Republic of Chile

PROGRAM FOR UNIVERSAL PRIMARY HEALTHCARE COVERAGE AND RESILIENCE (P179785)

Program for Results (PforR)

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT (ESSA)

FINAL DRAFT

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ACRONYMS AND ABBREVIATIONS

DEIS	Department of Health Statistics and Information *(Departamento de E*stadísticas *e Información de Salud*)
DGREYD	Emergency and Disaster Risk Management Department *(Departamento de Gestión del Riesgo de Emergencias y Desastres*
DIA	Environmental Impact Statement *(Declaracion de Impacto Ambiental)*
DIPRES	Chilean Budget Directorate *(Dirección de Presupuestos de Chile)*
DIVAP	Division of Primary Care (División de Atención Primaria)
DLIs	Disbursement Linked Indicators
DLR	Disbursement Linked Results
DOM	Directorate of Municipal Works *(Dirección de Obras Municipales)*
ECICEP	People-Centered Comprehensive Care Strategy
EHS	Environmental,-Health and-Safety
ENT	Non-Communicable Diseases *(Enfermedades No Transmisibles)*
E&S	Environmental and Social
ESSA	Environmental and Social Systems Assessment
FONASA	Public National Health Fund (*Fondo Nacional de Salud)*
GoCl	Chile Government
HS	National Health Services entities
ITO	Technical Site Inspector *(Inspector Técnico de Obra)*
LBGMA	Law on General Environmental Standards *(Ley de Bases Generales de Medio Ambiente)*
LGBTIQA+	Lesbian, gay, bisexual, transgender, queer, asexual and other gender identities
MIDESO	Ministry of Social Development and Family
MINSAL	Ministry of Health (MoH)
MMA	Ministry of Environment
PCT	Program Coordination Team
PDO	Program Development Objective/s
PforR	*Program for Results*
PHC	Primary Health Care
PRAPS	Reinforcement Program for Primary Healthcare *(Programa de Reforzamiento de la Atención Primaria de Salud)*
RAs	Result Areas
RCA	Environmental Qualification Resolution (*Resolución de Calificación Ambiental*)
SEA	Environmental Assessment Service *(Servicio de Evaluación Ambiental)*
SEREMIS	Regional Ministerial Health Secretariats *(Secretarías Regionales Ministeriales de Salud)*
RSEIA	Environmental Impact Assessment Service Regulations (*Reglamento del Servicio de Evaluación de Impacto Ambiental)*
UPHCP	Universal Primary Healthcare Program
WB	World Bank

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Chilean Government Program

The Health System Reform in Chile that guarantees universal access to health is one of the four structural reforms proposed in the Government Program of President Gabriel Boric. It emphasizes the elaboration of an intersectoral health strategy at the local level, based on the Primary Health Care (PHC) level, in order to guarantee universal access and zero discrimination in the public health network, focused on people and their diversity, as well as on the role of communities. The Government's program for the Universalization of PHC is designed with four objectives: (a) to expand effective coverage through the optimization of PHC, (b) to make PHC more resilient, (c) to improve the health and social care model, with dignity and quality, and (d) to optimize resources and implement a performance monitoring and evaluation framework that supports the PHC strategy. This program started to be implemented by the Ministry of Health this year 2023 with a pilot experience in seven communes (Alhué, Canela, La Cruz, Coltauco, Linares, Perquenco and Renca), which reflect the diversity and heterogeneity of the different territories in Chile, including, among others, the location (urban vs. rural), the composition of their population (already covered/reached by PHC or not) or the availability of infrastructure to deliver PHC.

Results-Based Program financed by the World Bank

The Program for Results (PforR) "Universal Primary Healthcare Coverage and Resilience" in Chile will support a part of the Government's program for the Universalization of PHC during the four-year period 2024-2027, with a geographical coverage of 187 communes (54% of the total number of communes in Chile) and some actions throughout the country. The PforR will support investments and activities related to: i) improve PHC coverage and quality; ii) strengthen PHC resilience (to face future challenges derived from public health emergencies such as epidemics and pandemics; consequences of climate change, among others); and iii) improve efficiency in PHC financing.

Environmental and Social Systems Assessment

The World Bank (WB) Policy and Directive on PforR financing requires an Environmental and Social Systems Assessment (ESSA) of operations financed under the PforR instrument. Accordingly, the WB conducted an ESSA of activities to be financed under this Program to assess the adequacy of national and sectoral environmental and social systems in the context of the Program boundaries. The scope of the ESSA was to assess the extent to which the Program's systems i) promote environmental and social sustainability in the design and implementation of the Program; ii) avoid, minimize or mitigate adverse impacts on natural habitats and physical cultural resources; iii) promote informed decision making related to the environmental and social (E&S) effects of the Program; iv) protect public and worker health and safety; v) manage land acquisition; vi) consider issues related to indigenous peoples and vulnerable groups; and (vii) avoid social conflicts. In addition, it identified actions needed to improve/strengthen the Program's systems and mitigate potential environmental and social (E&S) risks.

The objectives of the ESSA included the following: (i) identify potential E&S benefits, risks and impacts applicable to Program interventions, excluding activities with the capacity to generate significant negative E&S risks; (ii) review the legal framework and capacity of the systems of the Government of Chile and in particular the Ministry of Health (MINSAL) related to the management of E&S risks of Program interventions; (iii) assess the performance of relevant Program systems with respect to the core principles of the PforR instrument and identify gaps, if any; and (iv) identify actions and recommendations to

strengthen those systems where necessary, as informed by the Evaluation. Some of these identified actions have been incorporated into the Program Action Plan (PAP) and others are included in the Program Operations Manual (POM).

ESSA Methodology

The methodology for the preparation of the ESSA report consisted of: (i) the collection and analysis of information, including relevant regulatory frameworks, provided by MINSAL or obtained from the official websites of relevant Chilean Government agencies; (ii) virtual consultative meetings with technical staff from various MINSAL departments and agencies involved and associated with E&S aspects related to the Program; (iii) a face-to-face mission during the preparation of the Program led by the World Bank in March 2023, which involved face-to-face meetings and a field visit to two types of Primary Health Care centers; (iv) the socialization and validation of the Evaluation results with relevant government officials within MINSAL; (v) the publication of the draft ESSA report on the World Bank website and MINSAL's website prior to the Program Evaluation, to facilitate an informed consultation process; and (vi) the consultation of the ESSA draft with government representatives, regional and local authorities, PHC workers' unions and relevant civil society stakeholders, which was held during September 27 and 28 of 2023, following the Decision Meeting and prior to Negotiations. The ESSA Final Report was updated to reflect the relevant comments and observations from this consultation.

Environmental and social benefits

The Program will generate positive environmental and social benefits by providing better primary health services to the public and communities, particularly in rural areas. The main positive environmental effects are related to the use of sustainability and climate change resilience standards in the construction and operation of a new PHC facility model. The Program is also expected to strengthen the environmental management and supervision capacity of the agencies in charge of the construction of the new PHC facilities, as well as of the relevant local authorities that will supervise their operation and maintenance, through specific training activities relevant to the Program. The main social benefits are related to the cultural and territorial adequacy of PHC services aimed at special care groups, such as people who suffer gender-based violence (GBV), LGBTIQA+ population, elderly people, immigrants, rural residents and people belonging to indigenous and tribal peoples, among others, for which the sensitization and training of health personnel in the care of special care groups is contemplated, as well as the training of community agents to support on GBV. In addition, the expansion of the PHC network, through a telematic platform for health management and the construction of new PHCs, is considered an important step in terms of coverage and accessibility, with a positive impact on the population.

Potential environmental and social risks

The ESSA concludes that no significant adverse environmental and social impacts are expected due to the Program. The ESSA includes an exclusion list that excludes activities with a high or substantial environmental and social risk rating. This exclusion list includes, among others: (i) any construction in protected areas or priority areas for biodiversity conservation, as defined in national legislation; (ii) construction in areas of high risk to natural hazards (floods, landslides, earthquakes, tsunamis); iii) activities that have the potential to cause any significant loss or degradation of critical natural habitats, either directly or indirectly, or that would lead to adverse impacts on these habitats, including urban or rural wetlands; iv) purchase or use of banned/restricted chemicals for medical use; v) any activity that affects physical cultural heritage, such as tombs, temples, churches, historical relics, archeological sites, or other cultural structures; (vi) activities that due to their magnitude and scale require an Environmental Impact Study, according to Chile's Environmental Impact Assessment System; (vii) activities associated with the Program that may cause or lead to forced labor or child abuse, child labor exploitation or human trafficking, or that employ or involve children under the age of 18; (viii) any activity on land whose ownership or tenure rights are in dispute; (ix) any activity that causes physical and/or economic displacement of the population; and (x) any activity that requires obtaining the Free, Prior and Informed Consent of the indigenous peoples.

Main environmental risks

Despite the above, the construction and operation of the new model of PHC facilities supported under the PforR may have potential negative environmental risks and impacts, such as: (i) nuisances related to the generation of dust, vibrations, noise and odors; (ii) generation, handling and improper disposal of hazardous and non-hazardous solid waste; (iii) generation and discharge of wastewater from civil works; (iv) temporary disruptions to local traffic during the construction phase; (v) health and safety risks to the construction workforce and local communities, including exposure to hazardous materials/wastes and COVID-19; (vi) inadequate management of incidental cultural findings; and (vii) those risks associated with the operation of the facilities to be constructed, such as improper handling of medical equipment that may cause incidents such as fires, improper handling and disposal of non-hazardous and hazardous solid waste, wastewater generation and discharge, and worker health and safety. These risks and impacts are expected to be moderate, temporary, and site-specific and are expected to be mitigated by readily available measures required by national legislation and ongoing monitoring of environmental performance in accordance with the Program Action Plan.

Main social risks

The Program may also have some negative social risks and impacts, mainly related to: (i) the incorporation of new users attached to ISAPRES to the primary level of care, which may cause an increase in the demand for PHC services, an increase in the waiting time to obtain a medical appointment, as well as, an increase in the number of complaints and claims, and may even increase the level of dissatisfaction of the population; (ii) the bad reputation that the public health system has historically had among citizens, even at the primary level, which is associated with long waiting lists, poor quality of care and discriminatory practices; (iii) the capacity of MINSAL to carry out standardization in the care, management and operation of PHC facilities, due to the diversity and heterogeneity of the municipalities in charge of managing the 92.6 percent of PHC facilities; and (iv) risk of exclusion of vulnerable populations in rural areas that do not meet the minimum number of people for the construction of a PHC facility. However, these risks are well known to MINSAL and are expected to have a limited impact. These will be mitigated through the

continuous assessment of social risks and impacts, in accordance with the Program Action Plan, and the implementation of adequate participatory and consultative processes with all stakeholders regarding key Program activities, based, for example, on the periodic evaluation of user experience and the training and activation of community health agents at the local level.

Environmental and Social Systems Assessment

Based on the assessment of the Environmental and Social Management Systems applicable to the proposed PforR, it is concluded that Chile has environmental and social management systems in place to address environmental, health and safety, and cultural adaptations needed to serve indigenous and tribal peoples and other vulnerable groups related to the proposed activities under the PforR. Such systems are consistent with the core principles and key planning elements defined in the Bank's PforR Policy. The overall potential environmental and social risks of this PforR are rated as Moderate and can be effectively mitigated within existing environmental and social management systems. Chile has a well-developed general and sectoral environmental and social legal and regulatory framework, as well as an institutional framework with clear and delimited roles and resources to implement E&S management.

It is expected that the infrastructure constructions considered in the Program will be small-scale and will not require environmental assessment under Chile's environmental impact assessment system (SEIA), in accordance with Law No. 19,300 on General Environmental Standards and its regulations. However, the construction and operation of new PHC facilities will have to comply with the relevant national, regional and municipal environmental, safety and health regulations required by the competent authorities and relevant legislation, such as the Regulation on Waste Management of Health Care Facilities, the Health Code, the Ministry of Health Regulation for the storage of hazardous substances, the Regulation on Basic Sanitary and Environmental Conditions in Workplaces, as well as with the required local regulations, such as atmospheric decontamination plans, among others.

The Health Services (SS) will be responsible for bidding and supervising the execution of PHC infrastructure works included in the Program. These apply bidding processes, according to standard bases for this type of works established by the National Comptroller's Office, which include the requirement that the works comply with the applicable legal framework, including those related to the environment and occupational health and safety. The bidding documents must also include technical specifications including the requirements for environmental, health and safety prevention, mitigation and control planning, based on the complexity of the work in question, which the contractor must implement. The Municipalities in charge of the new PHC facilities will grant the building permits to build the new PHC centers and once built will receive the work verifying that it was built according to the technical specifications and pertinent legislation under which it was contracted, including those related to environmental and social aspects. During the operation of the new PHC centers, they will supervise that they comply with the necessary environmental and social regulations. The SEREMI of Health have specialized departments and units to supervise and address environmental quality (air, waste, chemicals and contaminated sites) and occupational health issues for any project in the country, and will also supervise compliance with environmental and health and safety issues during the construction and operation of new PHC facilities.

In addition, the respective SEREMIS will grant new PHC facilities the Sanitary Authorization[1] required for their functioning and operation.

Regarding the Program's interventions with social impact, MINSAL has divisions, departments and units in its two undersecretariats responsible for designing, disseminating and supervising public policies aimed at safeguarding the universal right to health and access to decent and quality services, in addition to having mechanisms for citizen consultation and participation, and for resolving complaints. In addition, health programs at the primary care level are monitored by the Undersecretariat for Social Evaluation of the Ministry of Social Development and the Budget Directorate of the Ministry of Finance within the framework of the State Program Supply Monitoring System, which analyzes their efficiency, effectiveness and targeting.

Actions and Recommendations for the E&S management of the Program

Specific actions and recommendations have been identified to strengthen the effective management of environmental and social risks during Program implementation. These include:

a. a requirement to designate within the Program Coordination Team (PCT) an environmental specialist (with OHS expertise) and a social specialist to facilitate inter-agency coordination, environmental and social performance monitoring of Program activities such as civil works, capacity building in E&S management and monitoring, and preparation of E&S performance reports for the WB, among others, as reflected in the Program Action Plan.
b. inclusion of an exclusion list in the MOP that excludes activities with a high or substantial environmental and social risk rating. The MOP will also include: (i) minimum technical specifications to be included in bidding documents for environmental and social management of civil works to be implemented by contractors, as well as environmental and social management guidelines to be applied during construction and operation of new PHC facilities, in accordance with national regulations, relevant international good practices, and the basic principles and key planning elements set out in the PforR Financing Policy and Directive; ii) guidelines for the preparation of semi-annual environmental and social monitoring reports to be submitted to the World Bank; and iii) a procedure for reporting incidents and accidents to the WB, among others.
c. recommendations in the ESSA report to strengthen environmental and social capacity among relevant health agencies, particularly the Health Services, and the regional and local authorities where PforR-funded infrastructure will be located.

[1] The Sanitary Authorization is the act by which the Regional Health Authority (SEREMIS) allows the operation of Institutional Health Care Providers, verifying that they comply with the structure and organization requirements, expressed in regulations. Decree with Force of Law No. 1 of 1989, Determines matters that require express sanitary authorization. Available at: https://www.bcn.cl/leychile/navegar?idNorma=3439

1. INTRODUCTION

In compliance with the Operational Policy (OPS5.04-POL.107 of 2017) and the Directive (OPS5.04-DIR.107 of 2022)[2] for the World Bank (WB) Program for Results (PforR) financing, this Environmental and Social Systems Assessment (ESSA), aims to present the findings and recommendations of the risk assessment conducted by the World Bank of the environmental and social management systems governing the implementation of the *Chile* Results-Based Program*: Program for Universal Primary Healthcare Coverage and Resilience (*P179785). An analysis of the legal and institutional aspects applicable to the PforR in preparation was carried out to determine whether they do the following:

- Promote environmental and social sustainability in the design of the Program; avoid, minimize and/or mitigate adverse impacts, and promote informed decision making regarding the social and environmental impacts of the Program.
- Avoid, minimize and/or mitigate impacts on natural habitats or physical and cultural resources that could be affected by the Program.
- Adequately protect communities and workers against potential risks arising from activities such as: i) construction and/or operation of facilities and other practices under the Program; ii) exposure to toxic products and hazardous wastes resulting from Program activities; and iii) reconstruction or rehabilitation of infrastructure located in areas vulnerable to the impact of natural disasters.
- Adequately manage land acquisition and restriction of access to natural resources in such a way as to avoid or minimize displacement and social and economic impacts by assisting affected groups to improve or at least restore living conditions to those prior to Program implementation.
- Ensure that the rights and interests of indigenous and vulnerable groups are taken into account through their informed participation in Program decisions that may affect them, while guaranteeing equitable and culturally appropriate access to Program benefits.
- Avoid exacerbating social conflicts, especially in fragile territories and areas with social conflicts or territorial disputes.

1.1. Purpose of the ESSA

The purpose of this ESSA was to: (i) identify potential environmental and social (E&S) risks that may affect the achievement of Program outcomes; (ii) assess the borrower's capacity to manage those risks (its legal framework, regulatory authority, organizational capacity, and performance), with emphasis on environmental and social policies, legislation, procedures, and institutional systems to assess their consistency with the World Bank Policy and Directive for PforR; and recommend specific actions to strengthen the capacity of implementing agencies with respect to effective management of environmental, health and safety, and social issues during implementation. Some of these actions are incorporated into the Program Action Plan (PAP) and others are incorporated into the Program Operating Manual (POM), as detailed in Section 6.

[2] PforR Policy and Directive, available at: https://www.worldbank.org/en/programs/program-for-results-financing#3.

1.2. ESSA Methodology

The ESSA is a World Bank document requirement for PforR investment operations and is prepared by WB staff, in collaboration with the government (MINSAL, in this case). The findings, conclusions and opinions expressed in the ESSA document are those of the WB. The draft ESSA report was shared with counterparts in the Chilean Ministry of Health (MINSAL) prior to the ESSA consultation meetings and the comments and inputs received were incorporated into this report. Relevant comments received from the focus group consultations were incorporated into the final ESSA report. The methodology for the development of this ESSA is aligned with that provided in the WB Guidance prepared for conducting ESSA for PforR financing operations. The methodology involved:

i. Identification of potential environmental, worker and population health and safety (H&S) and social risks that may result from the activities to be supported by PforR;
ii. Documentary review of the laws, regulations, requirements and guidelines of the national systems in terms of SSA and social management to prevent or mitigate the identified risks, provided by the client and/or consulted in the official websites of the relevant agencies of the Government of Chile;
iii. Meetings with representatives of the government agencies involved, including virtual missions to prepare for the operation and a field visit to two types of Primary Health Care facilities in the Coltauco commune (a Family Health Center, or CESFAM, and a health post). These missions provided a better understanding of the potential environmental and social risks associated with these types of activities and the capacity and procedure of government departments to address such risks, including relevant actions currently taken in accordance with relevant laws and regulations;
iv. Review of documents generated by the WB during the preparation of the PforR, such as the Program Appraisal Document (PAD) and Aide Memoire of the last preparation mission carried out;
v. Review of ESSA reports for other WB PforR operations;
vi. Preparation and publication of the draft ESSA prior to the Program evaluation mission, on the World Bank's external website;
vii. A consultation of the draft ESSA with government representatives and relevant civil society stakeholders, which was held during September 27-28, 2023, following the Decision Meeting and prior to Negotiations. The draft ESSA report was attached to the call for consultations; and
viii. The preparation and publication of the final version of the ESSA report taking into account the key comments gathered in the consultation.

2. PROGRAM DESCRIPTION

The following is a summary of the Program for Results for Universal Primary Health Care (PHC) Coverage and Resilience in Chile, based on the World Bank's Program Appraisal Document (PAD).

2.1. The Government Program

The Health Reform that guarantees universal access to health is one of the four structural reforms proposed in the Government Program Apruebo Dignidad of President Gabriel Boric[3] for the period 2022-2025. It emphasizes the development of an intersectoral health strategy at the local level, based on the primary health care system, capable of guaranteeing universal access and zero discrimination in the public health network, focused on people and their diversity, as well as on the role of communities. To this end, it proposes measures to modernize health management, improve accessibility to the public health system and the efficiency of public spending on health.

One of the pillars of the Health Reform is the **Universalization of Primary Care**[4], which is recognized as the heart of the public health system and as strategic in the prevention and promotion of health, in line with the Declaration Alma Ata. (1978)[5] and the Declaration of Astana (2018)[6].

The Government of Chile's (GoCl) program for the Universalization of Primary Health Care is one of the fundamental steps for the beginning of the transformation of the Chilean health system into a Universal Health System and is the main strategy of the GoCl to improve effective and timely access to high quality health services for the entire population. This program was formally established through the Resolution of the Ministry of Health Nº 112 published on February 9, 2023, which approved the Universal PHC program through the so-called Primary Health Care Strengthening Program (PRAPS). It is led by the National Commission for the Universalization of PHC, chaired by the Minister of Health, Undersecretaries of Public Health and Assistance Networks, and formed by a technical team composed of the corresponding Divisions and Departments of MINSAL, the Chilean National Health Fund (FONASA) and the Superintendence of Health.

The PHC Universalization program is designed with the following objectives: (a) to expand effective coverage by optimizing PHC, (b) to improve the contribution of PHC to the resilience of the health system, and (c) to improve the health and social care model, with dignity and quality.

This program began to be implemented this year 2023 with a pilot experience in seven municipalities (Alhué, Canela, La Cruz, Coltauco, Linares, Perquenco and Renca). These pioneer municipalities were chosen following a "scalability strategy" that establishes the path to follow so that the lessons from the pilot can provide the greatest amount of information on future viability and implementation (e.g., on

[3] The four structural reforms proposed in the Government Program I Approve Dignity (2022-2025) are: (i) Universal Access to Health; (ii) Decent pensions without AFP; (iii) Free and quality public education system; and (iv) Formation of the first ecological government in the history of Chile. Source: https://observatorioplanificacion.cepal.org/sites/default/files/plan/files/Plan%2Bde%2Bgobierno%2BAD%2B2022-2026%2B%282%29.pdf

[4] A general summary of what constitutes the Universalization of PHC can be found at: https://www.minsal.cl/universalizacion-de-la-atencion-primaria-de-salud/.

[5] Alma Alta Declaration. 1978. WHO - PAHO - UNICEF. Source: https://www.paho.org/hq/dmdocuments/2012/Alma-Ata-1978Declaracion.pdf

[6] Astana Declaration. 2018. United Nations. Source: https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration-sp.pdf

regulatory aspects, resource needs, the functioning of the health network), which will allow to increase its coverage annually until reaching half of the communes by the end of President Boric's term of office. In addition, the seven municipalities reflect the diversity and heterogeneity of the different territories of Chile, including, among others, the location (urban vs. rural), the composition of their population (already covered/reached by PHC or not) or the availability of infrastructure to deliver PHC.

As explained in section 2.2 below, the scope of the World Bank loan will only cover the financing of a portion of this government program for the Universalization of PHC.

2.2. Program for Results

2.2.1. Scope of the Results-Based Program

The proposed Program for Results (PforR) would support[7] the Government's PHC Universalization program during the four-year period 2024-2027, with a geographic coverage of 187 communes (54% of the total number of communes in Chile) and some actions throughout the country. The PforR will support improvements in PHC coverage and quality; strengthening PHC resilience; and efficiency in PHC financing, through investments and activities linked to the **Result Areas (RAs)** described below:

- **RA1: PHC Coverage and Quality:** This RA focuses on establishing a new care model where all people, regardless of their health insurance status and place of residence in the country, are effectively covered by PHC and can access quality PHC services. The activities linked to this RA seek to: (a) close gaps in the quality of care, with a special focus on the prevention and control of NCDs and the needs of women and people identified as LGBTIQA+; and (b) strengthen the implementation of a new Comprehensive People-Centered Care Strategy (ECICEP) and a patient navigation system.
- **RA2: Resilient PHC:** This area focuses on strengthening PHC to build a resilient health system that can effectively prevent, prepare for, respond to, and withstand future PHEs (i.e., due to epidemics) and the impact of climate change. The RA will also address preparedness for natural disasters, fragility, conflict and violence. Activities mainly include: (a) developing a guide for "Surveillance and Preparedness for PHEs and Climate Change Risks in universal PHC"; (b) training staff for emergency risk surveillance, and creating "Comprehensive Surveillance and Response Teams" appointed and georeferenced to participating municipalities; (c) organizing and conducting PHEs and climate change drills (e.g., infectious respiratory diseases, climate change related heat strokes, emerging vector borne diseases, etc.), and (d) designing and constructing a new PHC infrastructure model that is adjusted to climate-related hazard exposure, geographic distribution, and energy efficiency standards.

[7] This version of the ESSA is based on this described scope (based on the October 2023 version of the PAD included in the negotiation package). Any changes to this scope may imply changes to what is described/proposed in the final version of the ESSA.

RA3: Efficient and transparent PHC: This area focuses on improving the use of resources in healthcare, leading to more efficient and effective care. Activities will include: (a) modernizing the allocation of PHC funds based on health and social risks, (b) costing the current preventive component of the PHC Health Benefits Package (HBP), (c) training municipal PHC managers to develop effective capacities in leadership and in PHC budget execution skills, (d) developing and implementing an interoperable digital referral system between PHC facilities and specialist physicians in their corresponding hospital network, and (e) create a virtual health management platform for PHC users that allows them to access their health information and health services, schedule appointments, receive reminders and information on healthy lifestyles and/or threats, and evaluate PHC services received. Program Development Objectives.

2.2.2. The Program Development Objectives (PDO) are to improve coverage, quality, and efficiency of PHC, and the health system's resilience. The Program will have 3 outcome indicators to achieve its PDOs, which are:

(a) ***For PHC coverage and quality:*** Decrease in the rate of avoidable hospitalizations of PHC patients with multimorbidity in the participating municipalities.
(b) ***For the PHC contribution to health system resilience:*** Participating municipalities have participated in at least one drill for Public Health Emergency (PHE) and climate change risk preparedness conducted by Comprehensive Surveillance and Response Teams**.**
(c) ***For the efficiency and transparency of PHC financing***: Participating municipalities with positive user experience.

2.2.3. Disbursement Linked Indicators and Verification Protocols

Eight Disbursement Linked Indicators (DLIs) have been defined that are considered critical to the achievement of the PDOs. Based on these and their Disbursement Linked Results (DLRs) the World Bank will disburse funds to PforR. The following table presents a summary of these DLIs:

Table 1 Indicators linked to PforR Disbursements

Results Area	DLIs
RA1: PHC Coverage and Quality	- **DLI1.** It will track the progressive implementation of the Universal PHC program (UPHCP). The scaling up of the Universal PHC program is planned to reach 187 of 346 municipalities (i.e., 54 percent of all municipalities in the country) during the PforR implementation period **DLR 1.1** Will disburse for each municipality integrated in the UPHCP. A municipality will be considered included in the Program when a Participation Agreement, which shall include the obligations related to the PforR, including, inter alia, the ones set forth in the Operation Manual and the Anti-Corruption Guidelines (ACGs), has been signed between the municipality and the corresponding entity of the National Health Service, and when the municipality participates in the UPHCP in accordance with eligibility criteria set forth in the Operation Manual - **DLR 1.2** Will track the number of participating municipalities with at least 50 percent of the registered population receiving at least one PHC service, measured over one year.
	DLI2. It will support the advancement of the gender perspective and the control of violence within the framework of the Universal PHC model, with a focus on women and people identified as LGBTIQA+. This will involve various activities such as training, creation of new protocols and incorporation of sexual identity variables in Monitoring and Evaluation (M&E) programs. Progress in this area will be tracked through: - **DLR2.1** Will measure the availability of Community Health Agents in participating municipalities who are trained in gender-based violence (GBV). - **DLR2.2** Will measure the improvement of user experience among the LGBTIQA+ community.
	DLI3. It will monitor the decrease in the rate of avoidable hospitalizations for PHC patients with multimorbidity in participating municipalities. The indicator measures the decrease in avoidable hospitalization of people with multimorbidity as per ECICEP characterization for three different cohorts. - **DLR3.1** Cohort 1 will be composed of the population of the municipalities that will adhere to the UPHCP as of December 31, 2024 (estimated to be 20 municipalities). **DLR3.2** Cohort 2 will be composed of the population of the municipalities adhering to the UPHCP as of December 31, 2025 (estimated to be 47 municipalities) **DLR3.3** Cohort 3 will be composed of the population of the municipalities adhering to the UPHCP as of December 31, 2026 (estimated to be 60 municipalities)
	DLI4. It will monitor participating municipalities with an increase in the number of people using high-value health services to be determined during implementation in accordance with the WB.
RA2: Resilient PHC	- **DLI5. 5** will support the establishment and deployment of the "Surveillance and Preparedness for PHEs and Climate Change Risks in universal PHC" package I**DLR5.1** Design and implementation of a new Guide to manage public health and climate change risks and emergencies. - **DLR5.2** Supervise that participation of municipalities participate in at least one locally relevant and adapted drill.
	DLI6. It will support the design and implementation of a new PHC infrastructure model that will contribute to improving climate resilience.

	- **DLR6.1** It will be triggered by the publication of a Ministerial Resolution that establishes the new PHC infrastructure model that responds to the health needs of the territories, improves energy efficiency standards and climate resilience standards in the face of specific climate vulnerabilities at the local level. Further training of health infrastructure specialists from health services and municipalities on this new model will be carried out. - **DLR6.2** It will track the increase in new PHC facilities constructed and operating in accordance with the basic requirements of the new PHC infrastructure model.
RA3: Efficient and transparent PHC	**DLI7.** It will support a review of health care purchasing agreements. - **DLR 7.1** will review the process of costing the preventive services on the PHC HBP, which is outdated and will be optimized, providing transparency and the latest information to inform financial decisions on PHC. - **DLR 7.2** will support improvements to the current PHC payment mechanisms by reviewing and improving the capitation mechanism and reviewing the prioritization criteria for the creating and funding of PRAPSs. The new PHC financing decree will establish refined risk adjustment factors to be used by the MOH to finance PHC. In particular, the revised methodology will: (a) improve the adjustment of capitation payments based on epidemiological factors; and (b) increase the accountability of providers in the use of the resources received by incorporating new performance and outcome-based financing components.
	DLI8. It will support the design and rollout of a Virtual Health Management Platform. - **DLR8.1** This platform will be published and disseminated. - **DLR8.2.** Providing citizens with: (a) access to their own health information; (b) general health information and guidance; (c) access to the TeleHealth portal to be able to make appointments; (d) the possibility to interact with a health worker (operator) for health counseling and risk triage, or a referral to a teleconsultation with select specialists ; and (e) the possibility to provide feedback on their experience with the PHC services received.

2.2.4. Institutional arrangements for PforR implementation

The PforR will be implemented by the Ministry of Health (MINSAL) and the Health Services entities under the National Health Services System (SNSS). In addition, in most of the country municipalities supervise the provision of PHC services and therefore participate in the SNSS, as formalized through agreements entered into with the Health Services entities. The MINSAL (MoH) has the general steering role of the health system This develops norms, standards and guidelines and provides technical assistance for their implementation. The MoH Reform Team is part of the Minister's Cabinet Office and is in charge of the implementation of the UPHCP. Within the MoH Reform Team, a Program Coordination Team (PCT) has been created to support the UPHCP and PforR implementation. The PCT has a director who oversees two areas: a technical sub-division and a financial/administrative sub-division. Initial staff for the PCT has been hired and this team will continue to grow in size and build capacity prior to PforR implementation.

The technical subdivision will be responsible for the general supervision of the implementation of the PfoR and for high-level coordination with the other actors involved in the implementation of the Universal PHC Program. The specific functions of the technical sub-division are inter alia: (i) the general supervision of the Program execution; (ii) coordinating: (a) the implementation of the Program's activities across MoH's secretariats and other actors within and outside the health sector; (b) data collection, as applicable; and (c) the external verification process with the Verification Agents; (iii) monitoring performance and reporting of the DLIs/DLRs; and (iv) overseeing and following up on environmental and social (E&S) and fiduciary issues. Within the MoH departments relevant for the UPHCP and the PforR, as well as in each of the other participating entities, a team of one or two key staff members will be designated as focal points. These focal points will closely collaborate with the PCT and oversee PforR implementation according to their areas of competence to ensure the achievement of the DLRs.

The financial/administrative sub-division is responsible for financial management (FM) and procurement-related activities, as well as preparation of financial statements. Precisely, the financial/administrative coordination unit shall be responsible for budget management, procurement and financial management, including, inter alia: (i) coordinating and overseeing the Program's budget execution; (ii) overseeing the procurement and bidding processes executed by the National Health Services Entities and Division of Finance and Internal Administration (*División de Finanzas y Administración Interna,* DIFAI), and the activities under the Program carried out by participating municipalities; (iii) preparing financial statement reports; (iv) developing and facilitating the external verification process with the Verification Agents; and (v) facilitating access to information required for the carrying out of financial audits. The PCT will also coordinate with the Chilean Budget Directorate *(Dirección de Presupuestos de Chile*, DIPRES) to enable it to submit disbursement requests to the WB.

Regarding the **physical interventions of the Program**, based on information provided by MINSAL, the design of the prototype of the new PHC infrastructure to be built with the Program, including E&S sustainability standards, will be done at the central level of MINSAL and the responsibilities for the construction of this infrastructure will fall on the National Health Services entities (HS) , while the municipalities will be in charge of its operation.

One or more agents will be selected through public tendering to be responsible for the verification of DLIs. The terms of reference for the public tendering processes will be prepared in a manner acceptable to the WB. The agent(s) to be hired will provide an independent verification of the achievement of DLRs. Distinct types of DLRs will require different verification methodologies. First, DLRs reflecting processes, such as the development and approval of norms and guides, will require desk-based verification. Second, DLRs reflecting PHC coverage (DLI 1, DLI 4) and PHC quality (DLI 3) will be reported through existing

government information systems, particularly records available at FONASA, Health Services Entities reports, monthly statistical records and/or electronic clinical records, amongst others. Reporting and verification arrangements, processes, protocols, and methodologies acceptable to the WB will be documented in the Program Operation Manual.

2.2.5. Physical interventions of the Program for Results

MINSAL, based on a preliminary analysis of PHC infrastructure gaps in the country, foresees that **the infrastructure to be included in the Program for Results** (RA2, DLI6), to be financed by the Bank, will not be complex[8] and will have the following characteristics:

- Construction of new PHC facilities (called "neighborhood units") that would include 2 boxes (or care units) per facility. Each device of 100 m^2, occupying a land of 200-300 m^2, which is more feasible to find in urban and rural areas, and would serve about 3,000 inhabitants.
- It is estimated that one device will be built per commune to be universalized. It is expected that there will be 187 communes (52% of the total number of communes), which means that 187 devices will be built in four years (duration of the PforR).
- New technologies and energy efficiency principles are planned to be incorporated into these new devices.
- Investments would include construction, provision of basic services (electricity, water, sewage), equipment with minor clinical furniture, and until the device obtains sanitary authorization to operate, granted by the regional health authority, the Regional Ministerial Health Secretariats (SEREMIS).
- The devices will not be fitted with major medical equipment.
- The implementation of mobile clinics or tents will not be included.
- No financing will be provided for remodeling or upgrading of existing infrastructure.
- Works to establish Internet connectivity will not be financed, nor will investments for remodeling, refurbishment or expansion of existing PHC infrastructure.

Technical standards, sustainability, service offerings, among others, as well as the design of this new infrastructure will have to be developed and regulated prior to its construction.

Once MINSAL completes the gap analysis[9] on PHC infrastructure, the details of the new PHC infrastructure[10] to be built with funding from the Program will be confirmed, in terms of number of facilities, materials, design, exact location, sustainability standards to be included, among others.

[8] In accordance with Art. 2º of the Organic Regulations for health facilities of lower complexity and self-management network facilities, a facility of lower complexity is one that performs open, closed and emergency care activities, of low complexity, which mainly develops primary level activities and some specialty activities, according to its role within the Health Care Network it integrates and in the area of competence determined by the Service Director in consultation with the Health Care Network Integration Council.

[9] The final gap analysis is expected to be completed before the Program's effectiveness.

[10] The main environmental risk of this P4R derives from these physical interventions.

2.2.6. PforR activities that may have social impacts

Based on the documentation reviewed, it is possible to point out that the three result areas of this Program for Results address aspects related to improvements in the provision of PHC that have been identified by the Ministry and key health agents as fundamental elements to overcome gaps in accessibility, equity, quality, timeliness, pertinence and coverage of the PHC network, recognizing the diversity of both current and potential beneficiaries with a human rights approach and a gender and social inclusion perspective.

In the social area, RA1 activities include: (i) the design and implementation of a new Comprehensive People-Centered Care Strategy (ECICEP) with special focus on the prevention and control of Non-Communicable Diseases (NCDs); (ii) a renewed Health Benefits Package; (iii) a patient navigation system; (iv) the redesign of strategies for the participation of individuals, families and communities in decision making, to provide care and services acceptable to citizens and strengthen the social role of PHC; and (v) the development of a Universal PHC model with a gender perspective and focus on the control of gender-based violence in women and LGBTIQA+ communities through training of teams and measurement of user satisfaction.

In the social area, RA2 activities include: (i) the design of a Ministerial Guide for the Surveillance of Public Health Emergency Risks and Climate Change in the PHC Network; (ii) the training of health teams in the Guide; (iii) the formation of Comprehensive Community Response Teams with PHC personnel capable of monitoring public health emergency risks and climate change.

In the social area, RA3 activities include: (i) the design and implementation of a telematic system to manage PHC consultations through a web portal and a mobile application; (ii) the measurement of user experience; and (iii) the modernization of the PHC funds allocation system based on health and social risks; and (iv) the training of municipal PHC administrators to develop leadership skills and effective PHC budget execution.

2.2.7. Alignment with the Alma Ata. Declaration and the Astana Declaration

In general, the activities proposed in this PforR are considered to be in line with the principles of both declarations regarding the strengthening of Primary Health Care, eliminating biases in care through its universalization with a human rights approach and a gender and social inclusion perspective, through improvements in the Family Health Plan, the training of primary health personnel and the incorporation of the user experience as a modeling element of public policy in primary health care.

2.2.8. Exclusion list

Based on the findings of the ESSA, no significant adverse environmental and social impacts are expected as a result of the Program. The following exclusion list defines the typology of activities that cannot be included in the Program due to the significant adverse risks and impacts they would cause on the environment and/or affected people:

- Any construction in protected areas or priority areas for biodiversity conservation, as defined in national legislation[11];
- Construction in high-risk areas due to natural hazards (floods, landslides, earthquakes, tsunamis, fires);
- Activities that have the potential to cause significant loss or degradation of critical natural habitats, either directly or indirectly, or that may generate adverse impacts on these habitats, including urban or rural wetlands;
- Purchase or use of prohibited/restricted chemicals for medical use;
- Any activity that affects physical cultural heritage, such as tombs, temples, churches, historical relics, archaeological sites or other cultural structures;
- Activities that due to their magnitude and scale require an Environmental Impact Study *(Estudio de Impacto Ambiental-EIA)*[12], according to Chile's Environmental Impact Assessment System *(Servicio de Evaluación de Impacto Ambiental-SEIA)*;
- Activities that cause significant air, water or land pollution that may have significant adverse impacts on the health or safety of people, communities or ecosystems;
- Working conditions that expose workers to significant personal health and safety risks;
- Activities that may cause or lead to forced labor or child abuse, child labor exploitation or human trafficking, or that employ or involve children under the age of 18, in connection with the Program;
- Any activity on the land that has disputed ownership or tenure rights;
- Any activity that causes physical and/or economic displacement of the population;
- Any activity requiring Free, Prior and Informed Consent (FPIC) as defined in the World Bank's Environmental and Social Framework.

[11] Law Nº 21.600/2023 creates the Biodiversity and Protected Areas Service and the National System of Protected Areas (SBAP); Law No. 21.202 on the protection of urban wetlands; other priority sites, https://areasprotegidas.mma.gob.cl/otras-designaciones/.

[12] The projects and activities that must submit an EIA are regulated in Article 11 of Law 19,300 of the General Bases of the Environment and, in general, refer to those that have significant negative impacts.

3. POTENTIAL ENVIRONMENTAL AND SOCIAL EFFECTS OF THE PROGRAM

3.1. Potential Environmental Benefits and Risks

3.1.1. Potential Environmental benefits

Main positive environmental effects are related to the use of[13] sustainability and climate change resilience standards for the implementation of a new model of energy efficient PHC facilities (RA2, DLI6). The Program is also expected to strengthen the environmental monitoring and management capacity of the Health Services in charge of the construction of the new PHC facilities (RA2, DLI6), through specific training activities of the Program, as detailed in section 5 of this document, and capacity building in emergency response and in the implementation of community surveillance plans.

3.1.2. Potential Environmental, Health and Safety Risks and Impacts

No significant adverse EHS impacts are expected as a result of the Program. However, some of the activities supported under the PforR, specifically some related to RA2 will have potential negative risks and impacts associated with the construction of the new model PHC facilities and their operation. This new infrastructure is expected to include, mainly, the construction of the new PHC facility model, its connection to the electricity service, private drinking water supply and sewerage, among others, and an operation stage that contemplates the use of the infrastructure and the management of domestic and clinical solid waste. Table 2 below presents the potential environmental and health and safety risks and impacts expected associated with the construction and operation activities of the new PHC infrastructure that the Program would finance.

[13] To establish environmental sustainability and climate change resilience standards for new PHC facilities to be built under the Program, it is recommended that MINSAL review the following document: WHO guidance for climate resilient and environmentally sustainable health care facilities (2020). Available at: https://www.who.int/publications/i/item/9789240012226

Table 2 Potential Environmental and Health and Safety (H&S) Risks and Impacts

PRE-CONSTRUCTION STAGE OR PREPARATION OF THE CONSTRUCTION SITE		
Activity	**Environmental Risks**	**H&S Risks**
Removal of vegetation cover (during the opening of access roads and/or during land clearing at the construction site)	• Damage to the vegetation in the area due to the removal of trees and smaller species. • Damage to fauna associated with the affected vegetation, due to the disappearance of nesting, shelter and feeding areas, as well as direct damage to burrows and individuals that inhabit the removed vegetation. • Soil erosion due to vegetation removal on steep slopes and near slopes. • Affectation of air quality due to smoke generation in case of using fire to remove vegetation cover.	• Injuries to workers during vegetation removal activities for site preparation due to lack of use of personal protective equipment. Injuries due to reaching machinery and accidents with tools and equipment. • Injuries to workers due to snake bites or bites from other endangered animals during vegetation removal work and road opening. • Damage to the health of workers and people in transit through the work area, due to smoke inhalation.
Land clearing	• Direct impact on the soil by its removal at the construction site and by erosion at the edges of the cleared area, where it is carried away by wind and rainwater. • Affecting the stormwater runoff pattern of the site. • Air quality is affected by the generation of contaminating emissions from the operation of machinery that emits fumes and gases from its engines and raises particles from earthmoving. • Impact on the work environment at the construction site due to noise generation from the operation of machinery.	• Injuries to workers due to reaching machinery and accidents with tools and equipment. • Damage to workers' health due to exposure to noise at high levels for prolonged periods of time, in the event of not using the appropriate personal protective equipment.
Excavations and land leveling	• Affecting the natural topography of the site and the rainwater runoff pattern, with the possible effect of flooding the property or surrounding land, or reducing the infiltration rate to the subsoil. • Air quality is affected by the generation of particulate matter emissions and pollutants from the operation of machinery, which emits fumes and gases from its engines and raises particles from earthmoving. • Impact on the work environment at the construction site due to noise generation from the operation of machinery. • Damage to cultural heritage due to destruction or looting of historical or archaeological artifacts discovered during excavations. • Impact on air quality due to smoke and particle emissions during the transport of excavation waste to authorized dump sites.	• Damage to the health or physical integrity of workers due to falls into excavations or collapses in excavations with workers inside. • Injuries to workers due to reaching machinery and accidents with tools and equipment. • Damage to workers' health due to exposure to noise at high levels for prolonged periods of time, in the event of not using the appropriate personal protective equipment.

	• Damage to vegetation and associated fauna, to the landscape, and contamination of soil and surface and subway water due to improper disposal of excavation waste in unauthorized locations.	
Camp and materials storage	• Contamination of soil, surface water and groundwater by leaking or spilled fuels or other stored chemicals, which can be washed away by rain. • Contamination of bodies of water and impact on drainage and sewage systems near the construction site, due to construction materials dragged by wind or rain. • Contamination of soil, surface water and groundwater due to improper handling and disposal of sewage generated by personnel participating in the project.	• Damage to workers' health by direct contact with toxic materials, by inhaling their vapors or by consuming contaminated water or food. • Damage to the physical integrity of workers due to fire in the camp or materials warehouse. • Damage to workers' health from consuming water or food contaminated by sewage or feces from workers participating in the work.
Site preparation and construction	• Increased population at the project site due to the arrival of workers for the project, with the consequent increase in waste, impact on water quality and quantity, and emissions associated with increased traffic.	• Increased road insecurity, insecurity of people in the community, sexually transmitted diseases, insecurity.
CONSTRUCTION STAGE		
Activity	**Environmental Risks**	**H&S Risks**
Construction of foundations	• Air quality is affected by the generation of contaminating emissions from the operation of machinery that emits fumes and gases from its engines and raises particles from earthmoving. • Impact on the work environment at the construction site due to noise generation from the operation of machinery. • Damage to cultural heritage due to destruction or looting of historical or archaeological artifacts discovered during excavations.	• Injuries to workers due to reaching machinery, falls inside excavations or collapses in excavations with workers inside, and accidents with tools and equipment. • Damage to workers' health due to exposure to noise at high levels for prolonged periods of time, in the event of not using the appropriate personal protective equipment.
Transportation of construction materials, operation of machinery and vehicles	• Transfer of pollutants to the atmosphere (dust, combustion gases and noise). • Transfer of pollutants to soil and water, by falling or dispersion of construction materials during transportation.	• Damage to the health or physical integrity of site workers, residents in the area and people in transit through the site and its surroundings, due to exposure to dust and noise; due to machinery reach; or due to vehicular accidents when working in urban areas.
Maintenance of construction equipment and machinery	• Contamination of soil, surface water and groundwater due to improper handling and disposal of hazardous waste (spent lubricating oils, solvents used to clean parts, impregnated with oils and solvents, empty containers, etc.) resulting from the maintenance of the machinery involved in the work.	• Damage to workers' health by direct contact with toxic materials, by inhaling their vapors or by consuming contaminated water or food.

Exploitation of material banks	• Damage to vegetation and associated fauna, soil and water bodies due to the use of construction materials from unauthorized material banks. • Soil and road contamination and air quality contamination due to particulate and material emissions during transportation from the material bank to the construction site.	• Damage to the physical integrity of workers due to road accidents occurring during the transportation of materials to the construction site.
Rupture of pavements, demolition of sidewalks, major demolition.	• Transfer of pollutants to the atmosphere (dust and noise). • Damage to existing infrastructure in the work zone, such as communication lines, drinking water, drainage, natural gas, electricity, railways and similar. • Deterioration of the visual environment in and around construction sites. • Damage to vegetation and associated fauna, to the landscape, and contamination of soil and surface and groundwater due to improper disposal of demolition waste in unauthorized locations.	• Damage to the health or physical integrity of workers, residents in the area and people in transit through the construction site, due to exposure to dust and noise; or due to accidents with tools and equipment, or contact with materials leaking from damaged pipelines (gas, fuels).
Waste management	• Transfer of pollutants to soil and water and impact on associated flora and fauna, by dispersion of waste at the temporary storage site; or by dispersion during transportation and disposal of waste in unauthorized sites.	• Damage to the health or safety of site workers, residents in the area and people in transit through the site and its surroundings, due to exposure to hazardous waste such as solvents or other toxic substances; or due to consumption of water or food contaminated by site waste.
Management of fuels, lubricating oils, additives and other chemicals	• Contamination of soil, subsoil, surface and subway water and associated flora and fauna due to spills of fuels, oils, additives and other chemical products stored without spill control devices or leaked from vehicles and machinery involved in the work.	• Damage to workers' health by inhalation or direct contact with spilled chemicals.
Road closures and blocking of access to public places or businesses and residential areas	• Restriction of the use of highways or roads and accesses, with inconveniences for people in transit and inhabitants of the area. • Increased traffic and vehicular emissions in the areas surrounding the construction site.	• Damage to the health or physical integrity of workers and people in transit through the construction site, in the event of a fall into open pits, machinery reaching the site, accidents with tools and equipment, vehicular accidents when working on urban roads, etc.
Fire and accidents on the construction site	• Transfer of pollutants to the atmosphere (fumes).	• Damage to the health or physical integrity of workers, residents of the area and people in transit through the construction site, due to smoke inhalation or direct contact with the fire.
Wastewater management	• Contamination of soil, subsoil and bodies of water and impact on associated flora and fauna, due to inadequate handling and disposal of wastewater generated in the restrooms provided for personnel participating in the project.	• Damage to health from contamination of drinking water or food with sewage.
Dismantling of support infrastructure at the end of the construction work	• Transfer of contaminants to soil and water, damage to vegetation and associated fauna due to improper handling and disposal of waste in unauthorized sites.	• Damage to the physical integrity of workers due to accidents or incidents occurring during the dismantling of support infrastructure on site, or with tools and equipment.

	• Impact on the landscape due to the permanence of waste or remains of camps, warehouses and other support services for the work.	
OPERATIONAL PHASE		
Activity	**Environmental Risks**	**H&S Risks**
Use of services and road infrastructure in the area	• Impact on the availability of water, electricity, drainage, etc., due to an increase in demand resulting from the operation of the PHC facility. • Affecting roads near the project due to increased vehicular traffic, which implies higher air emissions and noise pollution. In addition, there will be an increase in the number of buildings and parking facilities.	• Accidents or road incidents due to increased traffic and pedestrians at and near the PHC facility site. • Disturbance to residents near the new PHC facility due to increased noise from increased traffic, vehicle emissions.
Use and storage of fuels and chemicals	• Soil and water contamination and damage to the physical integrity of the population and workers, due to leaks or spills of chemicals, fuels and generation of toxic vapors, or fire, resulting from the storage of chemicals (disinfectants and liquids for cleaning and maintenance of facilities) and fuels (LP Gas and diesel) without spill control systems and without fire control devices.	• Damage to the health and physical integrity of workers due to direct contact and handling of spilled chemicals and fuels without the corresponding protective equipment. • Damage to the health and physical integrity of workers and the population due to fires caused by the improper use and storage of combustible waste and chemical products.
Generation of atmospheric emissions	• Impact on air quality due to smoke emissions from steam generation and water heating systems (boilers).	• Affecting the health of site workers and the nearby population.
Wastewater generation	• Contamination of drainage systems and bodies of water due to discharge of chemical products from inappropriate management of cleaning products, clinical analysis, or discharge of water from the PHC facility's bathrooms.	• Impact on the health of the population in the area of the new PHC facility due to the alteration of drinking water quality.
Solid waste generation	• Contamination of the work environment due to inadequate storage of solid waste, which can lead to the proliferation of disease vectors such as insects and rodents. • Soil and water contamination due to improper handling and disposal of solid waste in unauthorized sites.	• Damage to the health of workers and the population due to contact with disease vectors such as insects and rodents.
Hazardous waste generation	• Soil and water contamination due to improper handling (mainly storage and transportation in unsafe conditions) and incorrect disposal of hazardous waste (maintenance waste and waste from chemical products, disinfectants, needles, as well as mercury-containing thermometers, pressurized containers and pesticide containers) in unauthorized sites.	• Damage to workers' health due to the handling of hazardous waste without adequate personal protective equipment and without the required training.

Generation of out-of-specification, expired or out-of-use medicines	• Improper management and disposal of pharmacological waste, which can contaminate soil and water bodies.	• Damage to the health of the population due to the consumption of off-spec, out-of-date or obsolete drugs, which are incorporated into the informal trade as a result of improper handling and disposal of pharmacological waste.
Generation of biohazardous waste	• Improper management and disposal of biohazardous waste, which can contaminate soil and water bodies.	• Damage to the health of the population and workers due to incorrect separation of biohazardous waste, which is taken untreated to common waste management sites. • Damage to the health of workers who directly handle biohazardous waste due to the spread of infectious diseases resulting from the lack of personal protective equipment and unsafe practices due to lack of training and supervision.
Attraction of street commerce	• Contamination of soil and water sources due to increased waste generation and the presence of disease vectors such as insects and rodents.	• Affecting the health of the population, due to the presence of disease vectors such as insects and rodents that develop in the uncontrolled waste generated by the installation of street stalls attracted by the influx of people in the vicinity of the project.
During the construction and operation of the new infrastructure included in the Program, there is a risk of disasters, such as earthquakes, floods, fires, among others. These can cause emergencies and endanger both the infrastructure and the safety and health of workers at the construction sites and operating facilities, as well as the population of the communities where these facilities are established.		

3.2. Potential Social Benefits and Risks

3.2.1. Potential social benefits

Main social benefits of the Program for Results are related to: (i) the incorporation of telematic platforms for remote care and requesting medical appointments in PHC that will provide beneficiaries with new ways of access, thus allowing not only to reduce crowds in PHC facilities, but also to provide care to population groups who, due to geographic determinants, schedules, movement problems or care responsibilities, among others, find it very difficult to access face-to-face services; (ii) improving the quality, timeliness and relevance of services at the primary health care level through actions that will make it possible to update and evaluate the Model of Comprehensive Family and Community Health Care through a human rights approach and a gender and social inclusion perspective, incorporating social determinants, and establishing minimum standards for the training of health teams and civil servant training systems in key areas to ensure dignified, relevant and non-discriminatory care; (iii) the strengthening of community participation through the training of community agents; and (iv) the permanent and systematic measurement of user satisfaction, providing a key opportunity to observe the effectiveness of activities at the local, regional and national levels; (v) the construction of new PHC centers as an important advance in territorial coverage, especially beneficial for inhabitants of rural, semi-rural or highly populated areas.

The main positive social effects are related to the institutional commitment in the cultural and territorial adequacy of PHC service provision aimed at special care groups, such as women who suffer gender-based violence, LGBTIQA+ population, elderly people, immigrants, rural residents, as well as people belonging to indigenous and tribal peoples, among others. Activities aimed at sensitizing and training health personnel in the care of special attention groups, as well as the training of community agents to support cutting-edge approaches to face gender-based violence, also stand out.

3.2.2. Potential social impacts and risks

No significant adverse social impacts are expected as a result of the Program, mainly due to the fact that Chile has a solid legal and regulatory framework in terms of: (i) protection of indigenous lands or lands with patrimonial moratorium; (ii) protection of workers; (iii) social inclusion and non-discrimination; (iv) citizen participation; (v) resolution of complaints in public services; and (vi) guarantee and access to health, where health care is guaranteed to the entire population, including people who are not registered with any type of social security health insurer, the extremely poor, immigrants in irregular migratory situations and people belonging to sex-generic diversities.

In relation to the construction of new PHC centers, MINSAL has a guideline for the selection of land in rural areas that includes a review of the feasibility of construction in terms of availability of basic services, land ownership and moratoriums, and proximity and accessibility for the target population, among other criteria that guarantee compliance with national and institutional regulations and that include social criteria in the selection of land. The poor perception of citizens regarding the functioning of the public health system, including the primary level (PHC), associated with long waiting lists, poor quality of care and discriminatory practices[14] are observed as a risk for the Primary Health Care Universalization Program, mainly in relation to: the incorporation of new PHC users, especially for those PHC centers that currently

[14] Study of Health Users regarding the Law of Rights and Duties. 2015. Superintendence of Health. Source: https://www.supersalud.gob.cl/difusion/665/articles-12611_recurso_1.pdf

serve a larger number of people than those for which they were designed; the results of the measurement of the user experience and the adjustments agreed therefrom; as well as the strengthening of a citizen participation system focused on collaboration rather than on complaints.

On the other hand, the diversity and heterogeneity of municipalities that manage approximately 92.6% of PHC facilities, in terms of equity of resources, both financial and human, as well as the capacity of the Ministry of Health to carry out the standardization of its management and performance capacities, have been considered by specialists as one of the main reasons for the persistence of inequity in health care[15] . From the point of view of social risks for the activities to be developed by the Program, it is a challenge for the Program to establish and standardize mechanisms, standards, criteria and procedures in the new PHC care model that will allow the population to perceive equity and quality in the care received without interference from historical deficiencies in the availability of financial resources and staffing or training, especially in the poorest municipalities.

In relation to the selection of communes for the construction of new PHC centers, it is suggested that the criteria used by MINSAL to define their location include: (i) the definition of rurality used by the National Rural Development Policy (PNDR)[16] ; (ii) data from the Rural Quality of Life Indicators System[17] ; and (iii) Social Determinants of Health[18] .

The following table describes the social risks associated with the construction of PHC centers.

[15] Primary Health Care in Chile and in the International Context: validity, experience and challenges. 2019. Gattini Collao, César. Chilean Public Health Observatory. Source: https://www.ochisap.cl/wp-content/uploads/2022/04/APS_en_Chile_e_Internacional_Gattini_OCHISAP_2019.pdf

[16] While the National Statistics Institute (INE) defines a rural locality as a human settlement with a population less than or equal to 1,000 inhabitants, or between 1,001 and 2,000 inhabitants where more than 50% of the population that declares having worked is engaged in primary activities, the National Rural Development Policy (PNDR) defines a rural commune or locality as one whose population density is less than 150 inhabitants/km², with a maximum population of 50,000 inhabitants, whose unit of reference is the commune. For the calculation of the regional rural area, mixed and rural communes are considered. Source: https://www.masvidarural.gob.cl/

[17] Rural Quality of Life Indicators System. National Institute of Statistics (INE). Source: https://www.ine.gob.cl/herramientas/portal-de-mapas/sicvir

[18] Social Determinants of Health. World Health Organization (WHO). Source: https://www.paho.org/es/temas/determinantes-sociales-salud

Table 3 Potential Risks and Social Impacts

PRECONSTRUCTION STAGE OF PHC CENTERS	
Activity	**Social risks**
Selection of communes where new PHC centers will be built	• Omission of demographic, social, cultural and health characteristics of the population that prevent the design of adequate facilities with cultural and territorial relevance. • Omission of characteristics related to geographic connectivity and the type of commune in which a PHC center will be built that would prevent improving accessibility to PHC centers for populations that currently do not have a nearby PHC center. • Incorporation of communities without Internet connection.
Selection of land on which new PHC centers will be built	• Selection of land that omits the demographic, social, cultural and health characteristics of the population, preventing the design of adequate facilities for dignified, timely and socially and culturally relevant care. • Involuntary physical and/or economic displacement as a result of the acquisition of the selected lands. • Construction of new PHC centers on indigenous lands or lands with patrimonial moratorium that affect the cultural, tangible and intangible heritage of the population and the country. • Omission of citizen and/or indigenous consultation that prevents the population from actively participating in the construction process of new PHC centers. • Selection of land with high levels of insecurity and violence. • Selection of land with no or infrequent public transportation. • Selection of land with low resilience and road access rehabilitation capacity in the event of climatic and sanitary emergencies or natural disasters.
Design of new PHC centers or redesign of existing PHC centers	• Omission of demographic, social, cultural and health characteristics of the population that prevent the design of adequate facilities, with cultural relevance and capacity for care. • Omission of citizen and/or indigenous consultation that prevents the population from actively participating in the design process of new PHC centers.
Selection of entities in charge of the construction of PHC centers	• Irregular hiring of workers by the contracting entities in charge of the construction of PHC centers that prevent compliance with national labor and social security regulations for workers at the construction sites. • Hiring processes for personnel involved in the construction of PHC centers that discriminate on the basis of sex, gender identity, ethnicity, nationality, age or other conditions protected by national and international regulations. • Exploitation of children by the entities awarded the contract for the construction of PHC centers.

Site preparation and construction of PHC centers	• Omission of multichannel information processes aimed at the community explaining the scope of the works and the mechanisms for requesting more information or making complaints and suggestions.
CONSTRUCTION PHASE OF PHC CENTERS	
Activity	**Social risks**
Construction of new PHC centers	• Increased floating population at the project site due to the arrival of workers for the project that could affect the coexistence of the inhabitants, such as: use of public spaces for food, rest or other purposes; increased vehicular traffic; increased insecurity due to theft, fights or other conflicts; increased incidence of gender-based violence, especially in relation to sexual exploitation and cases of sexual harassment and abuse; restrictions on the use of public roads and access to services. • Adverse impacts on merchants (e.g., reduction of income) affected by blocking access to their stores, even if temporary. • Lack of clear and expeditious mechanisms to receive and respond to complaints from the inhabitants regarding the impacts that the works may cause. • Risk that the new PHC centers will not be completed on time due to abandonment by the company awarded the contract.
STAGE OF OPERATION OF PHC CENTERS	
Activity	**Social risks**
Start-up of the PHC center	• Occurrence of illicit activities in the vicinity of the PHC center, such as: street commerce, robberies, sexual harassment and others that could affect the coexistence and safety of people passing by. • Informal commerce in the vicinity of the center that could be used by children and adolescents. • Lack of clear and expeditious mechanisms to receive and respond to complaints from the inhabitants regarding the impacts that the works may cause. • Risk of increasing the bad reputation of the public health system due to the increase in demand in PHC centers due to the incorporation of new users, especially in PHC centers that currently provide services to a larger population than the one for which they were designed. • Omission of communes whose majority of inhabitants belong to ISAPRE, in order to monitor how the referral system is developed with other levels of health care. • Difficulty in establishing minimum quality and equity standards in the new PHC care model due to the diversity and heterogeneity of municipalities. • Risk in the operation of PHC centers when health emergencies occur if the sector's response is not designed with a gender perspective, due to the feminization of health personnel working in PHC.

4. EVALUATION OF ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

4.1. Environmental Management Systems relevant to PforR

This section mainly contains a summary of the laws, regulations and institutional framework governing the management of environmental, safety and occupational health risks (in particular the risks highlighted in the previous section) in PHC facilities in Chile, with a focus on those of low complexity, as the new infrastructure model to be built with WB funds is expected to be. It should be noted that some aspects related to social management are strongly linked to environmental management and are therefore comprehensively addressed in the following sections, other specific aspects of social management are addressed in section 4.2.

4.1.1. Environmental Legal Framework relevant to the Program

Regarding the management of environmental risks and impacts of civil works, Chile has a robust environmental impact assessment system (SEIA, by its acronym in Spanish), administered by the Servicio de Evaluación Ambiental-SEA (Environmental Assessment Service). Based on the information available to date on the scope of construction of the new infrastructure to be included in the Program, as detailed in section 2.2.5, it is expected that it will not require submission to the environmental assessment system under Chile's SEIA, in accordance with Law No. 19,300 on General Environmental Standards (LBGMA, by its acronym in Spanish) and its regulations (Article 10 of Law No. 19,300 establishes the types of projects that must be submitted to the SEIA, and these are specified in Article 3 of the SEIA Regulations), which will not exempt them from complying with the relevant national, regional and local environmental and health and safety standards required by the competent authorities for this type of works.

On the other hand, once MINSAL (MoH) confirms the scope of the physical interventions to be included in the Program, in the event that any of them need to be submitted to the SEIA, it would have to be of a scope whose required impact assessment instrument is an Environmental Impact Statement (DIA, by its acronym in Spanish), in accordance with the LBGMA and SEIA Regulations (as explained in section 4.1.3), since activities that require the development of an Environmental Impact Study (*Estudio de Impacto Ambiental-EIA*) will be excluded from the Program.

The following tables identify the general and specific environmental regulations applicable to the Program. The latter are analyzed in relation to environmental components, such as air, water, soil, flora and fauna and cultural heritage, occupational health and safety, among others.

Table 4 General regulations applicable to the Program for Results in environmental matters

Law/Regulation	Description
Political Constitution of the Republic. Supreme Decree Nº100/2005. Ministry General Secretariat of the Presidency.	Fundamental norm of the national legal system that regulates the organization of the State, the rights and duties of individuals, the structure and functions of institutions, among other matters. The Political Constitution deals with environmental issues in Chapter III "On Constitutional Rights and Duties", specifically in Article 19 number 8, where it recognizes as a fundamental right "The right to live in an environment free of pollution. It is the duty of the State to ensure that this right is not affected and to protect the preservation of nature. The law may establish specific restrictions on the exercise of certain rights or freedoms to protect the environment". It also guarantees the terms that must be made compatible with the protection of the environment, the right to property, the freedom to acquire all kinds of goods, the right to develop any lawful economic activity, equality before the law and the right not to be discriminated against by the State or its agencies in economic matters, all of which are equally protected by law, and under which the holders assume their corresponding investment projects or activities in terms that must be compatible with the protection of the environment.
Resolution Nº 7 of March 26, 2019, of the Office of the Comptroller General of the Republic, which establishes rules on exemption from the process of taking the Comptroller General of the Republic **into account.**	The taking of evidence is a mandatory control of the legality of the acts, which safeguards the principle of probity, the right to good administration and the care and proper use of public resources.
Law Nº 19.886/2003 (last amendment 2022), Law of Bases on Administrative Supply and Service Contracts (Public Procurement Law).	The main purpose of this law is to standardize the administrative procedures for contracting the supply of movable goods and services necessary for the operation of the Public Administration and to improve transparency in the management of the Public Treasury at the State and municipal levels. With this law, the necessary institutional framework was created to ensure transparency and efficiency in procurement, preserve equal competition and consider due process. For these purposes, a web platform was also created, which is the Electronic System of Public Procurement www.chilecompra.cl, with the purpose of being able to carry out all the necessary transactions in a purchase, both public services and municipalities.
Law Nº 18.575/1986 Constitutional Organic Law of General Bases of the State Administration	This norm establishes the general principles and the structure that will govern the State Administration. It guarantees the right of citizens to petition or complain to any organ of the State Administration.
Law No. 19,880/2003, which establishes the bases of the administrative procedures that govern the acts of the organs of the State Administration.	This regulation governs the administrative procedures through which the State Administration acts and makes decisions.
Law Nº 19.300/1994 of General Bases of the Environment (LBGMA) and its amendments.	This norm regulates in a general manner the constitutionally guaranteed right to live in a pollution-free environment. It establishes the applicable principles, environmental management instruments, liability for environmental damage, oversight regulations, among other matters. Article 8 of this LBGMA establishes that "The projects or activities indicated in Article 10 may only be executed or modified after an environmental impact assessment, in accordance with the provisions of this law". Said Article 10 provides a list of "projects or activities susceptible of causing environmental impact, in any of their phases, which must be submitted to the environmental impact assessment system", which are specified in Article 3 of the Regulations of the Environmental Impact Assessment System (RSEIA).

Law/Regulation	Description
	Health infrastructure projects and therefore PHC, according to the provisions of Law 19,300 (Art. 10) belong to the typology of urban or real estate development projects.
Law No. 20,417/2010. Creates the Ministry, the Environmental Evaluation Service and the Superintendence of the Environment.	Creates the Ministry, the Environmental Evaluation Service and the Superintendence of the Environment.
D.S. N°40/2012, Approves Regulation of the Environmental Impact Assessment System (RSEIA) Ministry of the Environment	This regulation establishes the provisions governing the SEIA and Community Participation in the Environmental Impact Assessment process, as established in the LBGMA. Article 3 of the RSEIA (section g.1.2 and section h.1) specifies the criteria for urban development or real estate projects that are likely to cause environmental impact and must be submitted to the SEIA. Those that do not comply with these criteria must not be submitted to the SEIA. Article 26 of the RSEIA regulates consultations on the relevance of entering the SEIA, stating that "[...] the proponents may contact the Regional Director or the Executive Director of the Service, as appropriate, in order to request a ruling on whether, based on the information provided for this purpose, a project or activity, or its modification, must be submitted to the SEIA. The answer issued by the Service shall be communicated to the Superintendency".
Decree 458/2023 approves the new General Law of Urbanism and Construction. Ministry of Housing and Urbanism	It establishes the provisions related to urban planning, urbanization and construction. Article 5° provides that: "The Municipalities shall be responsible for applying this law, the General Ordinance, the Technical Standards and other Regulations, in their administrative actions related to urban planning, urbanization and construction, and through the actions of the respective public utility services, and shall ensure, in any case, compliance with its provisions.
Decree 14/2019 amending D.S. 47/92 of Housing and Urbanism of 1992, General Ordinance of Urbanism and Constructions (OGUC) Ministry of Housing and Urbanism.	Establishes the provisions and measures to be taken in all construction, repair, modification, alteration, reconstruction or demolition projects to mitigate the impact of dust and material emissions, deposit materials in authorized public spaces, maintain cleanliness of the public space where the work is located. Establishes the provisions for Communal Urban Planning that will regulate the physical development of urban areas, through a Communal Regulatory Plan (P.R.C.).[19]
Law Nº 20.703/2013, Creates and regulates the national registers of Technical Construction Inspectors (ITO) and structural calculation project reviewers, modifies legal norms to guarantee the quality of constructions and expedite applications before the municipal works directorates.	This Law establishes rules on Construction Technical Inspectors (ITO) and creates and regulates the National Registry of Construction Technical Inspectors (ITO) and the National Registry of Structural Calculation Project Reviewers. It establishes, among others, who may be registered in the National ITO Registry and remain registered in it, requirements for registration, as well as categories of technical inspectors, according to their technical suitability and professional experience in accordance with the type of work in question, under the terms set forth in this law and its regulations.

[19] Marco Normativo Plan Regulador Comunal, available at: https://www.catalogoarquitectura.cl/cl/oguc/marco-normativo-plan-regulador-comunal

Law/Regulation	Description
Law Nº . 21.455/2022 Framework Law on Climate Change	It establishes climate governance, powers and obligations of Chile's state agencies for climate action, and sets the goal of carbon neutrality and resilience by 2050.
D.F.L. N°725/1968, modified by Law N°21.030/2017 Sanitary Code. MINSAL	It governs all matters related to the promotion, protection and recovery of the health of the inhabitants of Chile, except those subject to other laws. Within its regulation it includes norms related to hygiene and safety of the environment and workplaces.
Law Nº 20.285/2008 on Access to Public Information	This law regulates the principle of transparency of the civil service, the right of access to information of the organs of the State Administration, the procedures for the exercise of the right and for its protection, and the exceptions to the disclosure of information.
Law No. 20,500/2011 on Associations and Citizen Participation in Public Administration	This law establishes definitions and mechanisms for forming public interest citizens' associations, and defines the ways in which such entities will participate in the management of the authorities.
Decree Nº680/1990 Approves instructions for the establishment of Information Offices for the public user in the State Administration of the Ministry of the Interior.	This Decree establishes the obligation of ministries and other public services to have Information, Complaints and Suggestions Offices (OIRS) and regulates their operation.
Law No. 21.305/2021 on Energy Efficiency	The purpose of this law is to establish the obligation of the Ministry of Energy to prepare a National Energy Efficiency Plan every 5 years. The "Plan" must contemplate, among others, a goal of reducing energy intensity by at least 10% by 2030, with respect to 2019; it also stipulates that homes, public buildings, commercial buildings and office buildings must have an energy rating to obtain the final or definitive reception by the respective Municipal Works Directorate, among others.
Law No. 21.364/2021 Establishes the National System for Disaster Prevention and Response.	This norm establishes the National Disaster Prevention and Response System and regulates a series of disaster risk management instruments.
Decree Nº1.434/2021 Exempt. Approves the National Emergency Plan 2020 - 2030 of the Ministry of the Interior and Public Security.	This Plan is an instrument for disaster risk management whose purpose is to establish response actions in the different areas of the country. operational phases, in emergency, disaster or catastrophe situations, with the objective of providing protection to people, their property and environment, in the national territory, through the coordination of the National Civil Protection System.

Table 5 Specific environmental regulations

Law/regulation	Description
Air quality and atmospheric emissions	
Decree No. 138 of the Ministry of Health establishes the obligation of the owners of fixed sources of emission of atmospheric pollutants to submit to the respective SEREMI of Health the necessary information to estimate the emissions from each of their sources.	It regulates the emission declarations of all economic activities. Emission declarations must be made by those who work in agriculture, commerce, tourism, industry, transportation and telecommunications, real estate, health, education, social and community services companies, among others that have hot water or steam boilers or use generators. The regulated companies must submit annual information to the Health Authority so that the State can estimate the emissions of atmospheric pollutants on an annual basis. This regulation does not establish emission limits, only the obligation to submit information to calculate emissions.
Emission standards established by the Atmospheric Decontamination Plans (PDA) and that must be met by all sources located where there is a PDA.	These are environmental management instruments that, through the definition and implementation of specific measures and actions, aim to reduce air pollution levels in a saturated zone in order to protect the health of the population.
DECREE S.G. N° 144/1961. Establishes Norms to Avoid Emanations or Atmospheric Pollutants of any Nature. Ministry of Health.	It establishes that gases, vapors, fumes, smoke, dust, emanations or pollutants of any nature, produced in any manufacturing establishment or place of work, must be captured or eliminated in such a way that they do not cause danger, damage or nuisance to the neighborhood.
D.S. NO. 279/1983. Approves Regulation for the Control of Pollutant Emission from Internal Combustion Motor Vehicles. Ministry of Health.	Establishes the regulatory and technical aspects for the control of pollutant emissions from the exhaust pipe of internal combustion motor vehicles.
D.S. N°75/1987, modified by D.S. N°78/1997. Establishes Conditions for the Transportation of Cargoes indicated. Ministry of Transportation and Telecommunications.	Establishes the conditions for the transportation of cargo
DECREE S. N°38/2011. Establishes Noise Emission Standard for Noises Generated by Sources Indicated. Ministry of Environment.	The levels generated by noise emitting sources shall comply with the maximum permissible sound pressure levels.
Road works	
Decree No. 90/2003 Approves New Text and Annexes of Chapter Five of the "Traffic Signaling Manual" that establishes Transitory Signaling and Safety Measures for Work on the Roadway	Chapter 5 of the Traffic Signaling Manual addresses the signs, devices, safety measures and signaling schemes to be used when road works are carried out, understood as any work or temporary restriction that causes partial or total obstruction of the road.
Solid waste	
DS 6/2009 Regulation on Waste Management in Health Care Establishments (REAS). MINSAL	Establishes norms for the management of "solid" waste generated in health care facilities
Law Nº20.920/2016. Establishes Framework for Waste Management, Extended Producer Responsibility and Promotion of Recycling. Ministry of Environment (MMA)	The purpose of this law is to incorporate waste recovery as a fundamental element in the management of solid waste and to introduce into the existing regulations on the subject an economic instrument that seeks to generate mechanisms to increase the recycling levels of waste that is currently disposed of in sanitary landfills or deposited in illegal dumps.

Hazardous Waste	
D.S. NO. 148/2003. Approves Sanitary Regulation on Hazardous Waste Management. MINSAL	Establishes the minimum sanitary and safety conditions related to the generation, possession, storage, transportation, treatment, reuse, recycling, final disposal and other forms of elimination of hazardous waste.
D.S. 43/15, Regulation of storage of hazardous substances. MINSAL	Establishes the storage conditions for hazardous substances classified in accordance with the provisions of NCh382:2013. The substances to which this regulation applies are compressed gases, flammable liquids, flammable solids, oxidizers and organic peroxides, acute toxic, corrosive and miscellaneous hazardous substances.
Basic Health Services	
Decree with Force of Law (D.F.L.) N° 382 of 1988, General Law of Sanitary Services, and its regulation D.S. N° 1199 of 1998 of the Ministry of Public Works (MOP**),** if the service is provided by a sanitary services concessionaire.	They govern the provision of basic drinking water and sewerage services in a health care facility located within the urban area.
MINSAL's Sanitary Code, articles 71 and 72, as well as the D.F.L. N° 1 of 1989, also from MINSAL, which determines the matters that require sanitary authorization expressed to operate	In the case of health facilities located outside the operational areas of the sanitation companies, basic services are provided through private drinking water supply and sewage disposal systems. The responsibility for constructing, operating and maintaining these particular systems lies with the owners of the properties. All private drinking water supply and sewage disposal systems must have project approval and operating authorization from the respective Regional Ministry of Health.
D.S. 735 of 1969 of MINSAL Regulation of water supplies intended for human consumption.	Regulates the quality of drinking water in both urban and rural areas.
D.S. 236 of 1926 of MINSAL, General regulation of private sewage systems.	It regulates the basic sanitary conditions of particular sewage disposal systems.
Water Code Law N° 21.435 Reform of the Water Code, of the Ministry of Public Works. Published on April 6, 2022	This set of codified norms regulates the use of the country's water resources, establishing, among other things, the right to use water. The present Law reforms the Water Code, recognizes access to water and sanitation as an essential and inalienable human right, which must be protected by the State; and that it is a national asset of public use, whose domain and use belong to all the inhabitants of the nation.
Occupational Health and Safety	
D.S. 594, Regulation on Basic Sanitary and Environmental Conditions in Workplaces.	It establishes the basic sanitary and environmental conditions that all workplaces must comply with, without prejudice to the specific regulations that have been or will be issued for those tasks that require special conditions. It also establishes the permissible limits of environmental exposure to chemical agents and physical agents, and those limits of biological tolerance for workers exposed to occupational risk. It also establishes fire prevention and protection measures.
Labor Code DFL No. 1/2003 of the Ministry of Labor and Social Security	Codified body of rules that regulates labor relations between workers and employers. The Labor Code includes rules relating to the employment contract (workers' rights, their obligations, regulation of remuneration, rest, termination); workers' protection (social insurance against risks and accidents, occupational exposure to noise, sexual harassment, among others); labor unions and collective bargaining; and labor jurisdiction.

Law No. 16,744/1968 Establishing Rules on Occupational Accidents and Occupational Diseases. Ministry of Labor and Social Security	This law regulates the mandatory insurance against occupational accidents and occupational diseases for both dependent and independent workers who contribute to the social security system. The insurance covers occupational accidents, commuting accidents, accidents suffered by union leaders and occupational diseases.
Decree No. 40/69 of the Ministry of Labor and Social Welfare approving the Regulations on Occupational Risk Prevention.	Establishes the regulations on the prevention of occupational risks, which are understood as accidents at work or occupational diseases. Among other measures, it establishes the obligation of employers to prepare and keep updated a health and safety regulation, inform workers of the risks they run and train them to face them adequately. It also states that statistics on accidents and occupational diseases must be kept.
D.S. N° 76/2007, Ministry of Labor and Social Security. Approves Regulations for the Application of Article 66 Bis of Law No. 16,744, on the management of Occupational Safety and Health in works, tasks or services indicated.	Article 66 bis of Law 16,744 establishes the main company's obligation to ensure that both contractors and subcontractors comply with health and safety standards. In addition, among others, it establishes that the main company, for the purpose of planning and complying with its obligations in health and safety matters, must maintain an updated record at the site, work or service, either on paper or digital, consisting, among others, of a history of accidents and occupational diseases at the site.
Decree 157/2007 Regulation of pesticides for sanitary and domestic use. MINSAL	It regulates the import, storage, possession, transport, distribution, application and disposal of pesticides for sanitary and domestic use, including a wide range of disinfectants and antiseptics.
Biodiversity and natural protected areas	
Convention on Biological Diversity. Decree Nº1963/1995 of the Ministry of Foreign Affairs.	The purpose of this treaty is the conservation of biological diversity, the sustainable use of its components and the fair and equitable sharing of the benefits arising from the utilization of genetic resources.
Decree Nº14/2008 National Biodiversity Strategy 2017-2030 of the Ministry of Environment.	The Strategy is a guiding document for the sustainable management of Chile's biodiversity, which has five strategic objectives (1) Promote the sustainable use of biodiversity for human well-being, reducing threats to ecosystems and species; (2) Develop awareness, participation, information and knowledge about biodiversity, as a basis for the well-being of the population; (3) Develop a robust institutional framework, good governance and fair and equitable distribution of biodiversity benefits; (4) Insert biodiversity objectives in policies, plans and programs of the public and private sectors; (5) Promote the sustainable use of biodiversity for human well-being, reducing threats to ecosystems and species; (3) Developing a robust institutional framework, good governance and fair and equitable distribution of biodiversity benefits; (4) Embedding biodiversity objectives in public and private sector policies, plans and programs; and (5) Protecting and restoring biodiversity and its ecosystem services.
Convention on Wetlands of International Importance, especially as Waterfowl Habitat. Decree Nº771/1981 of the Ministry of Foreign Affairs.	The purpose of this Convention is the conservation and wise use of wetlands, through actions at the local, regional, national, and international cooperation levels. Among its provisions, it establishes that the States must draw up a list of wetlands and implement plans for the conservation of wetlands and waterfowl.

Law Nº 21.600/2023. Creates the Biodiversity and Protected Areas Service and the National System of Protected Areas (SBAP).	This Law creates the Biodiversity and Protected Areas Service, whose purpose will be the conservation of the country's biodiversity, through management for the preservation, restoration and sustainable use of genes, species and ecosystems. The Service will manage the National System of Protected Areas and, among others, will have the function of administering the State's protected areas and supervising the administration of private protected areas, as well as supervising the activities carried out in them; it will be functionally decentralized, will have its own legal personality and assets, and will be subject to the supervision of the President of the Republic through the Ministry of the Environment. This law repeals Law No. 18.362/1984, which creates a National System of State Protected Wildlife Areas.
Law No. 20.283/2008. On Native Forest Recovery and Forestry Promotion and its Regulations (D.S. 93/2009 of the Ministry of Agriculture).	The purpose of this law is to protect, recover and improve the country's native species, ensuring their forest sustainability through management and preservation plans.
Law Nº . 21.202/2020 of the MMA Amends several legal bodies in order to protect wetlands.	Its purpose is to protect urban wetlands declared as such by the Ministry of the Environment, either on its own initiative or at the request of the respective municipality, in view of their great importance for the environment.
Cultural heritage	
Law Nº 17.288 and D.S. 484/1990, of the Ministry of Education, Regulation on Archaeological, Anthropological and Paleontological Excavations and/or Prospecting.	Legislation on the management and protection of the country's cultural heritage.

4.1.2. Institutional framework for the Program's environmental management

The main potential environmental and health and safety risks of this PforR are associated with the construction and operation of a new typology of PHC facilities with the WB loan.

Based on information provided by MINSAL, the **National Health Services entities (HS)** will be responsible for managing the construction of new PHC facilities, which will involve:

i. the contracting of works by bidding, through the Public Procurement system[20], which will be carried out according to standard bidding bases established by the Comptroller's Office[21] for this type of works (it is expected that the same bases will be used as for the construction of rural health posts -smaller PHC facilities, of about 400-500 m^2). The standard bidding documents consider the legal framework to be applied when building the infrastructure, including the socio-environmental one. The bidding documents also include technical specifications specific to the scope and risks of the work, including the environmental and social mitigation plans that the work in question must implement;
ii. the supervision of these works, including the application of the specific E&S regulations and mitigation for the work in question, for which the corresponding **Health Service Directorate** will entrust a professional of its dependence with the functions of **Technical Work Inspector** (ITO, by its acronym in Spanish), who will report to the Health Service Directorate and has administrative, civil and criminal responsibility. It must verify that the work complies with the conditions of the contract and all the applicable legal framework, including environmental, health and safety and social.

In addition, the **Contractor**, the company hired by the corresponding HS to execute the work, must include among its personnel a **risk preventionist**, a professional with the required competencies and must be registered with the respective SEREMI of Health. This person is responsible for ensuring compliance of the work with the specific regulations and prevention and mitigation measures on safety, health, labor conditions and rights, and the environment.

The budget of the work dedicated to the implementation of prevention, mitigation and environmental and social control measures is not included as a specific item, but is included in the general expenses item of the work that considers the administration of the work, and includes all the personnel of the company that will work in the work, which must include the risk preventionist and the specific specialists that also have to verify or execute actions according to the requirements of the regulations for the work in question.

As part of the contracting process to execute a work, there are guarantees that are requested from the contractor and are applied when the company presents a non-compliance (technical, environmental, health and safety, others) to cover the cost of what is involved. These guarantees are established based on the total cost of the work.

In order to start a construction project, a **building permit** must be requested from the corresponding municipality, through its **Municipal Works Department (Dirección de Obras Municipales-DOM)**, the governing body responsible for verifying that the contractor company complies with all the necessary regulations to start the execution of a construction project, including urban, environmental and social regulations, among others. Before requesting this permit, the contractor company must have all the feasibilities resolved, for example, the connection of the new PHC center to the potable water supply and sewerage, the connection to the electrical system, when necessary, a preliminary topography, a preliminary soil mechanics study, the land where it will be built, among others. The bidding file for the work is prepared by the corresponding Health Service entity, with all these antecedents resolved and feasibility to execute the work.

The DOM also oversees construction sites; it can visit the site and verify that it is complying with all applicable regulations, including environmental and social regulations. In addition, these works are also supervised by the ITO, the Labor Directorate and the corresponding SEREMI of Health.

[20] Mercado Público is a platform for public procurement of products, works and services in Chile, available at https://www.mercadopublico.cl/Home.

[21] The Office of the Comptroller General of the Republic is a superior oversight body of the State Administration, contemplated in the Political Constitution, which enjoys autonomy from the Executive Branch and other public bodies. It verifies that the organs of the State Administration act within the scope of their attributions and subject to the procedures established by law.

Complaints and claims that may arise from the work are handled by the DOM, in conjunction with the HS Management and the ITO. The claim of a person affected by the work can reach the DOM and from there the company is required to resolve the complaint or claim.

The Regional Ministerial Health Secretariats (SEREMIS) are the authorities that grant new PHC facilities the **Sanitary Authorization**[22] required for their functioning and operation.

Once the work has been completed, the municipality must request the **Municipal Reception**, this is the last verification that the work was executed in accordance with what was requested and with the applicable legal framework, including E&S aspects.

During the operation of new PHC facilities, the supervision of compliance with environmental and social requirements would be carried out by the SEREMIS and by the local authorities where the facility is located. The relevant legal framework (Table 6) establishes the roles and responsibilities of these agencies in the E&S management of PHC facilities.

According to information provided by MINSAL, the new PHC facilities to be built with the WB loan will be operated and managed by municipalities, through their Municipal Health or Primary Health Directorates, or PHC Corporations. Therefore, the environmental and social management of these centers will be supervised by the municipality where the new PHC facility is established and the corresponding SEREMIS. For example, for hazardous waste management, municipalities have contracts with companies that are supervised by the SEREMIS for the disposal of hazardous waste according to the regulations of the Regulation on Waste Management in Health Care Facilities *(Reglamento sobre el manejo de Residuos en Establecimientos de Atención de Salud-REAS)*. In addition, each municipal health directorate and each facility must register with the SEREMIS where they must declare how they manage their waste.

Table 6 below shows the main agencies of the State Administration that make up the institutional framework for environmental regulation, control and supervision in which the physical interventions of the Program will be developed.

[22] The Sanitary Authorization is the act by which the Regional Sanitary Authority (SEREMIS) allows the operation of Institutional Health Care Providers, verifying that they comply with the structure and organization requirements, expressed in regulations. Decree with Force of Law No. 1 of 1989, determines matters that require express sanitary authorization. Available at: https://www.bcn.cl/leychile/navegar?idNorma=3439

Table 6 Institutional framework for environmental regulation, control and oversight of the program

National Environmental Authorities	
Ministry of the Environment (MMA)	The MMA is responsible for coordinating environmental matters and for designing and proposing environmental policies that strengthen sectoral environmental regulatory frameworks, including the health sector, as well as for the protection and conservation of biological diversity and renewable natural and water resources, promoting sustainable development, the integrity of environmental policy and its normative regulation. The Ministry has a National Consultative Council and Regional Consultative Councils in each region of the country, created by Law No. 19,300 on General Bases of the Environment, as mechanisms for citizen participation in environmental issues. In addition, the Minister of the Environment presides over the Council of Ministers for Sustainability and Climate Change.
Environmental Evaluation Service (SEA)	The main function of the SEA is to manage the Environmental Impact Assessment System (SEIA), which regulates the evaluation process of projects that may generate significant impacts on the environment. The SEA's decision on the environmental evaluation is materialized in the Environmental Qualification Resolution (RCA), which establishes the mitigation, compensation and environmental monitoring measures that must be implemented during the execution of the project. In certain cases, a complaint may be filed with the Committee of Ministers against this resolution. The Service is also responsible for standardizing the criteria, requirements, conditions, background information, certificates, formalities, technical demands and procedures of an environmental nature established by the ministries and other competent government agencies, by establishing, among others, processing guides. In the event that any of the infrastructure works of the Program must be submitted to the SEIA, it must follow the process established in the LBGMA and RSEIA for the evaluation of its environmental risks and impacts and obtain the respective RCA. According to the Program's exclusion list, interventions requiring an EIA will be excluded from funding.
Superintendency of the Environment (SMA)	The SMA is the agency with exclusive authority to execute, organize and coordinate the follow-up and oversight of the Environmental Qualification Resolutions (RCA), of the measures of the Environmental Prevention and/or Decontamination Plans, of the content of the Environmental Quality Standards and Emission Standards, and of the Management Plans, when applicable, and of all other environmental instruments established by law. The SMA performs its function through three types of oversight: direct, by its officers; by other sectoral agencies, entrusting it with oversight tasks based on specific programs and subprograms; and through third parties accredited by the Superintendency. The infrastructure works included in the Program that require submitting an EIS to the SEA and obtaining the respective RCA will be subject to environmental oversight by the SMA.
Bodies of the State Administration with Environmental Jurisdiction (OAECA)	The OAECAs are the State bodies that participate in the Environmental Impact Assessment of the project or activity. Article 24 of the RSEIA defines them as those that have the authority to issue permits or sectorial environmental pronouncements regarding the particular project or activity. In the event that any infrastructure work included in the Program requires submission to the SEIA by means of an EIS, these bodies will make a pronouncement on the EIS of the work.
Directorate of Labor, Safety and Health	The Labor Directorate is a decentralized public service, supervised by the President of the Republic through the Ministry of Labor and Social Security. Among its roles are to oversee compliance with labor, social security and occupational health and safety regulations, and to carry out actions aimed at preventing and resolving labor disputes.
Regional Governments	Law N° 19,300 establishes the obligation of the regional governments to pronounce on the territorial compatibility of the projects presented in the region under their jurisdiction (Article 8). In the event that any of the infrastructure works included in the Program must be submitted to the SEIA by means of an EIS, the work

	must obtain a report from the Regional Government, the respective Municipality and the competent maritime authority, when applicable, on the territorial compatibility of the project submitted.
Municipalities	The operation of the Municipalities in Chile is governed by Law No. 18,695, the Organic Constitutional Law of Municipalities. The management of PHC facilities at the communal level depends on the municipality in 321 of the 345 municipalities in the country. In these cases, each one manages human and financial resources, purchases goods and services and is responsible for the maintenance of infrastructure and equipment. Municipalities have among their functions and responsibilities the management[23] of the environment and public health and safety in their municipality and develop mechanisms to comply with the responsibilities granted by the Constitution of the Republic on these issues, the LBGMA on environmental management (control of environmental quality, represent community complaints on environmental issues, implement decontamination plans, among others) and the Sanitary Code (ensure compliance with the provisions of hygiene and safety established in the General Ordinance of construction and urbanization. The municipalities are responsible for issuing the building permit to initiate a civil work in their territory and for granting the reception of the work once it is completed, as well as overseeing the compliance of the work with the applicable legal framework during construction and operation. The construction and operation of the new PHC infrastructure will be subject to compliance with the relevant municipal environmental and social norms, acts and ordinances. Municipalities in charge of PHC facilities have well standardized sanitation and ornamental management directorates in charge of environmental management, or there are municipalities that call them environmental management directorates.
Sectoral environmental authority (Health Authority)	
MINSAL	MINSAL is responsible for formulating and setting health policies to be developed within the national territory. It has, among others, the following functions and objectives: - To exercise the stewardship of the health sector - To ensure due compliance with health regulations, through the Regional Ministerial Health Secretariats, without prejudice to the competence assigned by law to other agencies. - Conduct public health surveillance and evaluate the health situation of the population. - At the national regulatory level, it has the power to formulate policies and regulations to control environmental factors that may endanger the health of the population. MINSAL manages PHC at the central level, represented by the Primary Health Care Division (DIVAP), under the Undersecretariat of Health Care Networks.
Emergency and Disaster Risk Management Department (DGREYD)	The mission of the DGREYD is to promote integrated risk management in emergencies and disasters in the health sector, taking into account the guidelines of the National Disaster Prevention and Response System (SINAPRED) and sectoral agreements within the international framework of disaster risk reduction. Among its objectives are: • Elaborate the necessary technical guidelines for the implementation of the Sectoral Policy for Risk Management in Emergencies and Disasters, as well as the necessary protocols for the formulation of plans, to follow up the implementation of said policy in MINSAL, in the SEREMIS, in the Health Services and in the facilities of the network.

[23] Municipal Environmental Management. 1995, available at: https://proactiva.subdere.gov.cl/bitstream/handle/123456789/52/GESTION_AMBIENTAL_MUNICIPAL.PDF?sequence=1&isAllowed=y

	• Coordinate and follow up at the national level the implementation of the Climate Change Adaptation Plan of the Health Sector, through the executive coordination unit for climate change belonging to this department. DEGREYD will contribute to monitoring and reporting on RA2 activities related to emergency preparedness and surveillance and climate change resilience of the PHC.
Environmental Health Department (Undersecretary of Public Health)	It is part of the Division of Health Policies and Promotion, which in turn reports to the Undersecretariat of Public Health. It is responsible for ensuring that all environmental factors, elements or agents that affect the health, safety and welfare of the country's inhabitants are eliminated or controlled in accordance with the provisions of the Sanitary Code and its regulations. Its policies, standards and mandates on environmental health issues should also be implemented in new PHC facilities to be built with the Program's credit.
Occupational Health Department (Undersecretary of Public Health)	It also depends on the Division of Healthy Public Policies and Promotion. Its main objective is to promote the development of healthy work environments to improve the quality of life of workers, therefore, it has regulatory, supervisory and advisory functions to contribute to the formulation of environmental and occupational health policies, developing national plans and programs to protect the health of the population and workers from the risks associated with the environment. Its policies, standards and mandates on occupational health issues should also be implemented in new PHC facilities to be built with the Program's credit.
Regional environmental management	
Regional Ministerial Health Secretariats (SEREMIS)	The regional health authority must oversee and sanction provisions of the Health Code and other regulations. The SEREMI de Salud also oversees matters such as hygiene and safety in the environment and workplaces; food; laboratories; pharmacies; burials; exhumations and transfer of corpses. In Occupational Health matters, oversight is the responsibility of the Occupational Health Units or Sub-departments of the SEREMIS in each region. In the area of environmental health, at the regional level, oversight is the responsibility of the Health Action Department of the SEREMIS, which may have a different conformation in each region. The SEREMIS will be responsible for monitoring and sanctioning provisions of the Sanitary Code and other regulations in new PHC facilities built with WB credit, during their construction and operation, related to environmental quality factors, emissions, waste, drinking water, sewerage, safety and hygiene in PHC facilities, among others. It is the regional authority that issues the sanitary authorization for the start of operation of a health facility.
Local environmental management	
Health Services (HS)	The HS depend on the Undersecretary of Health Care Networks of MINSAL. They are regulated by Law N° 19.937 on Health Authority and in the Regulation of Health Services (decree 140/2004). There are 29 SS in the country. Article 22 (of Decree 140) on the functions of the Subdirectorate of Physical and Financial Resources of the HS establishes, among others, that the SS must ensure compliance with policies and regulations on infrastructure, physical resources and supply. Based on information provided by MINSAL to date, the Health Services (HS) with jurisdiction in the communes where the new PHC facilities included in the PforR will be implemented, will be responsible for the construction, and corresponding E&S supervision of the construction of the new PHC facilities. The E&S management requirements will be aligned with the relevant national regulations and the basic principles established in the PforR Financing Policy and Directive, and will be supervised by the Health Service Directorate responsible for the work, through a Technical Work Inspector who will be hired by the HS to oversee the compliance of the execution of the work with the contract conditions and the legal framework applicable to the specific work.
Municipalities	Municipal governments have among their responsibilities to ensure environmental protection and guarantee the safety and public health of their territory, oversee compliance with environmental and public health and safety legislation for civil works in their municipality, grant construction permits, facilitate proper waste

	management, provide sanitation services to their commune, control atmospheric pollution, among others. This is done in collaboration with the regional environmental and health ministries of the region where they are located, among other relevant public institutions. The municipal government will apply its pertinent norms and ordinances in the construction and operation of new PHC facilities included in the Program, as already explained, in general, in this section.

4.1.3. Implementation of Environmental Management Systems

In Chile, the management and supervision of the environmental aspects of civil works in health facilities are regulated by various regulations and entities responsible for ensuring compliance with environmental provisions, as described in the previous sections.

First, the main legislation regulating environmental issues in Chile is Law No. 19,300 LBGMA. This law establishes the basic principles and norms for the protection, conservation and recovery of the environment, and establishes the Environmental Impact Assessment System and its regulations (RSEIA). The SEIA is an environmental management instrument that makes it possible to evaluate and foresee the environmental impacts that may be generated by projects and activities carried out in the country and that, according to the law, must be evaluated. Article 10 of Law No. 19,300 establishes which projects or activities must be submitted to the SEIA and Article 3 of the RSEIA specifies these projects.

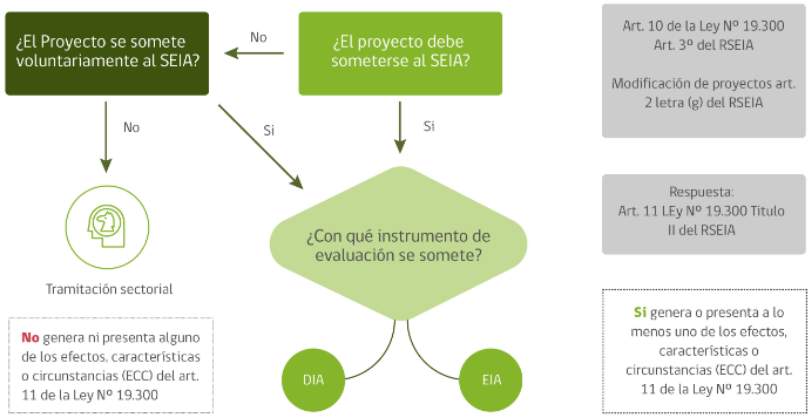
Law No. 19,300 also distinguishes between projects that must submit an Environmental Impact Statement *(Declaración de Impacto Ambiental -DIA)* and those that must submit an Environmental Impact Study *(Estudio de Impacto Ambiental-EIA)*. The projects and activities that must submit an EIA are regulated in Article 11 of the same law and, in general, refer to those that have negative significant impacts. The minimum contents of the EIA and the DIA are established in Articles 18 and 19 of the SEIA Regulations, respectively.

Therefore, in order to manage and supervise the environmental aspects of the civil works executed by the Health Services entities in Chile, the procedures established in Law No. 19,300 must be followed and the projects must be submitted to the SEIA, obtain the corresponding Environmental Qualification Resolution (Resolución de Calificación Ambiental-RCA) and comply with the established mitigation and environmental monitoring measures. The Environmental Assessment Service *(Servicio de Evaluación Ambiental-SEA)* is responsible for overseeing compliance with these provisions and applying sanctions in the event of noncompliance.

It is highlighted that, although the Program will exclude works that may cause significant risks and impacts, described in the exclusion list (section 2.2.8), including those that require, according to the LBGMA and its regulations, an Environmental Impact Study. Interventions that could require a DIA are not excluded, for example, in the case of the construction of the new PHC establishment model included in the Program, which would be small-scale works, they could require a DIA if the work has some regulatory impossibility, for example, that for its construction it is required to change the use of the land.

In general terms, the environmental assessment process can be graphed as follows:

Figure 1 Environmental assessment process.



Source: SEA, available at: https://www.sea.gob.cl/evaluacion-de-impacto-ambiental/cual-es-el-proceso-de-evaluacion-de-impacto-ambiental.

Health infrastructure projects and therefore PHC, according to the provisions of Law 19,300 and its regulations (RSEIA), belong to the typology of an urban or real estate development project and should be submitted to the SEIA if it is likely to cause environmental impact. To do so, one of the following specific criteria must be met (RSEIA, Article 3, section g.1.2 and section h.1):

- it is located in an area not declared saturated or latent and has a built-up area equal to or greater than 5,000 m^2;
- with a land area equal to or greater than twenty thousand square meters (20,000 square meters^2);
- a capacity of attention, affluence or simultaneous permanence equal to or greater than 800 people;
- has 200 or more vehicle parking spaces;
- The project is located in an area declared saturated or latent and requires its own systems for the production and distribution of drinking water or for the collection, treatment and disposal of sewage;
- has a capacity for 5,000 or more people;
- has 1,000 or more parking spaces.

In view of these criteria (previous paragraph), in the case of the new infrastructure planned to be built with WB credit, due to its typology and scope, described in section 2.2.5 of this document, these will not require submission to the SEIA, in accordance with Law No. 19,300 and its regulations, unless the work has some regulatory impossibility, such as the requirement of land use change for its construction, as previously mentioned. If a project does not meet the criteria established to submit to the SEIA and obtain an RCA, it is considered a smaller project or one with environmental impacts of lesser magnitude. However, even if an RCA is not required, it is important that the works under the responsibility of the Health Services entities comply with the environmental provisions established in the LBGMA and other applicable regulations as described in section 4.1.1. Therefore, the companies contracted to execute the works must comply with the legal framework applicable to the work and implement preventive measures, environmental mitigation and control, safety and health and social measures that must be specified in the bidding documents for the work and contract for the construction, as explained in section 4.1.2 of this document.

Some of the actions that are carried out to manage the environmental aspects of these projects that are not required to be submitted to the SEIA are, at a minimum, the following:

- **Identification of environmental aspects:** Conduct an initial assessment to identify potential environmental and social aspects associated with the project. This involves analyzing possible risks and impacts on the natural and social environment, such as waste generation, emissions, noise, availability and use of natural resources (water, soil, forest), risks of natural disasters (such as seismicity, floods, fires, landslides, droughts), among others.
- **Planning and design:** Consider environmental risk prevention, mitigation and control measures from the initial stages of construction. This implies designing and planning the work in a way that minimizes negative effects on the environment and the community and promotes sustainability.
- **Regulatory compliance:** Ensure compliance with all applicable local, regional and national environmental regulations. This includes regulations on air quality, waste management, land use, natural resource protection, road safety, among others.
- **Monitoring and follow-up:** Establish a monitoring and follow-up program to evaluate the environmental performance of the works during execution. This involves taking periodic measurements of relevant environmental variables and evaluating compliance with established limits and standards.
- **Training and awareness:** Promote training and awareness of personnel involved in the works (contractors, subcontractors, supervising firms, among others) regarding relevant environmental aspects and the mitigation and control measures to be implemented. This ensures that all those responsible are familiar with good environmental practices.

4.2. Social management systems relevant to PforR

4.2.1. Legal and regulatory framework for the Program's social management

The right to health is considered a universal and inalienable human right[24]. According to the World Health Organization "A human rights-based approach to health offers strategies and solutions to address and redress the inequities, discriminatory practices and unjust power relations that are often at the heart of inequity in health outcomes"[25].

In the area of human rights, Chile has signed all the substantive international treaties in force within the framework of the United Nations and the Inter-American System for the Protection of Human Rights, with three ratifications still pending[26, 27,28] as described in the Social Assessment Annex of this document. In

[24] Article Nº 25. Universal Declaration of Human Rights. 1948. United Nations. Source: https://www.un.org/es/about-us/universal-declaration-of-human-rights

[25] Health and Human Rights. 2022. World Health Organization. Source: https://www.who.int/es/news-room/fact-sheets/detail/human-rights-and-health

[26] As of the date of this report, the following are pending ratification: the International Covenant on Economic, Social and Cultural Rights; the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance; and the Inter-American Convention against All Forms of Discrimination and Intolerance.

[27] International Human Rights Treaties signed and ratified by Chile. International recommendations with constitutional impact. 2020. Parliamentary Technical Advisory. Government, Defense and International Relations Area. SUP Nº: 123705. Source: https://obtienearchivo.bcn.cl/obtienearchivo?id=repositorio/10221/28223/1/Acuerdos_internacionales_e_incidencia_constitucional_rev_BH.pdf

[28] See Annex Social Assessment: international legislative framework on human rights and health.

addition, in the area of Primary Health Care, Chile has signed the Declaration of Alma Ata (1978) and the Declaration of Astana (2018).

At the national level, the current Political Constitution of the Republic of Chile[29] assures all people the right to health protection, and states that "The State protects free and equal access to actions for the promotion, protection and recovery of health and rehabilitation of the individual. It shall also be responsible for the coordination and control of actions related to health. It is the State's preferential duty to guarantee the execution of health actions, whether they are provided through public or private institutions, in the manner and under the conditions determined by law, which may establish mandatory contributions".

[29] Decree No. 100, which establishes the Consolidated, Coordinated and Systematized Text of the Political Constitution of the Republic of Chile. 2005. Ministry General Secretariat of the Presidency. Source: https://bcn.cl/2f6sk

Since 1990, the Chilean State has progressively advanced in recognizing, promoting and guaranteeing human rights, non-discrimination, citizen participation and the resolution of claims addressed to the State Administration, by means of a set of laws, regulations, institutions and mechanisms that include guarantees in State actions and benefits for all citizens, but also for some Special Attention Groups (GEA)[30].

The Ministry of Health, like the rest of the State agencies, must consider this legal framework in its actions, which establishes acceptable levels of guarantee and protection of rights, non-discrimination, citizen participation and consultation, access to public information and mechanisms for filing complaints.

This regulatory framework can be seen in the following table:

Table 7 General regulatory framework on guarantee and protection of rights, non-discrimination, citizen participation and complaints procedures

Subject	Population Group	Type	NO.	Name	Ministry	Year	Detail
Human Rights	All	Constitutional Reform	Article Nº5	It elevates to constitutional rank the recognition and respect for human rights and the duty of the State to protect them.	All	1989	It establishes that the exercise of sovereignty recognizes as a limitation the respect for the essential rights that emanate from human nature. It is the duty of the organs of the State to respect and promote such rights, guaranteed by this Constitution, as well as by the international treaties ratified by Chile and which are in force.
	All	Law	20.405	Creates the National Institute of Human Rights (INDH).	Autonomous entity	2009	It creates the INDH as an autonomous corporation under public law in charge of ensuring respect for human rights.
	All	Law	20.885	Creates the Undersecretariat of Human Rights	Ministry of Justice and Human Rights	2016	It grants the Undersecretariat for Human Rights, of the Ministry of Justice and Human Rights, the mission to promote and protect human rights.
Citizen Participation	All	Law	20.500	On associations and citizen participation in public management	Ministry General Secretariat of Government	2011	It recognizes the right of all persons to associate freely for lawful purposes and obliges the State to promote and support the initiatives of civil society associations, as well as to encourage citizen participation.

[30] Special Attention Groups (GEA) are considered to be those groups composed of people who, due to various physical, social, economic or cultural conditions, are at a disadvantage in the enjoyment and exercise of their rights with respect to other groups in society, and who may require affirmative actions on the part of the State to compensate for this disadvantage, such as: Children and adolescents (NNA); victims of human rights violations by the State; women; population of sex-generic diversities; people living in poverty; migrants and refugees; elderly people; people with disabilities; persons deprived of liberty; indigenous and tribal peoples; and victims of the crime of trafficking in persons and sexual and labor exploitation. International Instruments, Observations and General Human Rights Recommendations on Equality, Non-Discrimination and Special Protection Groups. 2014. National Institute of Human Rights. Source: https://bibliotecadigital.indh.cl/bitstream/handle/123456789/654/instrumentos.pdf?sequence=1&isAllowed=y

	All	Ex. Res.	1.757	Creates Observatory of Citizen Participation and Non-Discrimination	Ministry General Secretariat of Government	2018	Its purpose is to contribute to making the mechanisms for linkage, dialogue and communication between the government and social organizations more efficient, favoring associationism and the strengthening of civil society, and promoting citizen participation in the management of public policies.
	All	Law	21.445	Climate change framework law	Ministry of Environment	2022	In order to provide the country with a legal framework that allows it to adapt to climate change, reducing vulnerability and increasing resilience to the adverse effects of climate change, and to comply with the international commitments assumed by the State of Chile in this area. This law establishes, among other things, the creation of a National System for Access to Information on Climate Change and Citizen Participation aimed at promoting and facilitating citizen participation in the preparation, updating and monitoring of climate change management instruments.
	All	Law	19.602	Amends Law No. 18,695, Organic Constitutional Law of Municipalities, regarding Municipal Management.	Ministry of the Interior and Public Security		It empowers the mayor to carry out communal plebiscites and non-binding consultations on matters of local administration related to specific communal development investments, the approval or modification of the communal development plan, the modification of the regulatory plan or others of interest to the local community, provided that they fall within the sphere of his competence.
Claims	All	Decree	680	Approves Instructions for the Establishment of Information Offices for the Public User in the State Administration.	Ministry of the Interior and Public Security	1990	It establishes the right that every person who resorts to the State Administration must find orienting information, timely and prompt attention, and the possibility of collaborating to a better service by means of a complaint or suggestion.
Access to Information	All	Law	20.285	About Access to Public Information	Ministry General Secretariat of the Republic	2008	It regulates the principle of transparency of the civil service, the right of access to information of the organs of the State Administration, the procedures for the exercise of the right and for its protection, and the exceptions to the disclosure of information.
Anti-discrimination	All	Law	20.609	Establishes anti-discrimination measures	Ministry General Secretariat of Government	2012	It defines the concept of arbitrary discrimination; establishes a judicial procedure to reestablish the right when such an act is committed; and obliges the organs of the Civil Administration of the State to elaborate and implement policies aimed at guaranteeing everyone, without

							arbitrary discrimination, the enjoyment and exercise of rights and freedoms.
	LGBTIQA+	Law	21.120	Recognizes and Protects the Right to Gender Identity	Ministry of Justice and Human Rights	2018	It recognizes and guarantees the right to gender identity of any person whose gender identity does not coincide with his or her sex and registered name, to request their rectification.
							Prohibits arbitrary discrimination and discrimination that causes deprivation, disturbance or threat to people and their rights, based on their gender identity and expression, as established in Law 20.609.
Indigenous Peoples	Indigenous Peoples	Law	19.253	Establishes norms for the protection, promotion and development of indigenous peoples and creates the National Corporation for Indigenous Development (CONADI).	Ministry of Social Development and Family	1993	It recognizes the right to land of indigenous peoples, obliges the State to include them in population censuses, establishes the creation in the national education system of a programmatic unit that promotes knowledge, appreciation and respect for indigenous cultures and languages, and obliges State administration services and regional organizations to listen to and consider the opinion of indigenous organizations in those matters that have a bearing on or are related to indigenous issues, among others. In addition to considering reserved quotas in their Councils for people belonging to Indigenous Peoples when the public policy contemplates services for this population.
	Indigenous Peoples	Decree	135	Organic Regulations of the Ministry of Health	Ministry of Health	2004	The Ministry of Health is responsible for formulating policies to incorporate an intercultural health approach in health programs, allowing and encouraging collaboration and complementarity between the health care provided by the system and that provided by indigenous medicine, which allows people in those communities with a high concentration of indigenous people to obtain comprehensive and timely resolution of their health needs in their cultural context.
	Indigenous Peoples	Decree	140	Organic Regulations of the Health Services	Ministry of Health	2004	establishes the powers of the Director of the Service, indicating that "In those Health Services with a high concentration of indigenous people (...) he/she must program, execute and evaluate, together with the members of the Network and with the participation of representatives of the indigenous communities, strategies, plans and activities that incorporate the intercultural approach to health in the health care model and in the health programs.

	Indigenous Peoples	General Administrative Rule	16	About Interculturality in Health Services	Ministry of Health	2006	It defines that the Ministry of Health, the Health Services and other health sector agencies shall ensure that their actions ensure respect, recognition and protection of the health systems of indigenous groups and their traditional community recognized agents.
	Indigenous Peoples	Decree	236	Promulgates Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries of the International Labor Organization.	Ministry of Foreign Affairs	2008	Promulgate ILO Convention No. 169.
	Indigenous Peoples	Decree	66	Approves Regulations Governing the Indigenous Consultation Procedure under Article 6 No. 1 (a) and No. 169 of Convention No. 169 of the International Labor Organization and Repeals Regulations that Indicate	Ministry of Social Development and Family. Undersecretary of Social Services	2013	Describes the regulations that will govern the indigenous consultation processes in the State Administration.
	Indigenous Peoples	Exempt Resolution	661	Provides for a process of participation and national consultation with Indigenous Peoples regarding the proposed regulation on the rights of persons belonging to Indigenous Peoples to receive culturally relevant health care.	Ministry of Health	2015	Creates a Working Group to prepare a proposal for a regulation on the rights of persons belonging to indigenous peoples to receive culturally relevant health care.
	Chilean Afro-descendant Tribal People of Chile	Law	21.151	Grants legal recognition to the Afro-descendant Chilean people	Ministry of Social Development and Family	2019	Obliges the State to value, respect and promote its cultural identity by recognizing its contribution to society in the category of intangible cultural heritage.
Inclusion of People with Disabilities	Disabled people	Law	20.422	Establishes rules on equal opportunities and social inclusion of persons with disabilities.	Ministry of Social Development and Family	2010	It is based on the principles of independent living, universal accessibility, universal design, intersectoriality, participation and social dialogue.
							It establishes a body to address the challenges generated by the full social inclusion of persons with disabilities: the National Disability Service; a Committee of Disability Ministers led by the Ministry of Social Development and Family; and a Disability Advisory Council composed of representatives of civil society, non-profit organizations and the private sector linked to disability.

	Disabled people	Law	21.015	Encourages the Inclusion of People with Disabilities in the Workplace	Ministry of Social Development and Family	2017	It encourages, both in government agencies and private companies, the inclusion of people with disabilities in the labor market under equal conditions, prohibiting any discriminatory act based on their condition.
Children's Rights	Children and adolescents	Law	21.067	Creates the Children's Ombudsman's Office	Autonomous entity	2018	Creates the Office of the Ombudsman for Children as an autonomous body whose mission is to promote and protect the rights of children.
	Children and adolescents	Law	21.430	On guarantees and comprehensive protection of children's and adolescents' rights	Ministry of Social Development and Family	2022	Its purpose is the guarantee and comprehensive protection, the effective exercise and full enjoyment of the rights of children and adolescents, especially the human rights recognized in the Political Constitution of the Republic, in the Convention on the Rights of the Child, in the other international human rights treaties ratified by Chile that are in force and in the laws in force.
Migration	Migrants	Law	21.325	Migration and foreigners	Ministry of the Interior and Public Security	2021	It establishes rules on migration and foreigners, in order to regulate the entry, stay, residence and exit of foreigners from the country, and the exercise of rights and duties, and creates the National Immigration Service.
Gender Violence	All	Law	20.005	Criminalizes and punishes sexual harassment	Ministry of Labor and Social Security	2005	Establishes standards to ensure a dignified work environment free of sexual harassment.
	All	law	21.153	Amends the Penal Code to typify the crime of sexual harassment in public spaces.	Ministry of Justice and Human Rights	2019	Establishes penalties for the crime of sexual harassment in public spaces.

In addition, Chile has a solid history in public health, with its origins dating back to the 19th century, and the Primary Health Care Network has played a fundamental role in prevention and health promotion over the years.

Among the main milestones of the Public Health System in Chile related to PHC development, the following stand out: the creation of the National Health Service (1952-1979), the reform that originated the National Health Services System in 1979, the PHC municipal administration modality since 1981; and the Health Reform in 2004 that created the Undersecretariat of Assistance Networks, in charge of managing the Health Network in its three levels of care.

The following is a description of the legal and regulatory framework governing the Ministry of Health with respect to the administrative aspects that govern the Primary Health Care Network, its coordination, the rights and duties explicitly guaranteed and the mechanisms for citizen participation.

Table 8 Regulatory Framework for the Primary Care Network in terms of coordination, guaranteed rights and duties, and mechanisms for citizen participation

Type	NO.	Name	Ministry	Date of enactment	Subject	Detail
Decree	602	Creates Local Health Councils	Health	01-09-71	Participation	Article 3. - The Local Councils shall be responsible for examining the health problems that affect the community; to tend to their solution through quick and effective actions; to promote the interest of the inhabitants to actively participate in their solution; to collaborate in the dissemination of the health action plans, and to represent the anomalies that appear in the execution of such actions. The Local Health Facilities Councils shall be composed of: 1. The head of the National Health Service facility, which serves as the local base for the Council. 2.- A representative of each of the population organizations (territorial and functional) of the Neighborhood Units of the sector corresponding to the jurisdiction of the health facility. 3.- One representative from each of the urban workers' organizations and/or Farmers' Councils constituted in the sector. 4.- A number of representatives, distributed in equal proportions among the following organizations of health workers of the Establishment: National Federation of Health Workers, Federation of Professionals and Technicians of the National Health Service and civil servants subject to Law No. 15.076. This number shall be determined jointly by the above mentioned organizations and shall not be greater than the sum of the representatives of the urban workers' organizations and/or Farmers' Councils. 5.- A representative of the Internal Government Service. 6.- A municipal representative. 7.- A representative of local education. ANNEX: However, and in relation to the functions foreseen for said Councils in the document under review and, in particular, to what is established in Articles 6 and 9 in order that the Joint

						Councils referred to in those precepts are directly responsible for the fulfillment of the "functions and attributions" assigned to the Local Health Councils and must "contribute to the elaboration of the health programs", it is appropriate, in the opinion of this Office of the Comptroller General, to point out that this can only be understood in the sense that the said Councils are to act as mere advisory or consultative bodies, without, therefore, being able to consider that those rules would allow the development of functions of a decision-making or executive nature, which are exclusive to the public agencies that must be created by means of a law.
DFL	36	Standards to be Applied in the Agreements entered into by the Health Services	Health	10-07-80	Execution	Describes the provisions governing the agreements entered into between the Health Services and the persons, natural or legal, who are entrusted with the performance of health actions through such agreements.
Law	18834	Approves the Administrative Statute	Interior	15-09-89	Public Administration	It regulates the relations between the State and the personnel of the Civil Administration of the State for the fulfillment of its administrative function.
DFL	4	Adecúa Plantas y Escalafones del Fondo Nacional de Salud al Artículo Nº 5 de la Ley 18.834 sobre Estatuto Administrativo.	Health	28-02-90	Public Administration	Describes the health personnel's plant and scales.
Law	19378	Establishes Municipal Primary Health Care Statute	Health	24-03-95	PHC Staff	It regulates the administration, financing and coordination of primary health care, whose management is transferred to the municipalities.
Law	19490	Establishes Allowances and Bonuses for Health Sector Personnel	Health	03-01-97	Public Administration	It establishes the annual creation of Improvement Programs associated with efficiency and quality of services goals that will accrue monetary incentives for health officials.
Law	19602	Amends Law No. 19695, Organic Constitutional Law of Municipalities, in matters of Municipal Management.	Interior	12-03-99	Municipalities	It empowers municipalities to develop, directly or with other bodies of the State Administration, functions related to public health and environmental protection. In addition, it establishes the duty of each municipality to have an ordinance for the modalities of citizen participation at the local level.
Law	19813	Provides Primary Health Benefits	Health	18-06-02	PHC Staff	Article 1.- Establishes for the personnel governed by the Primary Care Statute of Law No. 19.378, a development and stimulus allowance for the collective performance...

Law	19937	Amends D.L. No. 2763, of 1979, with the purpose of establishing a new concept of the health authority, different management modalities and strengthening Citizen Participation.	Health	30-01-04	Reform	It transforms the former Undersecretariat of Health into two Undersecretariats: an Undersecretariat of Public Health and an Undersecretariat of Health Care Networks. It also transforms the former Superintendency of ISAPREs into the Superintendency of Health, with powers to supervise not only the IISAPREs but also the National Health Fund (FONASA) and public and private health care providers.
Law	19966	Establishes the Health Guarantees Regime.	Health	25-08-04	Health Rights and Duties	It establishes explicit health guarantees related to access, quality, financial protection and timeliness with which the benefits associated with a prioritized set of programs, diseases or health conditions indicated in the corresponding decree must be provided. The National Health Fund and the Social Security Health Institutions must compulsorily ensure such guarantees to their respective beneficiaries.
Decree	136	Organic Regulations of the Ministry of Health	Health	08-09-04	Public Administration	Describes the functions of the Ministry of Health. The Ministry of Health shall ensure the effective coordination of the assistance networks, at all levels of complexity, articulating the entities of the system that provide promotion, prevention, protection, recovery, rehabilitation and palliative care services, so as to obtain the maximum efficiency and effectiveness in the development of these actions and the best use of the available resources. For the fulfillment of this function, it will dictate the resolutions and will adopt the necessary measures conducive to obtain an adequate and expeditious collaboration among such entities.
DFL	1	Establishes the Consolidated, Coordinated and Systematized Text of Decree Law No. 2,763 of 1979 and Laws No. 18,933 and No. 18,469.	Health	23-09-05	Equal access Free Access Participation	Art. 1: The Ministry of Health and the other agencies contemplated in this Book are responsible for exercising the State's function of guaranteeing free and equal access to actions for the promotion, protection and recovery of health and rehabilitation of the sick person.... Article 18º: ...The beneficiaries referred to in Book II of this Law shall register in a primary care facility that is part of the Health Care Network of the Health Service in which their domicile or place of work is located. Article 34: There shall be a User's Advisory Council, which shall be composed of 5 representatives of the neighboring community and 2 representatives of the workers of the Establishment. Article 40.- By means of a resolution of the Undersecretary of Assistance Networks, the manner in which the population using the Establishment may express their requests, criticisms and suggestions shall be regulated. The exercise of the constitutional right to health protection includes free and equal access to health promotion, protection and recovery actions and to those aimed at the rehabilitation of

						the individual, as well as the freedom to choose the state or private health system to which each person wishes to adhere.
Law	20548	Regulates the Rights and Duties of Individuals in Relation to Actions Related to their Health Care.	Health	13-04-12	Health Rights and Duties	Article 2 - Every person has the right, regardless of the provider who performs the actions for the promotion, protection and recovery of his/her health and rehabilitation, to have them provided in a timely manner and without arbitrary discrimination, in the forms and conditions determined by the Constitution and the laws.
Supreme Decree	23	Creates National Commission for the Protection of the Rights of Persons with Mental Illnesses	Health	12/06/2012	Rights and Duties in Mental Health	It creates the National Commission for the Protection of the Rights of Persons with Mental Illness, whose main function will be to watch over the protection of the rights of persons with mental or intellectual disabilities, assuming their defense with respect to the health care provided by public or private providers.
Law	20645	Creates an allowance associated with the improvement of the quality of customer service for employees governed by the Municipal Primary Health Care Statute.	Health	14-12-12	PHC Staff	Assignment to Municipal PHC employees associated with user treatment
Law	20646	Creates an allowance associated to the improvement of the quality of the treatment of the user, for the employees belonging to the technical, administrative and auxiliary staff of the health services establishments.	Health	14-12-12	PHC Staff	Assignment to Health Services employees associated with user treatment
Standard		Methodology for the Preparation, Evaluation and Prioritization of Primary Health Care	Ministry of Social Development	2013	Social variables to consider	Page 70 Consider the variables of: Gender focus (not detailed) Environment (yes details)

		Projects in the Health Sector.	and Family (MIDESO)			Intercultural and Heritage Relevance (yes, details)
Law	20850	Creates a Financial Protection System for High-Cost Diagnostics and Treatments	Health	01-06-15	Health Rights and Duties	Creates a Financial Protection System for Diagnosis and Treatment of High Cost Diseases, insured by the National Health Fund for the beneficiaries of Chile's social security health systems.
Exempt Resolution	31	Establishes the General Standard for Citizen Participation in Public Health Management.	Health	2015	Citizen Participation	It understands citizen participation as an active relationship between citizens and the State, oriented towards the exercise of their rights, and based on effective communication between both parties, strengthening the circulation of information and the establishment of listening, consultation and control of public policies.

4.2.2. Institutional framework for the social management of the Program

Currently, the health insurance system in the country is mixed: public and private. According to the public account of the National Health Fund (FONASA) 2022, 77% of the population living in the country is affiliated to FONASA; on the other hand, private health insurance (ISAPRE) covers 17% of the population.

Health System Governance: The Ministry of Health (MINSAL) is responsible for: (i) formulating, creating and coordinating health plans at the sectoral and intersectoral level (public and private) and for national and international coverage; (ii) issuing and ensuring compliance with general and specific health standards; (iii) conducting health surveillance and evaluating the health of the population; (iv) formulating and executing the annual sectoral budget; and (v) coordinating health care networks at all levels.

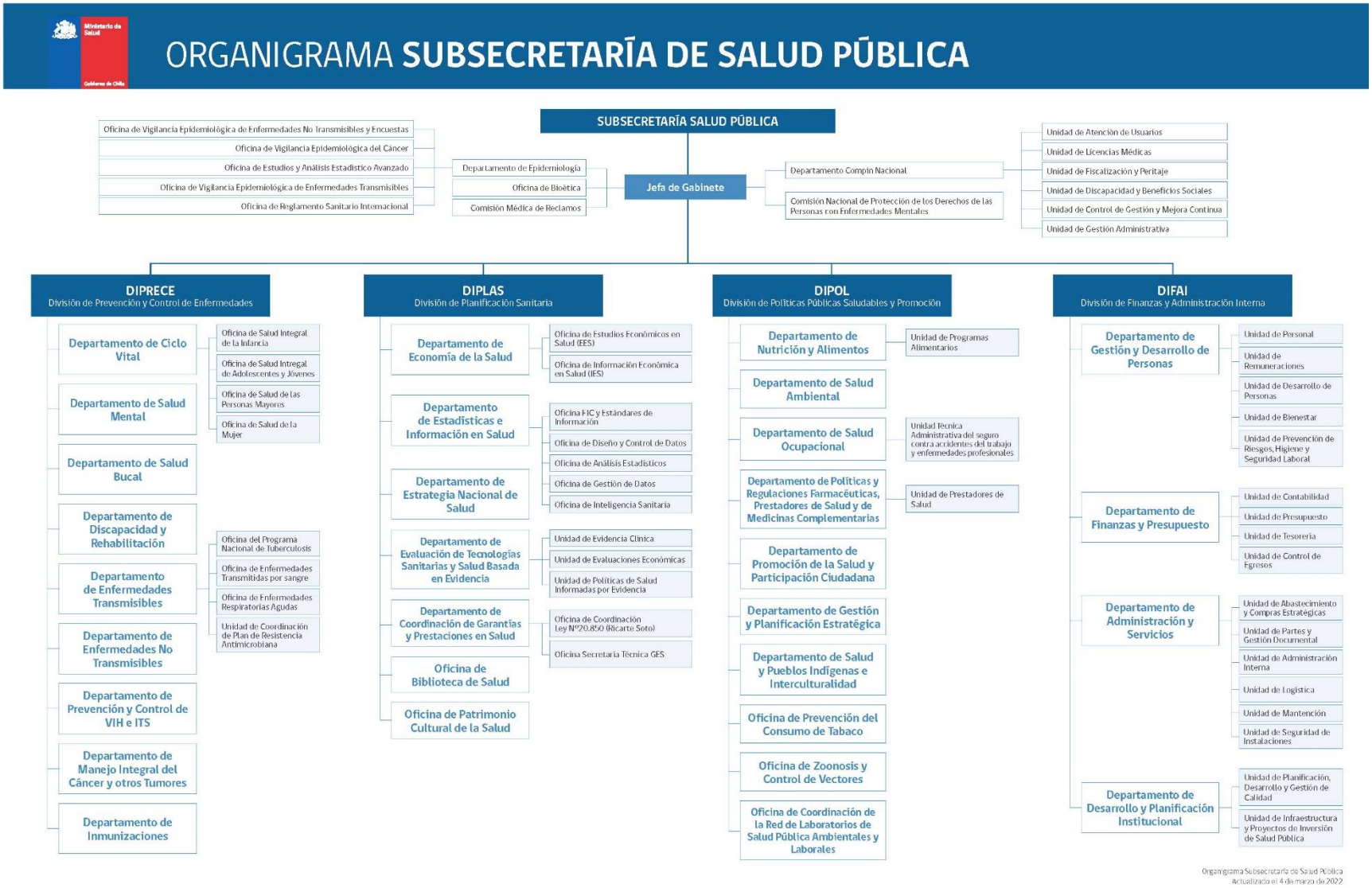
The Ministry is composed of two undersecretariats:

1. The Undersecretariat of Public Health is responsible for leading health strategies to improve the health of the population by exercising the regulatory, normative, surveillance and oversight functions that the State of Chile is responsible for in the area of public health.
2. The Undersecretariat of Health Care Networks is responsible for regulating and supervising the functioning of health networks through the design of policies, standards, plans and programs for their coordination and articulation.

Figure 2 Compact Organizational Chart of the Ministry of Public Health

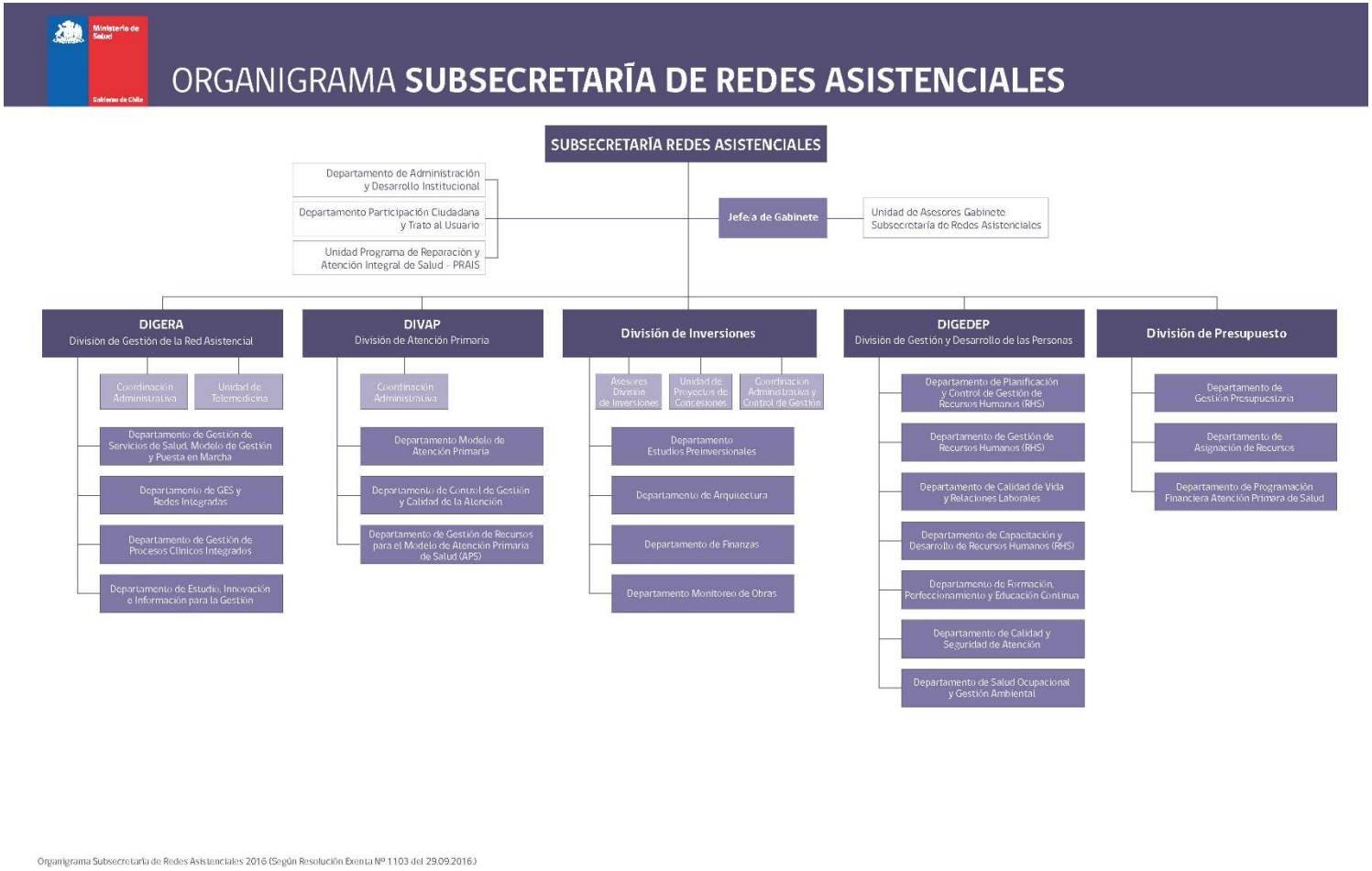
Source: MINSAL Presentation. 2020. Link: https://saludresponde.minsal.cl/wp-content/uploads/2020/11/Presentacion-estructura-minsal.pdf

Figure 3 Organizational chart Subsecretariat of Public Health



MINSAL Web site. Last accessed October 19, 2023. Source: https://www.minsal.cl/wp-content/uploads/2022/03/ORGANIGRAMA-GABINETE-MINISTRO-Y-SALUD-PU%CC%81BLICA.pdf

Figure 4 Organizational chart of the Undersecretariat for Health Care Networks



MINSAL Web site. Last accessed October 19, 2023. Source: https://www.minsal.cl/wp-content/uploads/2018/05/ORGANIGRAMA_SUBSECRETARIA-DE-REDES-ASISTENCIALES.pdf

The governance, regulation and other functions of the health system in Chile are exercised by the sector as a whole through the following entities:

Ministry of Health (MINSAL) whose mission is to build a health model based on a strengthened and integrated primary health care, which puts the patient at the center, with emphasis on the care of populations throughout the life cycle, and which also stimulates health promotion and prevention, as well as follow-up, traceability and financial coverage.

Bodies under MINSAL:

1. Ministerial Regional Health Secretariats (16 SEREMI of Health, one per region) that exercise the function of health authority in the regions.

Autonomous, decentralized bodies, with management autonomy, their own assets and dependent on MINSAL:

1. The 29 Health Services, in charge of managing the health care networks in their constituencies (region, province or other, depending on the size of the territory).
2. The National Health Fund (FONASA), which is responsible for collecting, managing and distributing the financial resources of the health sector, financing the health benefits granted to its users, characterizing the people benefited by this Fund and managing public health insurance.
3. Instituto de Salud Pública (ISP), which is responsible for regulating medicines and medical supplies, as well as acting as the national reference laboratory and producing vaccines and reagents.
4. Superintendence of Health, in charge of supervising ISAPREs and FONASA, among other functions.
5. The National Supply Center (CENABAST) in charge of acting as an intermediary for the purchase of products for the public health sector.

Management of the Health Care Network: In order to adequately manage the public health care network, MINSAL has 29 Health Services throughout the country that are related to MINSAL through the Undersecretariat of Health Care Networks, which exercises, among other functions, the role of coordination between the Health Services and the Ministry. In addition, PHC service providers are related to MINSAL through the Health Services.

The Health Services are functionally decentralized state agencies, endowed with legal personality and their own assets. They are administratively related to the health authority through the Subsecretaría de Redes Asistenciales.

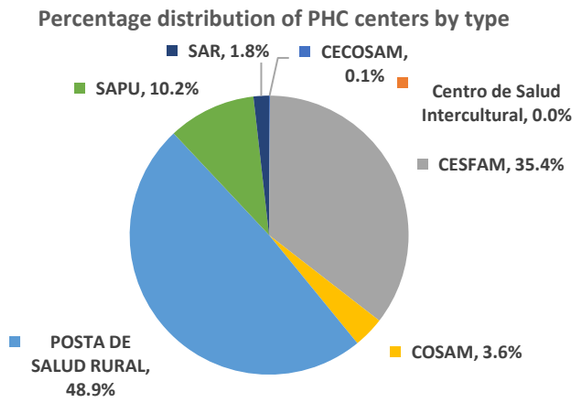
The health care network of each Health Service is made up of three levels of care: primary, secondary and tertiary, differentiated by the level of complexity of the care provided and the coverage they have. The primary level is considered the first point of contact of the community with the Network and is intended to provide services of lesser complexity oriented to health promotion and prevention; the secondary level is oriented to provide specialized services to those who have been referred from the primary level or from an emergency unit. The tertiary level is mainly oriented to high complexity services.

Primary Health Care Network: Chilean Primary Health Care has a wide geographical coverage and has different administrative units:

1. Municipal Primary Health Care, which is managed by municipal health administration entities and their network of facilities. According to the Department of Health Statistics and Information of MINSAL (DEIS), 92% of PHC Network facilities are managed by municipalities.
2. Primary Health Care, which depends on the Health Services themselves and is administered by the corresponding Health Service, with its facilities, rural and urban general clinics, attached or not. According to the DEIS, about 7% of PHC facilities are managed under this modality.
3. Non-Governmental Organizations (NGOs), which through DFL 36/80 agreements signed with the respective Health Services, carry out actions at the primary care level. Corresponds to 1% of the total.

PHC facilities are typified as follows:

- Community Mental Health Center (CECOSAM);
- Family Health Center (CESFAM);
- Intercultural Health Center;
- Mental Health Center (COSAM);
- Rural Health Post;
- Primary Emergency Care Service (SAPU);
- High-Resolution Emergency Primary Care Services (SAR).



Source: Own elaboration based on information published by the Department of Health Studies and Information. [29]

According to data published by the Department of Health Statistics and Information (DEIS)[31] of MINSAL, it is estimated that there are currently about 2,366 PHC facilities present in 336 of the 346 municipalities in the country. Rural Health Posts are the type of PHC facility with the greatest presence in the country, followed by Family Health Centers (CESFAM).

Health information systems: The most solid element of the information system is the vital events certificates (births and deaths), whose coverage reaches almost 100% and makes it possible to calculate mortality rates and disease burdens. The communicable disease surveillance system is also functional and universal. The scarcest data refer to other diseases that are not included in the surveillance system, as well as to financing and service provision, particularly in the private sector. During the COVID-19 pandemic, MINSAL's information systems were strengthened.

Organization of health regulatory actions: Health care is regulated by regulations framed in health programs established by the Ministry of Health. These programs define coverage, frequency or periodicity of contacts between users and providers, as well as responsibilities by level of care in the system.

The SEREMI of Health of each Region is responsible for the sanitary regulation of public sector health facilities.

Certification and the practice of health professions: Professional degrees can only be awarded by universities, which in turn are regulated by the Ministry of Education. The legal framework does not establish the obligation of certification of medical specialty after obtaining the professional degree of Medical Surgeon. By virtue of the changes derived from the 2004 health reform (Law 19.937), the Ministry of Health, together with the Ministry of Education, is assigned the responsibility of establishing a system for the certification of specialties and subspecialties of individual professional providers as natural persons. The Superintendence of Health is responsible for the supervision of all public and private health care providers, as natural persons, with respect to their certification.

The organization of public health services, in the context of a National Health Plan, establishes general objectives aimed at promoting healthy lifestyles and environments, increasing individual and community

[31] List of establishments. Department of Health Studies and Information (DEIS) of the Ministry of Health. Consulted in June 2023. Source: https://reportesdeis.minsal.cl/ListaEstablecimientoWebSite/default.aspx

knowledge and capacity for self-care, and strengthening the regulatory role of the State on health determinants.

4.2.3. Implementation of social management systems in terms of grievance resolution and public policy evaluation

According to the regulatory framework described in Tables No. 7 and No. 8 of this document. 8 of this document, which describes citizens' rights and institutional duties in terms of guaranteeing health care, citizen participation, access to information, resolution of claims and conflicts, as well as consultation with indigenous and tribal peoples in matters that concern them, the Ministry of Health has divisions, departments and units in its two Undersecretariats that design, disseminate and supervise public policies aimed at safeguarding the universal right to health, access to decent and quality services and the right of access to information and citizen participation.

Regarding citizen participation in PHC, the Primary Health Care Division of the Undersecretariat of Health Care Networks[32] considers citizen participation as a social determinant of health and believes that it should move from a "paternalistic" model to a "consultative" one that allows individuals and users to directly influence decision-making on health issues that directly affect their communities.

MINSAL has the following instances and mechanisms to channel citizen participation and complaints:

1. Formal bodies: Development Councils, Advisory Councils, Youth Advisory Councils and Local Committees, composed of representatives of organized users, neighborhood organizations and functional health organizations, among others.
2. Regular citizen consultation processes, in order to provide inputs for the design, implementation and evaluation of health policies. For example, through the elaboration of the Community Health Plan (PSC)[33] .
3. Participatory budgets, participatory public accounts.
4. Bills of Rights and Duties.
5. Information, Complaints and Suggestions Offices (OIRS) available at all health centers and remotely through the Integrated Citizen Information and Assistance System (SIAC).

The aforementioned instances and mechanisms are managed at the institutional level according to the following dimensions and actions:

[32] Citizen Participation in Primary Health Care. A contribution to the development of the Model of Integrated Family and Community Health Care and user satisfaction. MINSAL. Source: https://www.minsal.cl/sites/default/files/files/PARTICIPACI%C3%93N%20CIUDADANA%20APS.pdf

[33] "In accordance with Article 58 of Law No. 19.378, the PSC is the responsibility of each municipal health administration entity and must be framed within the technical standards and the model of care defined by the Ministry of Health". Technical Guidelines for Planning and Programming in RED 2023. P. 32. MINSAL. Source: https://www.minsal.cl/wp-content/uploads/2021/09/ORIENTACIONES-PLANIFICACION-Y-PROGRAMAC-EN-RED-2023.pdf

Table 9 Dimensions and Actions for Citizen Participation and Complaint Management

Dimensions	Shares
User satisfaction and humanization of care	Volunteer network in operation. Regular operation of the OIRS Management Committee (Information, Complaints, Suggestions, Compliments).
Communication and community strategies	Informative and consultative campaigns on family and community self-care issues.
Participatory Diagnosis	Participatory local planning. Roundtables.
Participation and Social Control	Development Council. Advisory Councils. Local Health Councils. Civil Society Councils (CESOC). School of Social Leaders.
Intersectoriality	Chile Grows with You. Health Promotion Plans.
Human Resources Qualification	Training of local leaders. Formation of local health teams.

Source: Citizen Participation in Primary Care. Un aporte al desarrollo del Modelo de Atención Integral de Salud familiar y comunitario y la satisfacción usuaria. MINSAL. Link: https://www.minsal.cl/sites/default/files/files/PARTICIPACI%C3%93N%20CIUDADANA%20APS.pdf

According to the interviews conducted by this team, the Integral System of Information and Citizen Attention (SIAC), which contains the Information, Complaints and Suggestions Offices, lacks a system for managing the knowledge generated from citizen requests at the national level, since the details of the requests are only known at the regional level, since only statistical data on requests reach the central level. In relation to public policy evaluation, the Ministry of Social Development and Family (MIDESO) through its Undersecretariat of Social Evaluation has developed a solid framework for the evaluation of social policies aimed at the permanent evaluation of social programs implemented by the State, including the programs of the Ministry of Health, through Ex-Ante and Ex-Post evaluations, whose objective is to evaluate the consistency of program design, in order to resolve situations of fragmentation and possible duplication of programs, i.e., interventions oriented to solve similar problems to those of the Ministry of Health: interventions aimed at solving similar problems for very similar populations.

Ex-Ante evaluation is the first step in the life cycle of public programs, both social and non-social. The Budget Directorate (DIPRES), under the Ministry of Finance, and the Undersecretariat of Social Evaluation, under the Ministry of Social Development and Family, verify that there is consistency between the public problem to be addressed, the affected population, the defined objectives and the measurement of results. This allows subsequent monitoring and ex-post evaluation of the initiative, which contributes to greater efficiency and transparency in the use of public resources. The results of the ex-ante and ex-post evaluations can be reviewed in the Integrated Bank of Social Programs[34].

These evaluations also generate inputs for the budget formulation process, which contributes to greater transparency in public spending and facilitates the monitoring and subsequent evaluation of the performance of public spending.

In general, the evaluations carried out by the Undersecretariat for Social Evaluation make recommendations that the agencies must adopt as soon as possible.

[34] Integrated Bank of Social Programs. Source: https://programassociales.ministeriodesarrollosocial.gob.cl/que_es#marcador-3

4.3. Evaluation of the Program's environmental and social management systems in relation to the basic principles of the PforR policy.

Based on the evaluation of the E&S systems applicable to the Program, it is concluded that in general, the legal and regulatory framework in Chile is aligned with the basic principles of the PforR policy and the planning elements of the PforR directive. The legal framework of laws, regulations, guidelines, policies and standards provide complete coverage on environmental, health and safety and social aspects. The country's legal framework, in general, provides a reasonable basis for addressing the environmental, health and safety and social issues likely to arise in the proposed PforR, as described in the previous section.

The following is the result of the evaluation carried out for each principle:

Table 10 Results of the Environmental and Social Assessment by Core Principles of PforR

Core Principle 1. The Program's environmental and social management systems are designed to (a) promote environmental and social sustainability in the design of the Program; (b) avoid, minimize or mitigate adverse impacts; and (c) promote informed decision making regarding the environmental and social effects of the Program.

In general terms, there is a well-developed legal and regulatory framework for general and sectoral E&S, as well as an institutional framework at the national and regional levels with clear and delimited functions, as detailed in section 4.1 and 4.2 of this report. Based on the information provided to date, the Health Services entities (HS) will be responsible for bidding and supervising the execution of PHC infrastructure works included in the Program. These apply bidding processes, according to standard bases for this type of works established by the National Comptroller's Office, which include the requirement that the works comply with the applicable legal framework, including the environmental and social framework. The bidding documents must also include technical specifications, including requirements for environmental, health and safety, and social prevention, mitigation, and control planning, based on the complexity of the work in question, which the contractor must implement. The HS entities will supervise the implementation of the E&S management requirements during the execution of the work with the support of an ITO, who is a professional that will report to the HS Management, with administrative, civil and criminal responsibility to perform this task. The contractor must also have a risk preventionist on staff who is responsible for supervising and enforcing compliance with the environmental, health and safety, and social requirements of the project. The work will be permanently supervised by different competent authorities. There is a complaint and claims mechanism that works in this type of works, where the DOM and the ITO receive the complaint or claim and must try to get the contractor to resolve it.

Therefore, based on the information available to date, as indicated in the previous paragraph and analyzed in more detail in sections 4.1 and 4.2, no relevant differences have been identified with respect to this principle and the processes for environmental and social management and supervision of the Program.

Core Principle 2: The Program's environmental and social management systems are designed to avoid, minimize or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. Program activities that involve significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR funding.

It is specified that the Program includes an exclusion list of activities as detailed in section 2.2.8, which include, among others, those associated with construction in protected areas or priority areas for biodiversity conservation, as defined in national legislation; activities that have the potential to cause significant loss or degradation of critical natural habitats, either directly or indirectly, or that may generate adverse impacts on these habitats, including urban or rural wetlands; and any activity that affects physical cultural heritage, such as tombs, temples, churches, historical relics, archaeological sites or other cultural structures; activities that due to their magnitude and scale require an Environmental Impact Study, according to the SEIA. Therefore, the interventions proposed in the Program are not expected to cause significant adverse impacts on critical natural habitats or critical cultural heritage.

In addition, as explained in section 4.1, based on the information provided to date on the scope and typology of the works to be built under the Program, these will not have to be submitted to the SEIA, however, they will also have to comply with applicable environmental and social legislation, regarding

E&S risk identification and management, related for example to environmental quality, natural resource management, hazardous and non-hazardous waste management, land use, among others. This will be addressed by the corresponding HS entity when preparing the bidding file for the work with all technical and regulatory issues resolved and feasibility to execute the work, including aspects of environmental prevention, mitigation and control, a requirement to obtain the building permit issued by the corresponding municipality.

Therefore, based on the information available to date, no relevant differences have been identified with respect to this principle and the processes for environmental and social management and supervision of the Program.

Core Principle 3: The Program's environmental and social management systems are designed to protect the safety of the public and workers from potential risks associated with (a) construction and/or operation of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and other hazardous materials under the Program; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

The Program's exclusion list excludes, among others, activities involving: (i) air, water or land pollution that causes significant adverse impacts on the health or safety of people, communities or ecosystems; (ii) working conditions that expose workers to significant personal health and safety risks; (iii) activities that may cause or lead to forced labor or child abuse, child labor exploitation or that employ or involve children, under the age of 18, in connection with the Program; iv) activities that may cause an increase in gender-based violence, sexual or labor exploitation, sexual harassment or abuse, and human trafficking in connection with the Program; v) construction in areas at high risk from natural hazards (floods, landslides, fires, earthquakes, tsunamis); vi) purchase or use of prohibited/restricted chemicals for medical use.

The national and sectoral institutional, legal and regulatory framework has policies, laws and regulations that establish measures, guidelines and rules to protect the safety and health of workers and the community from risks associated with the construction and operation of PHC facilities (as detailed in Tables 5 and 6). The corresponding HS entity Management, through the ITO will supervise the implementation on site of the prevention and control of potential risks related to labor health and safety, and community health and safety where the construction site is built. In addition the contractors that execute the works are also required by law to have a risk prevention professional on site to ensure the application of the relevant regulations and manage environmental, health and safety and social risks that may arise, including those related to gender violence (including sexual harassment and sexual abuse and exploitation), both in the work environment and in the community where the works are being built, due to the arrival of external labor. Likewise, during the operation of the new PHC facilities, they must apply the pertinent regulations and will be supervised by the corresponding municipality and SEREMIS.

Therefore, based on the information available to date, no relevant differences have been identified with respect to this principle and the processes for environmental and social management and supervision of the Program.

Core Principle 4: The program's environmental and social systems manage land acquisition and loss of access to natural resources in a way that prevents or minimizes displacement and helps affected people improve, or at least restore, their livelihoods and standards of living.

It is not clear whether the Program contemplates the acquisition of land and whether or not this could result in the loss of access to natural resources for individuals or communities. Even so, the national legal framework is clear in establishing that the expropriation of land by the State must be duly justified and that these must be remedied in such a way that people's livelihoods and standards of living are not affected. In addition, MINSAL has an internal protocol for the preliminary selection of land through which its feasibility is evaluated in conjunction with the municipalities, in terms of ownership, availability of basic services, accessibility and connectivity, among others.

Core Principle 5: The Program's environmental and social systems give due consideration to the cultural appropriateness of and equitable access to program benefits, with special attention to the

rights and interests of historically underserved indigenous peoples/traditional local communities in sub-Saharan Africa, and the needs or concerns of vulnerable groups.

One of the main axes of the Program is to strengthen the cultural adequacy of services at the primary health level, through a human rights approach, with a gender perspective and social inclusion, with emphasis on the LGBTIQA+ population and gender-based violence, as stated in RA1. In addition, MINSAL has the legal obligation to apply an intercultural health model in those territories with a high concentration of indigenous population, thus ensuring cultural adequacy for these communities.

Core Principle 6: The Program's environmental and social systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas or areas subject to territorial disputes.

According to the information available, it is not observed that the Program's actions may provoke social conflicts.

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5. ORGANIZATION AND CONDUCT OF CONSULTATION ON THE DRAFT ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT (ESSA) REPORT FOR THE PROGRAM

The preparation of the draft ESSA Report has been based on continuous consultations during the preparation of the Program with MoH counterparts. In addition, in accordance with the WB Policy and Guidelines for PforR operations, on September 27 and28, 2023, prior to the PforR negotiations, the draft ESSA Report was formally consulted on with key stakeholders. The World Bank organized four virtual focus groups with the participation of individuals representing: (a) local health councils; (b) civil society organizations, especially groups of indigenous peoples, LGBTIQA+ communities and rural residents; (c) unions and associations linked to the PHC system; (d) local government authorities; and (e) Ministry of Health officials. The results of the focus groups contribute to the finalization of the ESSA Report, prior to its public dissemination by the World Bank and the Ministry of Health.

The main objective of the consultation was to consult stakeholders on the draft report of the Environmental and Social Systems Assessment (ESSA) for the "Universal Primary Health Care Coverage and Resilience Program in Chile" Program for Results, in compliance with the World Bank's PforR Policy and Guidelines, through four virtual focus groups, during September 2023.

The focus groups were organized according to the profile of the key stakeholders identified according to the following table:

Focus Group	Profile	Date	Guests	Confirmed	Assistants			Remarks
					Men	Women	Total	
1	Civil society organizations linked to the health sector. Members of Local Health Councils.	27-09-23	30	13	3	4	7	Most of them belonged to the Los Lagos Region.
2	Associations and guilds of health workers in PHC	27-09-23	38	3	1	2	3	The national health workers' strike affected attendance.
3	MINSAL officials, central level	28-09-23	31	12	5	6	11	Officials of the Cabinet and of the Undersecretariat of Health Care Networks: Risk Management and Emergencies, Citizen Participation and Treatment of Users, Non-Communicable Diseases, Life Cycle, Immunizations, Health Statistics and Information, and Indigenous Peoples.
4	Health Service Directors, regional or provincial PHC	28-09-23	61	14	5	4	9	The majority belonged to regions or communes with a high percentage of rural and

	chiefs or managers, and Local Government authorities and officials.							semi-rural communes and localities.
Total			160	42	14	16	30	

All contacts were provided by the MINSAL Reform Team. The process of sending invitations, confirmation of attendance, sending the draft ESSA document and availability of the virtual room was carried out by the World Bank Country Office in Chile.

All persons who confirmed attendance received the draft ESSA report document in advance for reading. All participants in the focus groups agreed to be recorded during the activity. The recordings are confidential and have only been used by the Bank team in charge of the ESSA for the analysis of the information gathered.

All focus groups were moderated by the Bank's ESSA environmental and social specialists and were accompanied by at least one WB PforR Team Leader ("TTL"), a senior professional from the Bank's Social Development and Inclusion Practice and a Bank Country Office staff member, as well as representatives of the MINSAL Reform Team, who were present as listeners in order to address concerns that could go beyond the scope of the ESSA Report.

Each focus group lasted 1.5 hours. During the activity a presentation (15 min.) was projected describing: (i) The main Result Areas and activities of the PforR; (ii) The objectives and principles governing the Environmental and Social Systems Assessment (ESSA); and (iii) A timeline describing the PforR design and approval process.

Next, the same semi-structured guideline with 3 open-ended questions was used as the basis for the discussion, which was moderated by the ESSA managers, giving the floor to each of the participants.

The questions were:

1. Do you foresee any conflict around the activities included in the environmental or social Program for Results?
2. Are there any environmental aspects that have not been considered in the draft and if not, would you like to elaborate on any of the environmental risks and impacts detected in the draft ESSA?
3. Are there any social aspects that have not been considered in the draft and if not, would you like to elaborate on any of the social risks and impacts identified in the draft ESSA?

In general, all people who participated in the Consultation showed high adherence to both the Government's PHC Universalization Program and the Bank's Program for Results, noting that the Result Areas (RA) and the PforR activities address key factors to strengthen PHC, demonstrating high expectations in the implementation of the PforR. Participants also generally agreed that the ESSA report is of good quality; the review and analysis of national laws and regulations is comprehensive and well organized, and the environmental and social risks, impacts and benefits addressed in the ESSA are well articulated.

The three main topics that the participants of the Consultation discussed in depth were related to: (i) the construction of new PHC infrastructure: (i) The construction of new PHC infrastructure, it was suggested the possibility of integrating territorial, geographic, climatic, social, demographic and cultural variables that allow local adaptations to the guidelines established by the Central Level of MINSAL, with emphasis on rural communes and localities; (ii) The mechanisms for citizen participation considered in the PforR, where it was suggested to design binding participation processes in all stages of the PforR that also integrate civil society actors, PHC workers and local intersectoral institutions; and (iii) The new PHC management model proposed by the PforR, where emphasis was placed on integrating focused communication campaigns in order to disseminate the achievements of the PforR, as well as to develop a change management strategy aimed at moderating and adjusting PHC users' expectations, especially regarding the People-Centered Integrated Care Strategy (ECICEP) and the difference between a neighborhood facility and a Family Health Center (CESFAM).

The systematization of the information gathered can be reviewed in Annex 2, which summarizes the key comments mentioned by the participants, with their respective response and integration into the final ESSA Report, as appropriate.

Following the World Bank's PforR Policy and Guidelines, the ESSA Final Report is published on the World Bank's external website and on the client's website (in this case, MINSAL) prior to approval of the Program by the WB Board of Directors.

6. RECOMMENDATIONS AND ACTIONS FOR THE PROGRAM'S E&S SYSTEMS

Based on the assessment of the Environmental and Social Management Systems applicable to the proposed PforR, it is concluded that Chile has environmental and social management systems in place to address environment, health and safety, as well as land acquisition and the concerns of indigenous peoples and other vulnerable groups related to the proposed activities under the PforR. Such systems are consistent with the core principles and key planning elements defined in the Bank's PforR Policy. The overall potential environmental and social risks of this PforR are rated as moderate and can be effectively mitigated within existing environmental and social management systems.

However, specific actions and recommendations have been identified to strengthen the effective management of environmental and social risks during Program implementation.

6.1. Actions for inclusion in the Program Action Plan (PAP)

Actions proposed to be included in the PAP:

1. **Designate within the ECP an environmental specialist**, with occupational health and safety experience, as the focal point for Results Area 2 to facilitate inter-agency coordination. This specialist would have among his/her responsibilities:
    - Coordinate and implement programs for capacity building in E&S management and supervision of the Program's executing agencies (Health Services, Municipalities, SEREMI of Health);
    - Oversee the E&S management performance of the Program, including compliance with the E&S strengthening measures agreed in the PAP;
    - Support in the preparation of the Program Operating Manual (MOP) and supervise its compliance;
    - Implement an adaptive E&S management approach to the Program (identify changes in E&S risks and impacts assessed in the ESSA, as well as changes in the E&S systems that apply to the Program that may require new measures to be adopted);
    - Supervise the application of the exclusion criteria for activities defined in section 2.2.8.;
    - Prepare reports for the ECP coordinator on accidents occurring during construction of the works;
    - Coordinate and support the preparation of periodic monitoring reports demonstrating compliance with the E&S systems applicable to the Program and the measures agreed in the PAP and the MOP, as well as other agreed reports to be submitted to the WB.
2. **Designate within the ECP a social specialist**, with experience in public policies, human rights approaches and a gender and inclusion perspective, as a focal point for Results Areas 1 and 3 to facilitate inter-institutional coordination. This specialist would have among his/her responsibilities:
    - Coordinate and implement programs for capacity building in social management of the Program's executing agencies;
    - Oversee the E&S management performance of the Program, including compliance with the E&S strengthening measures agreed in the PAP;
    - Support in the preparation of the Program Operating Manual (MOP) and supervise its compliance;
    - Supervise the performance of the Complaint and Grievance Mechanisms and the Program's response capacity to complaints received and propose the necessary improvements;
    - Implement an adaptive E&S management approach to the Program (identify changes in E&S risks and impacts assessed in the ESSA, as well as changes in the E&S systems that apply to the Program that may require new measures to be adopted);
    - Supervise the application of the exclusion criteria defined by the Bank;
    - Coordinate and support the preparation of periodic monitoring reports demonstrating compliance with the E&S systems applicable to the Program and the measures agreed in the PAP and the MOP, as well as other agreed reports to be submitted to the WB.

6.2. Processes to be included in the Program Operations Manual (MOP)

Processes proposed to be included in the MOP include:

1. **Definition of the human resources that will be in charge of environmental and social management in the agency/agencies in charge of the execution of the new PHC infrastructure to be financed with the WB loan.** Define their roles, responsibilities and professional profile. At a minimum, these professionals should have experience in the application of the national legal framework and environmental and social management systems relevant to both the works to be built and the activities to be developed with the WB loan.
2. **Checklist to identify activities that meet the exclusion criteria** defined in the ESSA and therefore cannot be financed by the Program. This checklist shall correspond to the one included in section 2.2.8.
3. **Minimum technical specifications to be included in bidding documents for environmental and social management of civil works** to be implemented by contractors, as well as EHS and social management guidelines to be applied during construction and operation of new PHC facilities, consistent with national regulations, relevant international best practices, and the basic principles and key planning elements set out in the PforR Financing Policy and Directive.
4. **Template for the preparation of semiannual environmental and social monitoring reports to** be submitted to the WB, and shall include, at least, the minimum contents of the E&S reports, including the report on the resolution of complaints and grievances, as well as the responsibilities and procedure for their preparation.
5. **Procedure for reporting incidents and accidents to the BM**. It shall include, at least, deadlines, procedure, relevant information to be included in the report, such as: details of the incident (date, time, person responsible for the report), type and description of the incident, actions taken to address the incident, support provided to the affected person.
6. **Procedure/mechanism for handling complaints and grievances.** It shall include, at least: process for registering complaints or grievances, the process and deadlines for addressing and following up on them, measures implemented to prevent recurrence of the causes of grievances, those responsible for implementing the mechanism for addressing complaints and grievances.
7. **Include the Model of Participation of Indigenous Communities** developed by MINSAL when the Comptroller General of the Republic has approved it.
8. Others to be determined.

6.3. Recommendations

To strengthen the Program's environmental and social management systems, the following recommendations are proposed based on available information and input gathered during the focus group consultation of the ESSA:

- Design and develop a Change Management Plan aimed at current and new users, as well as PHC workers, to adjust their expectations regarding the new People-Centered Integrated Care Strategy (ECICEP) and, in general, the scope of the Program.
- For the design and location of the new PHC infrastructure model to be financed by the Program, in addition to consider climate hazards and disaster risks in the sites where the new centers are to be established, also consider other factors that may affect their construction and operation, such as: (i) the availability of potable water; (ii) the availability of electric power; (iii) the presence of uncontrolled pollution hotspots generated by industrial, agricultural, fishing or other activities in the area in question, which cause public health problems such as pests (insects, rodents and other animals), bad odors and contamination of water sources; and the (iv) use of construction materials or devices that prevent or mitigate noise pollution inside the new centers.
- Design and implement training and certification programs to strengthen the environmental and social management capacities of the Health Services entities and/or other agencies involved, both in the execution of infrastructure works included in the Program, as well as in the operation of new PHC centers to be built with Program financing.
- To rescue the experience and capacity building in E&S management for the execution of infrastructure acquired by the HS entities involved in the PforR in order to replicate it in the operation of other HS in the country.
- Advance in the energy diagnosis and inventory of greenhouse gases for the determination of the baseline at the PHC level to support the implementation of the country's Framework Law on Climate Change, in terms of adaptation and mitigation of climate change.
- Design and implement an information system for interoperability among the new PHC facilities supported by the PforR in the country to facilitate the exchange of information, experience, and

implementation of good practices in E&S management, challenges and lessons learned in the operation of the facilities.

- Incorporate socio-demographic, accessibility and connectivity criteria in the selection of the communes to be included in the PforR based on: criteria based on: (i) Social Determinants of Health; (ii) rurality level of the communes according to the rurality criteria used by the National Rural Development Policy; (iii) data from the Rural Quality of Life Indicators System of the National Statistics Institute (INE); and (iv) a survey of the population, especially migrants, both national and international.
- It is suggested to work intersectorally: Public Works and Telecommunications to project solutions specific to these sectors that could have a positive impact on the construction of new PHC centers in rural communities.
- Decouple the evaluation of the user experience from the performance goals of PHC staff members.
- Improve the mechanisms for participation and consultation, both citizen and indigenous, based on the current regulations[35] , but tending to implement mechanisms to guarantee the inclusive and binding nature of the participation and consultation processes, which also include health workers and other key actors, such as: intersectoral institutions, municipalities, civil society organizations and specialists, through mechanisms to return the results of the participation and consultation processes, explaining to the communities the reasons that led the institutions to make decisions. The processes can even be documented in order to provide MINSAL with an improved participation and consultation methodology.
- It is suggested that the gender perspective be incorporated into the design of the package "Surveillance of Public Health Emergency Risks and Climate Change in Universal PHC" given that approximately 70% of health personnel are women.

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8. ANNEX 1: INTERNATIONAL NORMS ON HUMAN RIGHTS, HEALTH AND PRIMARY HEALTH CARE TO WHICH CHILE HAS SUBSCRIBED

Table 11 Treaties and other international norms subscribed by Chile in the area of Human Rights and Health

Type	Instrument	Year of signature	Year of ratification, accession or succession	Mentions in Health
International Treaty	International Convention on the Elimination of All Forms of Racial Discrimination	1966	1971	Article 5 In fulfillment of the fundamental obligations set forth in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: [...] (e) Economic, social and cultural rights, in particular: [...] (iv) **The right to public health, medical assistance, social security and social services**; [...] (v) The right to **health care;** [...] (vi) The right to education; [...] (vii) The right to education; [...] (viii) The right to education; [...] (viii) The right to health care; [...] (viii) The right to education; [...] (viii) The right to education
International Treaty	International Covenant on Civil and Political Rights	1969	1972	
International Treaty	International Covenant on Economic, Social and Cultural Rights	1969	1972	The **States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.** The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth and infant mortality rate and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) **The creation of conditions which would assure to all medical service and medical attention in the event of sickness.**
International Treaty	Convention on the Elimination of All Forms of	1980	1989	States Parties shall take all **appropriate measures to eliminate discrimination against women in the field of health care in order to** ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

	Discrimination against Women (CEDAW)			Notwithstanding the provisions of paragraph I of the present article, States Parties **shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period,** granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.
International Treaty	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1987	1988	
International Treaty	Convention on the Rights of the Child	1990	1990	States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to **ensure that no child is deprived of his or her right of access to such health services**. 2. States Parties shall strive for the full implementation of this right and, in particular, shall take appropriate measures: (a) To reduce infant and child mortality; (b) To ensure the provision of necessary medical and health care for all children, with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of available technology and the provision of adequate nutritious foods and clean drinking water, taking into account the dangers and risks of environmental pollution; (d) Ensuring adequate prenatal and postnatal health care for mothers; (e) Ensuring that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation, and accident prevention; (f) Developing preventive health care, parenting and family planning education and services. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.
International Treaty	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	1993	2005	Article 28 **Migrant workers and members of their families shall have the right to receive all medical care urgently required for the preservation of their life or the avoidance of irreparable harm to their health**, on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused on the ground of any irregularity in respect of stay or employment. Migrant workers shall enjoy equality of treatment with nationals of the State of employment in respect of: (e) Access to social and health services, provided that the conditions for participation in the respective schemes are fulfilled; Article 45 1. Members of the families of migrant workers shall enjoy, in the State of employment, equality of treatment with nationals of that State in respect of: (c) Access to social and health services, provided that the conditions for participation in the respective schemes are fulfilled;

International Treaty	Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography	2000	2003	
International Treaty	Second Optional Protocol to the International Covenant on Civil and Political Rights Aiming at the Abolition of the Death Penalty	2001	2008	
International Treaty	Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict	2001	2003	
International Treaty	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	2005	2008	
International Treaty	International Convention for the Protection of All Persons from Enforced Disappearance	2007	2009	

International Treaty	Convention on the Rights of Persons with Disabilities	2007	2008	Article 25 - Health States Parties **recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability**. States Parties shall take all appropriate measures to ensure access by persons with disabilities to gender-sensitive health services, including health-related rehabilitation. In particular, States Parties shall: (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as other persons, including in the area of sexual and reproductive health and population-based public health programs; (b) Provide health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention, as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons; (c) Provide these health services as close as possible to the communities themselves, including in rural areas; (d) Requiring health professionals to provide the same quality of care to persons with disabilities as to others, including on the basis of free and informed consent, including by raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care; (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, to be provided in a fair and reasonable manner; (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.
Other universal standards	Declaration of Alma Ata. on primary health care	1978	s/i	VI. **Primary health care is** essential health care based on practical, scientifically sound and socially acceptable methods and technology, **made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of its development, in a spirit of self-reliance and self-determination**. It forms an integral part of both the health system of the country, of which it is the central function and main focus, and the overall social and economic development of the community. It is the first level of contact of individuals, family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element in a continuum of health care. VIII. **All governments should formulate national policies, strategies and action plans to implement and maintain primary health care as part of a comprehensive national health system and in coordination with other** sectors. This will require the exercise of political will, the mobilization of national resources, and the rational use of available external resources.
Other universal standards	Declaration on the right to development	1986	s/i	1. **States should undertake, at the national level, all necessary measures for the realization of the right to development and shall ensure, inter alia, equality of opportunity for all in their access to basic resources, education, health services, food, housing, employment and fair distribution of income.** Effective measures should be taken to ensure that women

				have an active role in the development process. Appropriate economic and social reforms should be carried out with a view to eradicating all social injustices.
Other universal standards	Declaration of Commitment on HIV/AIDS	2001	s/i	The realization of human rights and fundamental freedoms for all is essential to reducing vulnerability to HIV/AIDS Respect for the rights of people living with HIV/AIDS drives an effective response 58. By 2003, enact, strengthen or enforce, as appropriate, laws, regulations and other measures to **eliminate all forms of discrimination against people living with HIV/AIDS and members of vulnerable groups, and to ensure their full enjoyment of all human rights** and fundamental freedoms, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, health and social services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigmatization and social exclusion related to the epidemic; 59. By 2005, taking into account the context and nature of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote the shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection; 60. By 2005, implement measures to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, primarily through the provision of health care and health services, including sexual and reproductive health services, and through preventive education that promotes gender equality within a cultural and gender-sensitive framework; 61. By 2005, ensure the development and accelerated implementation of national strategies for the empowerment of women, the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of gender-based violence, ill-treatment and trafficking of women and girls;
Other universal standards	Astana Declaration on Primary Health Care	2018	s/i	I. We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. **Convinced of the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular justice and solidarity, and underline the importance of health for peace, security and socio-economic development, and their interdependence.** IV. We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. VI. We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. (...) We will protect and promote solidarity, ethics and human rights (...). VII. (...) In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices and with full respect for national sovereignty and human rights.

Rules for specific groups	Declaration of the Rights of the Child	1959	s/i	Principle 4 The child shall enjoy the benefits of social security. He shall have the right to grow and develop in health; to this end, special care and protection shall be provided for him and his mother, including appropriate prenatal and postnatal care. The child shall have the right to food, housing, recreation and medical services.
Rules for specific groups	ILO Convention No. 182: Worst Forms of Child Labor Convention	1999	s/i	(d) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.
Rules for specific groups	Declaration on the elimination of violence against women	1993	s/i	Article 3 Women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. These rights include, inter alia: (f) The right to the highest attainable standard of physical and mental health; [...] (g) The right to the highest attainable standard of health.
Rules for specific groups	Beijing Platform for Action - Women and Health	1995	s/i	Women have the right to enjoy the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and to their ability to participate in all areas of public and private life. [...]
Rules for specific groups	ILO Convention (No. 169) concerning Indigenous and Tribal Peoples in Independent Countries	1989	s/i	(2) The improvement of the living and working conditions and of the standards of health and education of the peoples concerned, with their participation and cooperation, shall be a matter of priority in the plans for the overall economic development of the areas which they inhabit. Special projects for the development of the areas concerned shall be so designed as to promote such improvement. Article 20 (2) Governments shall make every effort to prevent any discrimination between workers belonging to the peoples concerned and other workers, in particular with regard to: [...] (c) Social and medical assistance, occupational safety and health, all social security benefits and any other work-related benefits, and housing; [...] Article 25 1. Governments shall ensure that adequate health services are made available, or provide resources to enable the peoples concerned to design and deliver such services under their own responsibility and control, in order that they may enjoy the highest attainable standard of physical and mental health. Health services should, as far as possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and shall take into account their economic, geographical, social and cultural conditions, as well as

				their traditional preventive care, healing practices and medicines. The health care system shall give preference to the training and employment of local community health workers, and shall focus on primary health care, while maintaining strong links with other levels of health services. 4. The provision of these health services shall be coordinated with other social, economic and cultural measures in the country.
Rules for specific groups	United Nations Declaration on the Rights of Indigenous Peoples	2006	s/i	Article 21 1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security. Article 23 Indigenous peoples have the right to determine and develop priorities and strategies for the exercise of their right to development. In particular, indigenous peoples have the right to participate actively in the development and determination of health, housing and other economic and social programs affecting them and, to the extent possible, to administer such programs through their own institutions. Article 24 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their medicinal plants, animals and vital minerals. Indigenous individuals also have the right to access, without discrimination, to all social and health services. 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.
Rules for specific groups	Standard rules on equal opportunity for persons with disabilities	1993	s/i	22. The term "prevention" refers to actions aimed at preventing the onset of physical, intellectual, psychiatric or sensory impairments (primary prevention) or at preventing impairments from causing permanent functional limitation or disability (secondary prevention). Prevention can include many different types of actions, such as primary health care, prenatal and postnatal care, nutrition education, immunization campaigns against communicable diseases, control measures for endemic diseases, safety standards, accident prevention programs in different environments, including adaptation of workplaces to prevent occupational disabilities and diseases, and prevention of disability resulting from environmental pollution or armed conflict.
Rules for specific groups	The United Nations Principles for Older Persons	1991	s/i	1. Older persons should have access to adequate food, water, housing, clothing and medical care through the provision of income, family and community support and self-help; 11. Older persons should have access to health care to help them maintain or regain the optimal level of physical, mental and emotional well-being and to prevent or delay the onset of disease.

Sources:

1. International Health Standards. United Nations. Accessed June 2023. Source: https://www.ohchr.org/es/special-procedures/sr-health/international-standards-right-physical-and-mental-health
2. Status of ratification by country and/or by treaty. Accessed June 2023. Source: https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=35&Lang=SP
3. International human rights treaties signed and ratified by Chile. International recommendations with constitutional impact. Parliamentary Technical Advisory. Government, Defense and International Relations Area. Nº SP: 123705. 2020. Library of the National Congress. Source: https://obtienearchivo.bcn.cl/obtienearchivo?id=repositorio/10221/28223/1/Acuerdos_internacionales_e_incidencia_constitucional_rev_BH.pdf

ANNEX 2 SUMMARY OF THE RESULTS OF THE CONSULTATION ON THE ESSA **DRAFT REPORT**

According to the thirty participants of the four focus groups on the Draft Environmental and Social Systems Assessment (ESSA) of the PforR "*Universal Primary Health Care Coverage and Resilience in Chile (P179785)",* a summary of the social and environmental issues mentioned is presented below.

In general, the participants broadly accepted the main conclusions and recommendations of the ESSA. They also made a number of comments to clarify and improve the Report. Relevant comments were responded to during the workshop and incorporated into this final version of the ESSA.

The three main topics addressed during the Consultation were: (i) the redesign of strategies for the participation of individuals and communities; (ii) the new PHC care model proposed by the Program; and (iii) the construction of new PHC infrastructure.

1) **Redesign of Strategies for Participation**: Results Area 1 (RA1) PHC Coverage and Quality establishes that the redesign of strategies for the participation of individuals, families and communities in decision making will be supported, in order to provide care and services acceptable to citizens and strengthen the social role of PHC. In this regard, the people consulted elaborated on the following aspects that they consider may present risks to guarantee the success of the new participation strategy:
   a) Risk of low adherence to the Program if the full range of key stakeholders is not included in the participation strategy. In order to strengthen social control and adherence to the Program, it is suggested that the redesign of participation strategies involve not only individuals and their communities, but also unions, confederations and associations of health workers, PHC specialists, Advisory Councils, intersectoral institutions and executing entities (municipalities), both in the design and implementation of the new model of care, as well as in the definition of the typology of the new centers, the selection of their location, and the mechanisms for management, measurement and accountability of the Program.

Reply	- Tables 7 and 8 of the ESSA mention the regulations in force regarding citizen participation, civil society, indigenous and tribal peoples, and health workers' confederations in the design, implementation and evaluation of public policy. - In section 6.3 ESSA recommendations, it is suggested that the PforR take the participation and consultation regulations described in the ESSA as the minimum standard for guaranteeing the participation of key stakeholders, but that it should seek to implement mechanisms to guarantee the inclusive and binding nature of the participation and consultation processes, including documenting the results of these processes to provide MINSAL with an improved participation and consultation methodology.

b) Risk in the redesign of the participation strategy if a binding and far-reaching participation methodology is not developed that considers: (i) training of users, officials and leaders in order to level the dialogues; (ii) development of dialogue processes that begin at the public policy design stage and continue through to the evaluation stages, ensuring binding iterations between participants and the authority throughout the process; (iii) allocation of resources for the design and operation of a Knowledge Management Model that contemplates the creation of User Management Committees in PHC Centers (like the one that currently exists in hospitals) and that not only manages the results of consultations, but also the results of user satisfaction measurements, as well as previous MINSAL experiences on the subject, such as the Model of Participation of Indigenous Communities developed by MINSAL in 2015 and whose regulations are currently before the Comptroller General of the Republic.

"The citizenry wants to be co-responsible in public policy" Male. Group1.

Reply	- Administrative mechanisms to encourage citizen and community participation are mentioned in Section 4.2.3 *Implementation of social management systems for grievance resolution and evaluation of public policy*. - The following are incorporated in Table No 7 *General regulatory framework on guarantee and protection of rights, non-discrimination, citizen participation and procedures for **ESSA** claims*: (i) MISNAL Exempt Resolution No 661 (2015); (ii) MINSAL's General Administrative Regulation (2006); (iii) MINSAL Decree No 135 (2004); and (iv) MINSAL Decree No 140 (2004). - In section 6.2 *Processes to be Included in the* ESSA *Operations Manual (MOP)* It is recommended to include in the PforR Operations Manual (MOP) the Regulations of the Indigenous Community Participation Model developed by MINSAL when the Comptroller General of the Republic has approved it.

2) **New PHC care model**: Area by Results No. 1 (RA1) PHC Coverage and Quality establishes the establishment of a new PHC care model where people, regardless of the type of health insurance they have, will have access and will be effectively covered by PHC, with a strong equity component, aiming at closing gaps in the quality of care, with a special focus on the prevention and control of Non-Communicable Diseases (NCDs) and with a gender perspective (women and LGBTIQA+ people). In this regard, those consulted identified the following risks to the fulfillment of this RA:
   a) Risk of generating expectations regarding the new care model that are not met, due to: lack of knowledge on the part of key stakeholders about the scope of the Program; that the new care model does not meet users' needs; or that its implementation is not relevant or feasible in the territories. In this regard, it is suggested to: (i) Design communication campaigns differentiated by type of audience (users, officials, new users, municipalities and others), at national and local level, and multiplatform, to adequately inform the population about the scope of the Program, especially regarding the preventive nature of the new model; (ii) Raise awareness and train PHC officials, as well as Municipal Health Managers on the new model and its equity and gender perspective and inclusion component; and (iii) Develop a Change Management Strategy that not only involves the measurement of user satisfaction, but also other complementary actions, such as: the management of knowledge obtained historically through complaints and suggestions in PHC and consultations with staff and other key stakeholders.

"A change management process needs to be carried out: from resolutive care to preventive care." Male, Group 3

Reply	- Section 3.2.1 *Potential social benefits* of the ESSA mentions "*the improvement of the quality, timeliness and relevance of services at the primary health care level through actions that will make it possible to update and evaluate the Model of Comprehensive Family and Community Health Care through a human rights approach and a gender and social inclusion perspective, incorporating social determinants, and establishing minimum standards for training health teams and civil servant training systems in key areas to guarantee decent, relevant and non-discriminatory care*". - One of the RA1 activities is the Training of Community Agents in each of the municipalities that will be integrated into the Program to support the gender perspective component. It is incorporated in section 2.2.6 *Program Activities that may have* ESSA *social impacts.* - The PforR's RA3 *Efficient and Transparent PHC* considers the establishment of a Leadership School for management skills and budget execution for municipal managers. It is incorporated in section 2.2.6 *Program Activities that may have social impacts*. - The implementation of a multiplatform communication campaign is the responsibility of the Government through the Program for the Universalization of PHC and not of the PforR. - Neither the PforR nor the Governance Program have considered the design and development of a Change Management Plan. Section 5.3 ESSA Recommendations suggests the development of this activity.

b) Risk of exclusion of cultural, identity and territorial diversities due to the centralized design of the new model of care. It is suggested the definition of participative and binding local strategies that involve all key stakeholders and that allow for the adaptation of the new PHC care model according to local specificities, so that both citizens and civil servants find meaning and relevance to the new model that will be implemented in their communities and territories, even allowing for local adjustments to the programs.

"It would be good, for example, if the People-Centered Integrated Care Strategy (ECICEP) model could be modified and adapted according to the view of the communities where it is implemented." Male, Group4.

"The Universalization of PHC is a concept that has been tried to be installed in the country for decades. The way to guarantee its success is to recognize the diversities of the communities and their territories and involve them from the beginning, agree on the purpose and integrate the intersector" Man, Grupo4.

Reply	- Both the current regulations and the institutional mechanisms for participation and inclusion are mentioned in Section 4.2.3, as well as in Tables 7 and 8 of the ESSA. - In section 6.3 ESSA recommendations, it is suggested that the redesign of the participation and consultation mechanism should be based on existing regulations and mechanisms as the minimum standard to guarantee the participation of key stakeholders, but that it should seek to implement mechanisms to guarantee the inclusive and binding nature of the participation and consultation processes.

c) Risk that MINSAL does not have the capacity to guarantee the standardization of the quality of PHC care due to the fact that most PHC devices are managed by municipalities whose authorities do not necessarily adhere to or know the principles of PHC Universalization and where the technical capacities of municipal personnel to manage PHC centers are not homogeneous, the participants of the Consultation suggested: (i) Developing a governance model that clearly establishes: the mechanisms for transferring capacities from MINSAL to the municipal staff that will be in charge of the PforR, both in the control processes for the compliance of the Program's

activities, as well as in the mechanisms for monitoring inequality in access to PHC centers that are integrated and the creation of a data governance and interoperability model; (ii) Definition of a data and information management system related to the implementation of the PforR that allows municipal teams to observe how they are progressing in the development of the Program through the creation of their own Data Units; and (iii) the incorporation of Health referents belonging to the Civil Society in the municipalities, in order to improve citizen control.

"It is necessary to improve the relationship of PHC centers with the Health Services and with the Undersecretariat of Health Care Networks. For now, the ministerial authority does not control or supervise PHC centers, they act as <a voice mailbox>". Woman, Group 2.

Reply	- The risk on MINSAL's capacity to establish minimum quality and equity standards in the new PHC care model due to the diversity and heterogeneity of municipalities is mentioned in section 3.2.2 *Potential social impacts and risks* of the ESSA as part of the social assessment context, however, MINSAL's management capacity is not part of the PforR activities. - In Table 3 *Potential Risks and Social Impacts*, in the operation stage, it is difficult to establish minimum quality and equity standards in the New PHC Care Model due to the diversity and heterogeneity of municipalities. - The PforR's RA3 *Efficient and Transparent PHC* considers the establishment of a Leadership School for management and budget execution skills for municipal managers. It is incorporated in section 2.2.6 *Program Activities that may have social impacts.*

d) Risk of increasing the bad reputation of the public health system due to the incorporation of new PHC users. In this regard, the people consulted pointed out that if the public health system is already under stress, in terms of staffing and infrastructure, it is likely that the incorporation of new users will cause an increase in the stress of PHC centers, especially those that currently serve a larger number of people than those for which they were designed. In addition, the incorporation of users who are not FONASA is a complexity for the referral systems to other levels of the Network, such as Referral Centers and High Complexity Hospitals, since these users could not be referred since they are not FONASA. Some of the suggestions are: (i) Integrate in a first stage of the PforR those communes whose majority of inhabitants belong to ISAPRE, in order to monitor how the referral system develops with other levels of health care; (ii) Integrate the other levels of health care in the Universalization of Access to Health.

"It is necessary that the standardization of the new care model also involves the other levels of care and not only PHC" Woman, Group 3.

"We are concerned that the PforR guarantees the necessary staffing to carry out the Program in the municipalities. Currently, the municipalities have serious staffing problems for the People-Centered Integrated Care Strategy (ECICEP)" Male, Group 4.

Reply	- In section 3.2.2 *Potential Social Impacts and Risks,* the word "challenge" is changed to "risk" in the sentence that states that the incorporation of new users to PHC could deepen the bad reputation of the public health system. The phrase "especially those that currently serve a larger number of people than they were designed for" is also added. - *Potential Social Risks and Impacts*, in the PHC Centers Operation stage, we add **the** risk of increasing the bad reputation of the public health system due to the increase in demand in PHC centers due to the

	incorporation of new users, especially in PHC centers that currently provide services to a larger population than they were designed to serve. - Regarding the integration of other levels of health care, it is necessary to point out that this is beyond the scope of the activities programmed for the PforR.

3) **New PHC Infrastructure**: The Program for Results (PforR) mentions that one of the activities contemplated in the Results Area No. 2 (RA2) Resilient PHC is the development and subsequent construction of a New Infrastructure Model, adjusted to the exposure to climate-related hazards, geographic distribution and energy efficiency standards. In addition, based on information provided by MINSAL to the ESSA team, the design of the prototype of the new PHC infrastructure, including the definition of E&S sustainability standards, will be done at the central level of MINSAL, while the responsibilities associated with the construction of this infrastructure will fall on the Health Services (SS) of MINSAL and the municipalities will be in charge of its operation. The PforR mentions that during its implementation (2024-2028) it is expected to integrate 187 communes (54% of the total number of communes). In this regard, the people consulted have mentioned several aspects that could present risks for the optimal fulfillment of this activity:

a) Risk of bias in the selection of municipalities to be included in PforR if social determinants of health are not considered.[1] of the population, especially for the population living in territories considered as rural or semi-rural and which represent 82% of the national territory, where an estimated 25.5% of the country's total population lives, according to the criteria of the National Rural Development Policy (PNDR).[2]The inclusion of communes with high rates of population that do not belong to FONASA is also included. It is suggested to agree on the selection criteria with the key actors of the health sector: users, citizens, civil society, specialists, PHC officials, executing entities (municipalities) and intersectoral institutions, and then make the selection criteria public.

Reply	- Section 3.2.2 Potential social impacts and risks of the ESSA indicates that MINSAL has a land selection guideline in rural areas that considers social criteria. In section 6.3 *Recommendations*, it is suggested that criteria based on: (i) Social Determinants of Health; (ii) Level of rurality of the communes according to the rurality criteria used by the National Rural Development Policy; and (iii) Data from the Rural Quality of Life Indicators System of the National Statistics Institute (INE) be included in the definition of criteria for the selection of communes in which new PHC centers will be built.

b) Risk of building new devices in sectors that are not appropriate to ensure accessibility, safety and connectivity of the population. It is suggested to broaden the range of selection criteria, both for the communes that will enter the PforR and the physical location of the new devices, including socio-demographic and economic aspects related to the Program's target population and other elements that could influence the accessibility, connectivity and security of the new devices, their users and officials, such as: lack of internet connectivity, delay times to reach the device, sectors with high rates of violence and insecurity (shootings, robberies and homicides, among others), existence of illegal dumps, waste sites, lack of public lighting, lack or scarce frequency of public transportation, resilience and rehabilitation capacity of road access in the face of climatic and sanitary emergencies, or natural disasters.

Reply	- Table 3 *Potential Risks and Social Impacts,* in the Pre-Construction stage, includes the risks of construction in communities without internet connection and in areas with high levels of insecurity and violence, lack or infrequency of public transportation and with low resilience and capacity for rehabilitation of road access in the event of climatic and sanitary emergencies or natural disasters. - In section 6.3 *Recommendations,* it is suggested to work with intersectoral institutions: Public Works and Telecommunications to project solutions specific to these sectors that could have a positive impact on the construction of new PHC centers in rural communities.

c) Risk of building a typology of new PHC devices that is not related to the expectations and needs of the communities. Due to a centralized and homogeneous design of the new devices contemplated in the PforR that, it is understood, will be elaborated by the Central Level of MINSAL without considering communication and binding participation processes, both with: citizenship; civil society; civil servants' associations; and local intersectoral institutions, which allow for the flexibility and territorial and cultural adaptation of the new facilities, from the definition of their typology, to the location of the center, its construction, habilitation and operation, including the design of targeted and relevant communication and change management campaigns in which there is also participation of key local stakeholders.

"The proposed model is similar to the previous one: it is not health that reaches people, but people that reach health" Male, Group 4.

"The same thing that happened with the Community Family Health Centers (CECOSFs) may happen, because citizens do not understand a care system. It may be that the same thing that happened with the Community Family Health Centers (CECOSF) will happen, because the citizens do not understand a system of care, they are much more accustomed to resolution than to prevention" Man, Group 3.

Reply	- Both the current regulations and the institutional mechanisms for participation and inclusion are mentioned in Section 4.2.3, as well as in Tables 7 and 8 of the ESSA. - In section 6.3 *ESSA recommendations*, it is suggested that the redesign of participation and consultation strategies should take the current regulations and mechanisms in force as the minimum standard to guarantee the participation of key stakeholders, but that it should seek to implement mechanisms to guarantee the inclusive and binding nature of the participation and consultation processes.

d) Risk of delays or suspension in the construction of new PHC centers. As it has happened in the past, due to factors such as the fact that the awarded companies do not comply with the deadlines established in the bidding conditions, or else, they start bankruptcy processes.

Reply	- In Table 3, *Potential Risks and Social Impacts,* in the construction stage, the risk that the new PHC centers will not be completed on time due to abandonment by the company awarded the contract is added.

e) Risk of building new facilities that do not respond to the specific needs of the population in terms of building spaces that guarantee the quality and confidentiality of care with cultural relevance and gender and inclusion perspectives, both for indigenous and tribal communities, as well as for people who suffer gender-based violence and users with specific pathologies, such as mental disorders or Alzheimer's, among others that require special care. It is suggested to carry out local,

focused and binding consultation processes that allow the cultural adaptation of the devices to be built in each territory.

Reply	- Table 3 *Potential Risks and Social Impacts,* in the Preconstruction stage, mentions the risk of omission of demographic, social, cultural and health characteristics of the population that would prevent the design of adequate facilities, and adds "with cultural and territorial relevance".

f) Risk of building new PHC facilities in locations with climatic threats such as extreme temperatures, fires, floods; lack of drinking water; and uncontrolled pollution sources generated by industrial, agricultural, fishing or other activities in the area in question that cause public health problems such as pests (insects, rodents and other animals), odors and contamination of water sources. It is suggested to consider in the design and prefeasibility studies for the construction of the new model of PHC facilities, the location and technical specifications ties appropriate to the environmental and climatic context of the territory, as well as to strengthen the supervision of environmental management by the corresponding municipalities and SEREMIS, not only on the new facilities, but also in the territory where they are established to prevent and mitigate environmental and public health risks and impacts that may affect the operation of the new PHC facilities.

Reply	- The Program already considers climate-related risks and the territorial context for the development of the design of the new PHC infrastructure model. In addition, this ESSA includes an exclusion list that defines the typology of activities that cannot be included in the Program due to the significant risks and adverse impacts they would cause on the environment and/or affected people, including construction in high risk areas due to natural hazards, such as floods, landslides, earthquakes, tsunamis or fires. - It is recommended to consider for the design and location of the new PHC infrastructure model to be financed by the Program, in addition to climate hazards at the site where the new PHC facilities will be established, other environmental and health and safety factors that may affect their construction and operation, Included in numeral 6.3 on Recommendations. - It is recommended to strengthen the training of competent personnel in municipalities where new PHC facilities and corresponding SEREMIS are established in order to strengthen the control of environmental and safety compliance in the new facilities and their territory during their operation. Included in numeral 6.3 on Recommendations.

4) **Creation of Comprehensive Response Teams for health emergencies**: The main objective of the Area by Results No. 2 (RA2) Resilient PHC is to strengthen PHC in its contributing role to build a resilient health system to face future challenges derived from public health emergencies, incorporating the lessons learned from the COVID-19 pandemic. Among the activities included in this RA is the creation of designated Integrated Response Teams (geo-referenced to participating municipalities) and trained for Emergency Risk Surveillance. In this regard, the participants of the Consultation mentioned as a positive aspect the use of the experiences learned during the last Pandemic for the design and implementation of a surveillance and response system for health emergencies. However, they mentioned the following risk:

a) Risk of lack of PHC staffing to respond to health emergencies if the surveillance and response system proposed by PforR does not incorporate the gender perspective in its design, since approximately 70% of PHC health personnel are women and, according to what happened during

the COVID-19 pandemic, when health centers quickly collapsed, it could be because many of them had to be relieved from their functions in order to be able to take care of their families. In this sense, it is suggested to incorporate the gender perspective in the design and implementation of surveillance and response mechanisms to health emergencies, including care systems that allow PHC workers to continue in their functions.

"In Pandemia, many of them had to be excused because of the caregiving duties they perform in their families. If there had been nurseries, perhaps the health system would not have been so collapsed in Pandemic" Woman, Group 2.

Reply	- Table 3 *Potential Risks and Social Impacts, in the* Operation stage*,* adds the risk in the operation of PHC centers when health emergencies occur if the sector's response is not designed with a gender perspective, due to the feminization of health personnel working in PHC.

5) **Other matters:** During the Consultation, it was also mentioned the concern for knowing the financing mechanisms, specifically in relation to knowing how financial resources will be transferred from MINSAL to the Municipalities and if they will have autonomy for the execution of such resources. Finally, it was suggested to make special emphasis on establishing mechanisms that guarantee equity and safety for PHC workers, such as: official accompaniment and incorporation of regulations aimed at the prevention and sanction of violence at work based on gender or identity.

Reply	- Although AR 3 of PforR *PHC Efficient and Transparent* contemplates among its activities the modernization of the PHC funding allocation system based on health and social risks, the review of mechanisms for transfers between the Central Level of MINSAL and municipalities is not within the scope of the ESSA Assessment. - Section 3.2.1 *Potential social benefits* of the ESSA mentions "*the improvement of the quality, timeliness and relevance of services at the primary health care level through actions that will make it possible to update and evaluate the Model of Comprehensive Family and Community Health Care through a human rights approach and a gender and social inclusion perspective, incorporating social determinants, and establishing minimum standards for training health teams and civil servant training systems in key areas to guarantee decent, relevant and non-discriminatory care*". - In section 6.3. ESSA *recommendations* suggest incorporating the gender perspective in the design of the package "Surveillance of Public Health Emergency Risks and Climate Change in Universal PHC" due to the fact that approximately 70% of health personnel are women.