 **Selection and contracting of consultants.** The contracts will be executed using the standard request for proposals issued by the Bank. The sector specialist will be responsible for reviewing terms of reference for the contracting of consulting services. Consultants will be selected and contracted in accordance with the Policies for the Selection and Contracting of Consultants Financed by the IDB (document GN-2350-9).

5.4 **Use of country procurement system.** The *Pregão Eletrônico* electronic reverse auction system, which is the country procurement (sub)system approved by the Bank, will be used for the procurement of goods and nonconsulting services involving amounts of up to US$5 million. Any system or subsystem subsequently approved will be applicable to the operation. The procurement plan and its updates will state which procurement processes are to be executed using the approved country systems.

5.5 **Retroactive financing and recognition of expenditures.** The Bank may finance retroactively, as a charge against the loan proceeds, up to US$20 million (20% of the proposed amount of the loan), and it may recognize, as a charge against the local contribution, up to US$25 million (25% of the estimated amount of the local contribution) in eligible expenditures incurred by the borrower before the loan approval date for contracts involving the detailed designs of program works, and expenditures for construction of the Brasilândia Hospital and the urgent care units and the procurement of equipment therefor, provided requirements substantially similar to those established in the loan contract have been met. These expenditures must have been incurred on or after 4 April 2018 (project profile approval date), but under no circumstances will expenses incurred more than 18 months prior to the loan approval date be included.

Table 1. Thresholds for ICB and international short list

Method	ICB works	ICB goods and nonconsulting services	International short list for consulting services
Threshold	US$25 million	US$5 million	US$1 million

Table 2. Main procurement processes

Contract purpose	Selection method	Estimated date	Estimated amount (US$)
Works			
Construction, renovation, and expansion of health units	NCB	Q 1/2019	16,363,636
Goods and nonconsulting services			
Contracting of solution for the consolidation and distribution of clinical data	NCB	Q 1/2019	18,181,818
Consulting assignments			
Patient risk classification and integrated management	QCBS	Q 1/2019	4,560,363
Support for program management	QCBS	Q 1/2019	5,000,000

* Click here to access the 18-month procurement plan.

B. Procurement supervision

5.6 The supervision method will be ex post, except in those cases where ex ante supervision is justified and in the event of single-source selection. When the country system is used for procurement, the country system will also be used for supervision.

5.7 The supervision method must be identified for each selection process. Ex post reviews will be conducted every 12 months in accordance with the program supervision plan. The ex post review reports will include at least one physical inspection visit, selected from among the procurement processes subject to ex post review.

Table 3. Threshold for ex post review

Works	Goods	Consulting services
NCB and Shopping	NCB and *Pregão Eletrônico*	Less than US$1 million

C. Records and files

5.8 The executing agency will be responsible for process documentation through the PCU, which will retain the necessary documentation for supervision and auditing purposes.

VI. Financial Management

6.1 **Programming and budget**. The São Paulo Municipal Health Department, acting through the PCU, will coordinate the entire process of planning for the execution of activities as set out in the multiyear execution plan and in the annual work plan.

The São Paulo Municipal Health Department's entities use the following planning instruments: Multiyear Plan, Budgetary Guidelines Law, which lays down budget directives, and Annual Budget Law (LOA).

6.2 The executing agency, through the PCU, will ensure that the budgetary resources for the program, from the Bank and the local contribution, are budgeted annually and earmarked for execution in accordance with the program schedule. Budgetary resources must be recorded in the year of execution in the Budget and Finance System (SOF) as an external source. The LOA must include the funds necessary for implementation, including both the external loan and the local counterpart.

6.3 **Accounting and information systems.** Public entities in the Município of São Paulo work with the SOF, which performs all the financial, accounting, and financial planning execution involving the Município's operations. Still, the Município lacks an automated accounting-financial information system that is integrated with general accounting. It needs to develop a financial management model that is integrated with the SOF or acquire one for generating program disbursement processes and financial statements as well as the basic reports requested by the IDB.

6.4 **Disbursements and cash flow.** Disbursements will be made in U.S. dollars under the advance of funds modality. Advances will be based on a projection of financial resources for a plan previously agreed upon with the Bank of up to 180 days. Future advances will require accounting for at least 80% of the cumulative total amount for which supporting documentation has not been provided.

6.5 For purposes of accounting for the loan proceeds and the local contribution, the executing agency will use: (i) the effective exchange rate used to convert the funds advanced in the operation's currency to the local currency, for IDB resources; and (ii) the effective exchange rate of the payment date, for reimbursement of expenditures and recognition of expenditures charged to the local contribution. Expenses deemed ineligible by the Bank must be repaid from local contribution resources or other resources, at the borrower's discretion and with the Bank's approval, depending on the nature of the ineligibility.

6.6 The Bank's resources will be administered through an exclusive account in which the loan proceeds can be identified, and banking reconciliation of such funds can be performed.

6.7 **Internal control and internal audit**. The Município of São Paulo's internal control is exercised by the its Comptroller General's Office (CGM), which is the hub of the internal control system of the executive branch. The CGM performs the functions of internal control, government audit, public hearings, public transparency, and societal oversight. Program activities will come under its control.

6.8 **External control and reports.** External control is exercised by the Município's Audit Office. The program's external audit will be performed by an independent external auditing firm acceptable to the Bank, to be hired by the executing agency in accordance with the IDB's relevant procedures and policy.

6.9 The annual audited financial reports will be delivered, in accordance with terms of reference agreed upon with the Bank, by a firm of external auditors acceptable to the Bank, within 120 days after the close of each fiscal year. Supporting documentation for expenditures incurred will be subject to ex post review by the

external auditing firm responsible for the audits and/or by a consultant appointed by the Bank.

A. Financial supervision plan

6.10 This plan may be amended during execution to reflect changes in risk levels or the need for additional oversight.

Table 4. Supervision plan

Nature and scope	Frequency	Responsibility	
		Bank	Executing agency
Annual audit	Annual	Fiduciary team	PCU/external auditor
Review of disbursement requests	Periodic	Fiduciary team	
Supervision visit	Annual	Fiduciary specialist	

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/18

Brazil. Loan ____/OC-BR to the Municipality of São Paulo. City of São Paulo Health Care Networks Restructuring and Quality Certification Project - AVANÇA SAÚDE SP

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Municipality of São Paulo, as Borrower, and with the Federative Republic of Brazil, as Guarantor, for the purpose of granting the former a financing aimed at cooperating in the execution of the City of São Paulo Health Care Networks Restructuring and Quality Certification Project - AVANÇA SAÚDE SP. Such financing will be for the amount of up to US$100,000,000 from the resources 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.

(Adopted on ___ _____ 2018)

LEG/SGO/CSC/EZSHARE-620307903-25530
Pipeline No.: BR-L1429