Republic of Chile

PROGRAM FOR UNIVERSAL PRIMARY HEALTHCARE COVERAGE AND RESILIENCE (P179785)

Program for Results (PforR)

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT (ESSA)

DRAFT dated

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Prepared by the World Bank

ACRONYMS AND ABBREVIATIONS

A&S	Environmental and Social
APS	Primary Health Care
RA	Results Areas
SSA	Environmental, Health and Safety
ASSL	Environmental and Occupational Health and Safety
WB	World Bank
GIVE	Department of Health Statistics and Information
DGREYD	Department of Emergency and Disaster Risk Management
DIPRES	Directorate of Budgets of the GoCl
DIVAP	Division of Primary Care
DLI	*Disbursement Linked Indicators*
DLR	*Disbursement Linked Results*
DOM	Municipal Works Directorate
ECICEP	People-Centered Comprehensive Care Strategy
ENT	Noncommunicable diseases
THOSE	Environmental and Social Systems Assessment
ESSA	*Environmental and Social Systems Assessment*
FONASA	National Health Fund
GoCl	Government of Chile
ITO	Technical Works Inspector
LGBTIQA+	Lesbian, gay, bisexual, transgender, queer, asexual, and other gender identities
MINSAL	Ministry of Health
MMA	Ministry of Environment
PDI	*Program Development Objective Indicators*
PDO	*Program Development Objective*
PforR	*Program for Results*
RCA	Environmental Qualification Resolution
RSEIA	Regulation of the Environmental Impact Assessment Service
SEREMIS	Regional Ministerial Secretariats of Health
SS	Health Services
IPU	Program Implementation Unit

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1. INTRODUCTION

In compliance with the Operational Policy (OPS5.04-POL.107 of 2017) and the Directive (OPS5.04-DIR.107 of 2022[1]) for the financing of Programs for Results (PforR) of the World Bank (WB), this Environmental and Social Systems Assessment (ESSA) aims to present the findings and recommendations of the risk assessment carried out by the World Bank of the environmental and social management systems that govern the implementation of the Program for Universal Primary Healthcare Coverage and Resilience (P179785). An analysis of the legal and institutional aspects applicable to the PforR in preparation is being carried out in order to determine whether:

- 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 the activities of the Program; 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 the living conditions in which they find themselves prior to the implementation of the Program.
- They 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 ensuring equitable and culturally appropriate access to the benefits of the Program.
- They avoid exacerbating social conflicts, especially in fragile territories and areas with social conflicts or territorial disputes.

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

1.1 Purpose of ESSA

The purpose of this ESSA is to: i) identify potential environmental and social (E&S) risks that may affect the achievement of the Program's results; ii) assess the borrower's ability to manage these 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 executing agencies with respect to the effective management of environmental, health and safety, and social issues during implementation. Some of these measures will be incorporated into the Program Action Plan (PAP) and others will be incorporated into the Program Operational Manual (POM), as detailed in Section 5.

1.2 ESA Methodology

The ESSA is a World Bank document requirement for PforR's 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. Comments received from public consultations will be incorporated into the final ESSA report as appropriate.

The methodology for the development of this ESSA is aligned with the provisions of the WB Guide prepared to conduct the ESAs for PforR financing operations. The methodology involves:

i. Identification of potential environmental, safety and health risks of workers and the population (SSA) and social risks that may result from the activities to be supported by the PforR;

ii. Documentary review of the laws, regulations, requirements and guidelines of the national systems in matters of SSA and social management to prevent or mitigate the risks identified, provided by the client and / or consulted on 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 care facilities in the commune of Coltauco (a Family Health Center -CESFAM- and a health post). These missions provided a better understanding of the potential environmental and social risks associated with such activities and the capacity and procedure of government departments to address such risks, including relevant measures 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 Evaluation Document (PAD) and Memory Help of the last preparation mission carried out.

v. Review of ESSA reports for other WB PforR operations.

vi. Preparation and publication of the draft of the ESA prior to the evaluation mission of the Program, on the external website of the World Bank.

vii. A public consultation of the ESSA draft, to be held after the Decision Meeting, with government representatives and relevant civil society actors. The draft ESSA report shall be annexed to the call for consultations; and

viii. The preparation of the final version of the ESSA report taking into account the comments and observations gathered in the consultation. This final version will be published both on the MINSAL

website and on the external website of the World Bank, after the negotiations and before the approval of the Program by the Board of Directors of the World Bank.

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 version provided in the World Bank's August 2023 Program Evaluation 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 I approve Dignity of President Gabriel Boric[2] for the period 2022-2025. It emphasizes the development of an intersectoral health strategy at the local level, based on the primary care system, capable of guaranteeing universal access and zero discrimination in the public health network, focused on people and their diversities, as well as on the role of communities. To this end, it proposes measures aimed at modernizing health management, improving accessibility to the public health system and the efficiency of public spending in this area.

One of the pillars of the Health Reform is the **Universalization of Primary Care, [3]**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 Alma Ata Declaration. (1978)[4] and the Astana Declaration (2018).[5]

The Government of Chile (GoCl) program for the Universalization of Primary 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 is led by the National Commission for the Universal PHC, chaired by the Minister of Health, Undersecretaries of Public Health and Healthcare Networks, and made up of a technical team composed of the corresponding Divisions and Departments of MINSAL, the National Health Fund of Chile (FONASA) and the Superintendence of Health.

The Universal PHC program is designed with four objectives: (a) to expand effective coverage through PHC optimization, (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 (M&E) framework that supports the PHC strategy.

This program began to be implemented this year 2023 with a pilot experience in seven communes (Alhué, Canela, La Cruz, Coltauco, Linares, Perquenco and Renca). These pioneering municipalities were chosen following a "scalability strategy" that sets the way forward so that the lessons of the pilot can provide as much information as possible on future feasibility and implementation (e.g. on regulatory aspects, resource needs, the functioning of the health network), which will allow their coverage to be increased annually until reaching half of the communes by the end of President Boric's term. In addition, the seven

[2] 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

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

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

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

municipalities reflect the diversity and heterogeneity of Chile's different territories, including, but not limited to, location (urban versus rural), composition of their population (already covered/reached by PHC or not) or availability of infrastructure to deliver PHC.

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

2.2 Program by Results

2.2.1 Program Scope by Results

The proposed Program for Results (PforR) would support the [6] Government's program of Universalization of PHC during the four-year period 2024-2028, with a geographical coverage of 187 communes (54% of the total communes in Chile) and some actions throughout the country. The PforR will support improvements in PHC coverage and quality; strengthening resilience in PHC; and efficiency in PHC financing, through investments and activities linked to the **Results Areas (RAs)** described below:

- **RA1: PHC Coverage and Quality:**

  Under this RA, a new model of care will be established where all people, regardless of the type of health insurance to which they are enrolled, will have access to and will be effectively covered by PHC, having a strong equity component. This RA would also close the gaps regarding the quality of care, with a special focus on the prevention and control of Noncommunicable Diseases (NCDs) and with a gender perspective (women and LGBTIQA+ people). Activities under this RA will strengthen and install a new People-Centered Comprehensive Care Strategy (ECICEP), a revamped Health Benefits Package, and a patient navigation system. Finally, it will support the redesign of strategies for the participation of individuals, families and communities in decision-making, to provide acceptable care and services for citizens and strengthen the social role of PHC.

- **RA2: Resilient** PHC: This area aims to strengthen PHC in its contributing role in building a resilient health system to face future challenges arising from public health emergencies such as epidemics and pandemics; consequences of climate change; natural disasters; fragility, conflict and violence, among others, incorporating the lessons learned from the COVID-19 pandemic. The activities mainly include: the development of a Guide for the 'Surveillance of Emergency Risks of Public Health and Climate Change in Universal PHC', the training of personnel, the creation of designated "Integral Response Teams" (georeferenced to the participating municipalities) and trained for the Surveillance of Emergency Risks, and the development and subsequent construction of a New Infrastructure Model (adjusted to exposure to related hazards). with climate, geographical distribution and energy efficiency standards).

- **RA3: PHC efficiency:** This area is focused on improving the processes associated with PHC management that favor the optimization of the use of resources and, consequently, of health care. Among other activities, it would include actions to: (i) modernize the allocation of PHC financial resources based on social and health risks, (ii) train municipal PHC administrators to install capacities related to effective leadership and efficiency in budget execution in PHC, (iii) ensure connectivity in PHC, and data governance and interoperability, and (iv) generate a dual virtual health management platform. This platform (i.e. web portal and mobile application) on the one hand will allow citizens to verify health information and health services, schedule appointments, receive reminders and information on healthy lifestyle, evaluate the services received in APS, among others. It is also expected to build an evaluation framework that has

[6] This version of the ESSA is based on this described scope (based on the August 2023 version of the PAD). Any change in this scope could imply changes in what is described/proposed in the final version of ESSA.

sentinel indicators of health and epidemiological management for decision makers at the local level and the central authority, as well as to change the accreditation model of PHC, creating a single comprehensive performance evaluation instrument.

2.2.2 Program Development Objectives (PDOs) and Performance Indicators at PDO level

The **Program Development Objectives (PDOs**) are to support improvements in: (i) primary health care coverage and quality; (ii) the contribution of primary care to the resilience of the health system; and (iii) the efficiency of PHC financing.

Program Development Goal (PDI) indicators. The Program will have 3 result indicators to achieve its PDOs, these are:

- ***RA1 PHC Coverage and Quality – PDI1*:** Decrease in the rate of avoidable hospitalizations of PHC patients with multimorbidity[7].
- ***RA2 Resilient PHC – PDI2*:** The Participating Municipalities have a Health Sector Plan that includes a plan for 'Emergency Risk Surveillance in Public Health and Climate Change.
- ***RA3 Efficiency in PHC financing – PDI3*:** Participating municipalities with positive user experience.

2.2.3 Indicators linked to disbursements

To date, 8 disbursement-related indicators (DLIs) have been defined that are considered critical for the achievement of PDOs. Based on these and their results (DLR), the World Bank will disburse the funds to PforR. The following table presents a summary of these DLIs:

[7] "Participating Municipality" means any Municipality that has signed a Participation Agreement and participates in the Universal PHC Program in accordance with the eligibility criteria set forth in the Operational Manual.

Board 1 Indicators Linked to PforR Disbursements

Results Area	DLIs
RA1: PHC Coverage and Quality	**DLI1.** Gradual implementation of the Universal PHC Program and increase its coverage. The expansion of the APS Universal program is planned to reach 187 municipalities (out of 346) by the end of the PforR period, covering 54% of the total number of municipalities in the country. - **DLR 1.1** will be considered successful when 187 Municipalities join the Universal APS program[8], - **DLR 1.2** will track the increase in the number of people enrolling in an APS center for the first time to ensure program reach.
	DLI2. Gender mainstreaming and control of gender-based violence, considering women and LGBTIQA+ people within the framework of the universal PHC model. - **DLR2.1** Community health agents trained in gender-based violence in participating municipalities. - **DLR2.2** Improvement of positive quality treatment to the user in relation to the LGBTIQA+ community.
	DLI3. Decreased rate of avoidable hospitalizations of people living with multimorbidity.
	DLI4. Use of new services of high health value of the new Family Health Plan II - **DLR4.1** materialization of the new Family Health Plan II. - **DLR4.2** Increased use of new high-value health services, to be determined during implementation in accordance with the WB.
RA2: Resilient APS	**DLI5.** Establishment and deployment of the package "Surveillance of public health emergency risks and climate change in universal PHC". - **DLR5.1** Design and implementation of the Ministerial Guide for Emergency Risk Surveillance in Public Health and Climate Change in Universal PHC. - **DLR5.2** Development of capacities and human resources assigned to manage public health risks and emergencies. It will contribute to the evaluation of training and the formation of community 'Comprehensive Response Teams' with PHC personnel to monitor public health emergency risks and climate change.
	DLI6. New infrastructure model adjusted to the geographical distribution of the population and energy efficiency standards and the necessary conditions to reduce climate vulnerabilities. - **DLR6.1** Will support the design of the new APS infrastructure. - **DLR6.2** Further training of health infrastructure specialists from health services and municipalities on this new model will be carried out, with the subsequent construction of new health care facilities.
RA3: APS Efficiency	**DLI7.**Modernization of the mechanisms for allocating financial resources of the PHC**.**
	DLI8. Design and implementation of a virtual health management platform for citizens and those responsible for health services. - **DLR8.1** Development of the ecosystem for the virtual health operational center. - **DLR8.2** Queries managed through the web portal and mobile application and user experience.

[8] A Municipality will be considered included in the program when a Participation Agreement is signed between the Municipality and the corresponding National Health Services Entity.

2.2.4 Institutional arrangements for the implementation of the PforR

MINSAL will implement the Program, since it has the function of general stewardship of the health system. Within the Reform Team of the Minister's Cabinet, the Program Implementation Unit (IPU) will be created. The IPU will consist of a Program Coordinator, and 2 branches: a technical coordination branch and a financial/administrative coordination branch.

The **functions of the technical coordination branch of** the IPU will be: (i) to coordinate the execution of the activities of the Program among the different Areas and Units of MINSAL and other actors inside and outside the health sector, (ii) to coordinate the collection of data when appropriate, (iii) to monitor the performance of indicators and report of DLIs, (iv) coordinate the external verification process with the verifying agency, and (v) supervise and follow up on environmental and social (E&S) issues and fiduciaries. Within the MINSAL departments relevant to the Program, 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 to oversee the implementation of the Program, according to their areas of competence and ensure timely coordination to achieve the objectives of the DLIs. The focal points will work closely with the IPU.

The **functions of the IPU Financial/Administrative Coordination Branch** shall be:

i) Responsible to DIPRES, Comptroller General of the Republic, Health Services and Municipalities for all administrative, financial, budgetary and audit matters of the Program; ii) responsible for coordinating the preparation, discussion, approval and execution of the budget of the Program; (iii) safeguard the proper use and pertinent distribution of resources; (iv) supervise that the execution of the budget (including procurement, bidding processes, etc.) is within the framework of the conditions established by the Program; (v) prepare financial statement reports; (vi) develop and facilitate the external verification process with the verification agency and assist the financial audit' (vii) responsible to the Directorate of Budgets of the GoCl (DIPRES) to enable it to submit disbursement requests to the WB; viii) lead the coordination of audits required by the World Bank by the PforR; (ix) responsible to the World Bank for all administrative and financial matters of the Program; and (x) Responsible for supporting all Program documentation.

One or more bodies shall be selected by public tender to be responsible for the verification of DLIs. The Terms of Reference for public bidding processes will be revised and acceptable to the WB. Such agencies shall be able to provide independent verification of DLIs and ensure credible verification of the achievement of DLRs.

With respect to 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 Health Services (SS) of MINSAL. while the municipalities will be in charge of its operation.

2.2.5 Physical Program Interventions by Results

At the date of this ESSA draft, MINSAL, based on a preliminary analysis of the gaps in PHC infrastructure in the country, foresees that the infrastructure to be included in the Program for Results (RA2, DLI6) to be financed by the Bank would be less complex[9] and would have the following characteristics:

[9] In accordance with Article 2 of the **Organic Regulation of Less Complex Health Establishments and Self-Management Establishments in a Network**, the Least Complex Establishment is one that carries out open, closed and emergency care activities, of low complexity, which mainly develops primary level activities and some specialty, according to their role within the Care Network that integrates and in the area of competence determined by the Director of Service in consultation with the Integration Council of the Care Network.

- Construction of new APS devices (called "neighborhood units") that would include 2 boxes (or care units) per device. Each device of 100 m2, occupying a land of 200-300 m2, which is more feasible to find in urban and rural areas, and would serve around 3,000 inhabitants.
- It is estimated the construction of a device per commune that is universalized. It is expected that there will be 187 communes (52% of the total number of communes), which is estimated to build 187 devices in four years (duration of the PforR).
- It is planned to incorporate new technologies and principles of energy efficiency into these new devices.
- The investments would include the construction, provision of basic services (electricity, water, sewerage), equipment with minor clinical furniture, and until obtaining the sanitary authorization of the device to operate, granted by the regional health authority, the Regional Ministerial Secretariats of Health (SEREMIS).
- Devices shall not be equipped with major medical equipment.
- The implementation of mobile clinics or tents will not be included.
- No remodeling or refurbishment of existing infrastructure will be financed
- No works will be financed to establish internet connectivity, nor investments in remodeling, conditioning or expansion of existing PHC infrastructure.

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

This ESSA has been developed based on this information on the scope and typology of the planned infrastructure that the Program will include. Any changes to this information may involve changes to what is described/proposed in a future version of this evaluation.

Once MINSAL completes the gap analysis[10] on PHC infrastructure, the details of the new PHC infrastructure[11] to be built with financing from the Program will be confirmed, in terms of number of establishments, materials, design, exact location, sustainability standards that it will include, among others.

2.2.6 Social interventions of the Program

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 itself and key health agents, as fundamental elements to overcome the gaps of accessibility, equity, quality, timeliness, relevance and coverage of the PHC network, recognizing the diversity of both current and potential beneficiaries with a human rights approach and a gender perspective and social inclusion.

In the social sphere, the activities of the RA1 include: (i) the design and implementation of a new People-Centered Comprehensive Care Strategy (ECICEP); (ii) a renewed Health Benefits Package; (iii) a patient navigation system; and (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. LGBTIQA+

[10] The final gap analysis is expected to be before the effectiveness of the Program.
[11] The main environmental risk of this P4R stems from these physical interventions.

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

In the social field, the activities of the RA3 include: (i); the design and implementation of a telematics system to manage APS queries through a web portal and a mobile application; and (ii) the measurement of the user experience.

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

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

2.2.8 Exclusion list

Based on the findings of this ESSA draft, no significant adverse environmental and social impacts are expected as a result of the Program. The following exclusion list defines the type 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 the people affected. This exclusion list shall include, but is not limited to:

- any construction in protected areas or priority areas for biodiversity conservation, as defined in national legislation[12];
- construction in areas at high risk from natural hazards (floods, landslides, earthquakes, tsunamis);
- activities that have the potential to cause significant loss or degradation of critical natural habitats, either directly or indirectly, or that may lead to adverse impacts on these habitats, including urban or rural wetlands;
- purchase or use of prohibited/restricted chemicals for medical use;
- any activity affecting 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 (EIA),[13] according to the Environmental Impact Assessment System (SEIA) of Chile;
- activities that cause significant air, water or land pollution that may have significant adverse impacts on the health or safety of individuals, communities or ecosystems;
- working conditions that expose workers to significant risks to personal safety and health;
- activities that may cause or lead to forced labor or child abuse, child labor exploitation, or human trafficking, or that employ or involve children, ages 14 and older and under the age of 18, in connection with the Program;
- any activity on land that has disputed ownership or tenure rights;
- any activity that causes physical and/or economic displacement of the population;

[12] National System of Protected Wild Areas of the State (Law No. 18,362); Law No. 21.202 on the Protection of Urban Wetlands; Other priority sites, https://areasprotegidas.mma.gob.cl/otras-designaciones/

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

- any activity that requires Free, Prior and Informed Consent (FPIC) as defined in the World Bank's Environmental and Social Framework.

3. POTENTIAL ENVIRONMENTAL AND SOCIAL EFFECTS OF THE PROGRAM

3.1 Potential Environmental Benefits and Risks

3.1.1 Potential Environmental Benefits

Based on the findings of this draft, the main positive environmental effects are related to the use[14] of sustainability and resilience to climate change standards for the implementation of a new model of energy-efficient PHC establishments (RA2, DL6). 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 Program-specific training activities, 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 and Health and Safety Impacts and Risks

No significant adverse SSA 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 risks and negative impacts associated with the construction of the new model of PHC establishments and their operation. It is expected that this new infrastructure will include, broadly speaking, the construction of the new model of establishment of PHC, its connection to the electric service, supply of drinking water and private sewerage, among others, and an operation phase that includes the use of infrastructure and the management of domestic and clinical solid waste. Table 2 below presents the potential expected environmental and health and safety risks and impacts associated with the construction and operation activities of the new PHC infrastructure that the Program would finance.

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

Board 2 Potential Environmental and Health and Safety (SSA) Risks and Impacts

PRE-CONSTRUCTION STAGE OR CONSTRUCTION SITE PREPARATION		
Activity	**Environmental risks**	**SS Risks**
Removal of vegetation cover (during the opening of access roads and/or during land clearing on the construction site)	• Damage to the vegetation of the area by removal of trees and smaller species. • Damage to the fauna associated with the affected vegetation, due to the disappearance of nesting, refuge and feeding areas, as well as direct damage to burrows and individuals that inhabit the removed vegetation. • Soil erosion by removal of vegetation on steeply sloping land and near slopes. • Impact on air quality by smoke generation in case of using fire for the removal of vegetation cover	• Injuries to workers during vegetation removal activities for site preparation due to lack of use of personal protective equipment. Injuries from machinery rears and accidents with tools and equipment. • Injuries to workers from snake bites or bites from other threatened animals during vegetation removal work and during road openings. • Damage to the health of workers and people in transit through the work area, by inhalation of fumes.
Land clearing	• Direct impact on the soil due to its removal at the construction site and erosion at the limits of the depalmed area, where it is dragged by wind and rainwater. • Affectation to the rainwater runoff pattern of the site. • Impact on air quality due to the generation of polluting emissions due to the operation of machinery, which emits smoke and gases from its engines and raises particles due to the movement of earth. • Affectation to the work environment within the work site by noise generation from the operation of the machinery.	• Injuries to workers from machinery reach and accidents with tools and equipment. • Damage to the health of workers due to exposure to noise with high levels for a long time, in case of not using adequate personal protective equipment.
Excavations and leveling of the ground	• Affectation to the natural topography of the site and the pattern of rainwater runoff, with possible effect of flooding of the property or surrounding lands, or reduction of the rate of infiltration into the subsoil. • Impact on air quality due to the generation of emissions of particulate matter and pollutants by the operation of machinery, which emits smoke and gases from its engines and raises particles due to the movement of earth. • Affectation to the work environment within the work site by noise generation from the operation of the machinery. • Affectation to cultural heritage by destruction or looting of historical or archaeological artifacts discovered during excavations.	• Damage to the health or physical integrity of workers by falling into excavations or by landslides in excavations with workers inside. • Injuries to workers from machinery reach and accidents with tools and equipment. • Damage to the health of workers due to exposure to noise with high levels for a long time, in case of not using adequate personal protective equipment.

	• Impact on air quality due to smoke and particle emissions during the transport of excavation waste to authorized tailings sites. • Damage to vegetation and its associated fauna, to the landscape, and contamination of soils and surface and groundwater, due to improper disposal of excavation waste in unauthorized places.	
Camp and warehouse of materials	• Contamination of soil, surface water and groundwater, by leakage or spillage of fuels or other stored chemicals, which can be washed away by rain. • Contamination of water bodies and affectation of drainage and sewerage systems near the construction site, by construction materials dragged by wind or rain. • Contamination of soil, surface water and groundwater due to incorrect handling and disposal of wastewater generated by the personnel participating in the work.	• Damage to the health of workers by direct contact with toxic materials, by inhaling their vapors or by consuming contaminated water or food. • Damage to the physical integrity of workers by fire in the camp or warehouse of materials. • Damage to the health of workers by consuming water or food contaminated by sewage or feces of workers participating in the work.
Site preparation and construction of the site	• Increase in the population at the project site due to the arrival of workers for the project, with the consequent increase in waste, affecting the quality and quantity of water, emissions associated with increased traffic.	• Increased road safety, insecurity of people in the community, sexually transmitted diseases, insecurity.
CONSTRUCTION STAGE		
Activity	**Environmental risks**	**SS Risks**
Construction of foundations	• Impact on air quality due to the generation of polluting emissions due to the operation of machinery, which emits smoke and gases from its engines and raises particles due to the movement of earth. • Affectation to the work environment within the work site by noise generation from the operation of the machinery. • Affectation to cultural heritage by destruction or looting of historical or archaeological artifacts discovered during excavations.	• Injuries to workers by reaching machinery, by falling inside excavations or by collapses in excavations with workers inside and by accident with tools and equipment. • Damage to the health of workers due to exposure to noise with high levels for a long time, in case of not using adequate personal protective equipment.
Transport of construction materials, operation of machinery and vehicles	• Transfer of pollutants to the atmosphere (dusts, flue gases and noise). • Transfer of contaminants to soil and water, by falling or dispersing construction materials during transport	• Damage to the health or physical integrity of construction workers, residents in the area and people in transit through the site and its surroundings, due to exposure to dust and noise; by range of machinery; or by vehicular accident when working in urban areas.
Maintenance of construction equipment and machinery	• Contamination of soil, surface water and groundwater due to incorrect handling and disposal of hazardous waste (spent lubricating oils, solvents used for cleaning parts, impregnated with oils and solvents, empty containers, etc.) resulting from the maintenance of the machinery participating in the work.	• Damage to the health of workers by direct contact with toxic materials, by inhaling their vapors or by consuming contaminated water or food.

Operation of material banks	• Damage to vegetation and associated fauna, soil and bodies of water, by use of construction materials from banks of unauthorized materials. • Contamination of soil and roads, and affectation of air quality, by emissions of particles and materials during transport from the material bank to the construction site.	• Damage to the physical integrity of workers due to road accidents that occurred during the transport of materials to the construction site.
Breaking of pavements, demolition of sidewalks, major demolitions.	• Transfer of pollutants to the atmosphere (dust and noise). • Damage to existing infrastructure in the work area, such as communication lines, drinking water, drainage, natural gas, electricity, railways and the like. • Deterioration of the visual environment in the work areas and their surroundings. • Damage to vegetation and its associated fauna, to the landscape, and contamination of soil and surface and groundwater, due to improper disposal of demolition waste, in unauthorized places.	• Damage to the health or physical integrity of workers, residents in the area and people in transit through the work, due to exposure to dust and noise; or by accident with tools and equipment, or by contact with leaked materials from damaged pipelines (gas, fuels).
Waste management	• Transfer of pollutants to soil and water and affectation of the associated flora and fauna, by dispersion of waste in the temporary storage site; or by dispersion during transport and by disposal of waste in unauthorized sites.	• Damage to the health or safety of construction workers, residents of the area and persons in transit through the site and its surroundings, due to exposure to hazardous waste such as solvents or other toxic substances; or by consumption of water or food contaminated by the waste of the work.
Management of fuels, lubricating oils, additives and other chemicals	• Contamination of soil, subsoil and surface and groundwater and affectation of the associated flora and fauna, by spills of fuels, oils, additives and other chemical products, stored without spill control devices or leaks from the vehicles and machinery participating in the work.	• Damage to workers' health by inhalation or direct contact with spilled chemicals.
Closure of streets and blocking of access to public places or businesses and residential areas	• Restriction of the use of roads or roads and accesses, with inconveniences for people in transit and for inhabitants of the area. • Increase in traffic and vehicular emissions in the areas surrounding the work.	• Damage to the health or physical integrity of workers and people in transit through the work, in case of fall into open pits, by scope of machinery, by accident with tools and equipment, by vehicular accident when working on urban roads, etc.
Fire and accidents within 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 work, by smoke inhalation or by direct contact with fire.
Wastewater Management	• Contamination of soil, subsoil and bodies of water and affectation of the associated flora and fauna, due to inadequate management and disposal of wastewater generated in the sanitary services enabled for the personnel participating in the work.	• Damage to health from contamination of drinking water or food with sewage.
Dismantling of supporting infrastructure at the end of the work	• Transfer of pollutants to soil and water, damage to vegetation and its associated fauna due to improper management and disposal of waste in unauthorized sites.	• Damage to the physical integrity of workers due to accidents or incidents that occurred during the dismantling of support infrastructure on site, or with tools and equipment.

	• Affectation to the landscape by permanence of waste or remains of camps, warehouses and other support services for the work.	
OPERATION STAGE		
Activity	**Environmental risks**	**SS Risks**
Use of road services and infrastructure in the area	• Impact on the availability of water, electricity, drainage, etc., due to an increase in demand derived from the operation of the APS establishment. • Affectation of the roads near the project due to an increase in vehicular circulation, which implies greater emissions into the atmosphere and sonic pollution. In addition to promoting an increase in buildings and parking facilities.	• Road accidents or incidents due to increased traffic and pedestrians at and near the APS establishment site. • Disturbance to residents near the new APS facility due to increased noise due to increased traffic, vehicle emissions
Use and storage of fuels and chemicals	• Contamination of soil and water and damage to the physical integrity of the population and workers, by leakage or spillage of chemicals, fuels and generation of toxic vapors, or by fire, derived from the storage of chemical products (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 by direct contact and handling with chemicals and fuels spilled without the corresponding protective equipment. • Damage to the health and physical integrity of workers and the population from fires caused by the improper use and storage of combustible waste and chemical products.
Generation of emissions to the atmosphere	• Impact on air quality due to smoke emission from steam generation and water heating systems (boilers).	• Impact on the health of the workers of the site and nearby population
Wastewater generation	• Contamination of drainage systems and water bodies by dumping chemicals from improper management of cleaning products, clinical analysis, or discharge of water from the bathrooms of the PHC establishment.	• Impact on the health of the population in the area of the new PHC establishment due to the alteration of the quality of water for consumption.
Solid waste generation	• Contamination of the work environment by improper storage of solid waste, which can generate proliferation of disease vectors such as insects and rodents. • Contamination of soil and water by 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.
Generation of hazardous waste	• Contamination of soil and water by improper handling (mainly storage and transport in unsafe conditions) and improper disposal of hazardous waste (maintenance waste and chemical residues, disinfectants, needles, as well as mercury thermometers, pressurized containers and pesticide containers) in unauthorized sites.	• Damage to workers' health from hazardous waste handling without proper personal protective equipment and required training

Generation of medicines out of specification, expired or in disuse	• 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 medicines out of specification, expired or in disuse, which are incorporated into informal trade as a result of incorrect handling and disposal of pharmacological waste.
Generation of waste with biological risk	• Incorrect management and disposal of biohazardous waste, which can contaminate soil and water bodies.	• Damage to the health of the population and workers due to the incorrect separation of waste with biological risk, which is taken without treatment to common waste management sites. • Damage to the health of workers who directly handle waste with biological risk, due to the spread of infectious diseases, derived from the lack of personal protective equipment and the performance of unsafe practices due to lack of training and supervision.
Attraction of street trade	• Contamination of soil and water sources due to increased waste generation and presence of disease vectors such as insects and rodents.	• Impact on 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, as well as the safety and health of the workers of the works and the establishments operating, as well as the population of the communities where these establishments are established.		

3.2 Potential Social Benefits and Risks

3.2.1 Potential social benefits

Based on the findings of this draft evaluation, the main social benefits of the Program for Results are related to: (i) the incorporation of telematic platforms for remote care and request for medical appointments in PHC that will provide beneficiaries with new access routes, thereby allowing not only to reduce crowds in PHC facilities, but to provide care to groups of the population who, due to geographical determinants, hours, movement problems or care responsibilities, among others, find it very difficult to access face-to-face services; (ii) the improvement of the quality, timeliness and relevance of services at the primary health 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 perspective and social inclusion, incorporating social determinants, and establishing minimum standards for the training of health teams and civil service training systems in matters key to ensuring dignified, relevant and non-discriminatory care; (iii) strengthening 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 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 the provision of PHC services aimed at special attention groups, such as women who suffer gender violence, LGBTIQA+ population, the elderly, immigrants, rural residents, as well as people belonging to indigenous and tribal peoples, among others. Also noteworthy are the activities aimed at sensitizing and training health personnel in attention to special attention groups, as well as the training of community agents to support cutting-edge approaches to address gender-based violence.

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 an irregular migratory situation and people belonging to gender diversities.

In relation to the construction of new PHC centers, MINSAL has a guideline for the selection of land in rural areas that [15] includes a review of the feasibility of construction in terms of availability of basic services, ownership and moratoriums of the land, and proximity and accessibility for the target population, among other criteria that guarantee compliance with national and institutional regulations and that contemplate social criteria in the selection of Land. The poor perception of citizens about the functioning of the public health system, including the primary level (PHC), associated with long waiting lists, poor quality of care and discriminatory practices[16] are observed as a challenge for the Universal Program of Primary Health Care, especially with regard to: the incorporation of new PHC users; the results of the measurement of

[15] According to Indicator BS21: Average time in minutes to the primary health center closest to the rural entity, of the System of Rural Quality of Life Indicators, in the 2019 version. in the country's rural communes (54%) the average travel time to the nearest APS enclosure is 29 minutes, reaching more than an hour in 21 rural communes of the country Source National Institute of Statistics: https://www.ine.gob.cl/herramientas/portal-de-mapas/sicvir

[16] 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

the user experience and the adjustments agreed thereto; as well as the strengthening of a system of citizen participation focused on collaboration rather than complaint.

On the other hand, the diversity and heterogeneity of municipalities that administer approximately 92.6% of PHC facilities, in terms of equity of resources, both financial and human, as well as the capacity that the Ministry of Health may have to carry out the standardization of its management and performance capacities, have been seen by specialists as one of the main reasons for the persistence of care [17]inequity. From the point of view of social risks, this continues to be the main challenge for the Program: to establish and standardize mechanisms, standards, criteria and procedures in PHC that allow the population to perceive equity and quality in the care received without interfering with the historical deficiencies in the availability of financial resources that the poorest municipalities have experienced so far due to the financing model.

In relation to the construction of PHC centers, it is expected that within the criteria used by MINSAL to define the location of the new PHC infrastructure, it is considered that in the rural communes of the country (54%) the average travel time to the nearest PHC enclosure is 29 minutes, reaching more than an hour in 21 rural communes of the country[18].

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

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

[18] Indicator BS21: Average time in minutes to the primary health center closest to the rural entity. System of Rural Quality of Life Indicators. 2019. National Institute of Statistics. Source: https://www.ine.gob.cl/herramientas/portal-de-mapas/sicvir

Board 3 Potential Risks and Social Impacts

PRE-CONSTRUCTION STAGE OF APS 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 prevents the design of adequate enclosures. • Omission of characteristics related to geographical connectivity and the type of commune in which an APS center will be built that prevents improving accessibility to PHC centers for populations that do not currently have a nearby PHC center.
Selection of land on which new APS centres will be built	• Selection of land that omits the demographic, social, cultural and health characteristics of the population that prevents the design of adequate enclosures for dignified, timely care with social and cultural relevance. • 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 that have a heritage 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 process of building new PHC centers.
Design of new PHC centers or redesign of existing PHC centers	• Omission of demographic, social, cultural and health characteristics of the population that prevents the design of adequate enclosures, with cultural relevance and attention capacity. • Omission of citizen and/or indigenous consultation that prevents the population from actively participating in the process of designing new PHC centers.
Selection of entities responsible for the construction of PHC centres	• Irregular hiring of workers by the contracting entities in charge of the construction of PHC centers that prevents compliance with national regulations on labor and social security of the workers of the works. • Recruitment processes for personnel involved in the construction of PHC centers that discriminate based on sex, gender identity, ethnicity, nationality, age or other conditions protected by national and international regulations. • Child exploitation by the contracting entities in charge of the construction of PHC centres.
Site preparation and construction of PHC centers	• Omission of multichannel processes of information addressed to the community explaining the scope of the works and the mechanisms to request more information or make claims and suggestions.
STAGE OF CONSTRUCTION OF APS CENTERS	
Activity	**Social risks**

Construction of new PHC centres	• Increase of 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 others; increased vehicular traffic; increased insecurity due to robberies, 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. reduced revenue) affected by blockages of access to their stores, even temporary. • Lack of clear and expeditious mechanisms to receive and respond to complaints from the inhabitants in relation to the effects that the works could cause.
STAGE OF OPERATION OF PHC CENTERS	
Activity	**Social risks**
Commissioning of the APS centre	• Occurrence of illicit activities in the vicinity of the APS center, such as: street trade, robberies, sexual harassment and others that could affect the coexistence and safety of the people who transit there. • Informal trade in the vicinity of the center that could use children and adolescents. • Lack of clear and expeditious mechanisms to receive and respond to complaints from the inhabitants in relation to the effects that the works could cause.

4. ASSESSMENT OF ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

4.1 Environmental Management Systems relevant to the PforR

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

4.1.1 Legal framework on environmental matters relevant to the Program

Regarding the management of risks and environmental impacts of civil works, Chile has a robust environmental impact assessment system (SEIA), administered by the Environmental Assessment Service-SEA. Based on the information available to date on the scope of construction of the new infrastructure that will 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 the SEIA of Chile, in accordance with Law No. 19,300 on General Environmental Standards (LBGMA) 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 has confirmed the scope of the physical interventions to be included in the Program, in the event that any requires submission to the SEIA, it would have to be of a scope whose required impact assessment instrument is an Environmental Impact Statement (EIS), in accordance with the LBGMA and SEIA Regulations (as explained in section 4.1.3), since the activities that require the development of an Environmental Impact Study will be excluded from the Program.

Next, the following Tables identify the environmental regulations applicable to the Program of a general and specific nature. The latter are analyzed in relation to environmental components, such as air, water, soil, flora and fauna and cultural heritage, safety and health at work, among others.

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

Law/Regulation	Description
Political Constitution of the Republic. Supreme Decree No. 100/2005. 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 the persons, the structure and functions of the institutions, among other matters. The Political Constitution deals with environmental issues in its Chapter III "On constitutional rights and duties", specifically in its 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." Additionally, it 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 them equally protected jurisdictionally, 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 procedure of Taking of reason of the Office of the Comptroller General of the Republic	The taking of reason is a mandatory control of the legality of the acts, which ensures the protection of the principle of probity, the right to good administration and the care and good use of public resources.
Law No. 19.886/2003 (last amendment 2022), Law on Bases on Administrative Contracts for the Supply and Provision of Services (Law on Public Procurement)	The main objective of this Law is to standardize the administrative procedures for contracting the supply of movable goods and services necessary for the functioning of the Public Administration and to improve transparency in the management of the Public Treasury at the level of the State and the municipalities. This law created the necessary institutions 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 aim 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 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 petition or claim on the part of citizens to any organ of the State Administration.
Law No. 19.880/2003 establishing the basis for the administrative procedures governing the acts of the organs of the State Administration.	This norm regulates the administrative procedures through which the State Administration acts and adopts decisions.
Law No. 19.300/1994 on the General Bases of the Environment (LBGMA) and its amendments	This norm regulates in a general way the right guaranteed in the Constitution to live in an environment free of pollution. It establishes the applicable principles, environmental management instruments, liability for environmental damage, control standards, 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 assessment of their environmental impact, in accordance with the provisions of this law." Article 10

Law/Regulation	Description
	indicates a list of "projects or activities likely to cause environmental impact, in any of its phases, which must be submitted to the environmental impact assessment system", which are specified in turn, in article 3 of the Regulation of the Environmental Impact Assessment System (RSEIA). Health infrastructure projects and therefore PHC, in accordance with the provisions of Law 19,300 (Article 10) belong to the typology of urban or real estate development projects.
Law No. 20.417/2010. It creates the Ministry, the Environmental Assessment Service and the Superintendence of the Environment.	It creates the Ministry, the Environmental Assessment Service and the Superintendence of the Environment.
Supreme Decree No. 40/2012, Approves Regulation of the Environmental Impact Assessment System (RSEIA) Ministry of Environment	This regulation establishes the provisions governing the SEIA and the Participation of the Community in the Environmental Impact Assessment process, in accordance with the provisions of the LBGMA. Article 3 of the RSEIA (literal g.1.2 and literal h.1) specifies the criteria of urban or real estate development projects that, because they are likely to cause environmental impact, must be submitted to the SEIA. Those who do not meet these criteria should not undergo the SEIA. Article 26 of the RSEIA regulates the consultations of pertinences of entry to the SEIA stating that "[...] proponents may contact the Regional Director or the Executive Director of the Service, as appropriate, in order to request a ruling on whether, on the basis of the background information provided for that purpose, a project or activity, or its modification, should be submitted to the SEIA. The response issued by the Service shall be communicated to the Superintendence."
Decree 458/2023 approves new General Law on Urban Planning and Construction. Ministry of Housing and Urban Development	It lays down provisions relating 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 must ensure, in any case, compliance with its provisions.
Decree 14/2019 amending D.S. 47/92 of housing and urban planning of 1992, General Ordinance of Urbanism and Constructions (OGUC) Ministry of Housing and Urban Planning	It establishes the provisions and measures that must be taken in any construction, repair, modification, alteration, reconstruction or demolition project 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 Works Inspectors (ITO) and reviewers of structural calculation projects, modifies legal norms to guarantee the quality of constructions and expedite applications before the municipal works directions.	This Law dictates rules on Technical Works Inspectors (ITO) and creates and regulates the National Registry of Technical Works Inspectors (ITO) and the National Registry of Structural Calculation Project Reviewers. It establishes, among others, who may be registered in the National Registry of ITO and remain registered in it, requirements to register, as well as categories of technical inspectors of work, according to their technical suitability and professional experience according to the type of work in question, in the terms indicated by this law and its regulations.

[19] Regulatory Framework Communal Regulatory Plan, 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 Chilean state agencies for climate action, and establishes the goal of carbon neutrality and resilience by 2050.
D.F.L. N°725/1968, amended 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 standards related to the 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 public 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 publication of information.
Law No. 20.500/2011 on Associations and Citizen Participation in Public Management	This law establishes definitions and mechanisms for forming associations of citizens of public interest, and defines the ways in which such entities will participate in the management of the authorities.
Decree No. 680/1990 Approving Instructions for the Establishment of Information Offices for the User Public in the State Administration of the Ministry of the Interior	This Decree establishes the obligation of ministries and other public services to have Offices of Information, Complaints and Suggestions (OIRS) and regulates their operation.
Law No. 21.305/2021 on Energy Efficiency	This law aims to establish the obligation of the Ministry of Energy to develop a National Energy Efficiency Plan every 5 years. The "Plan" must contemplate, among others, a goal of reducing energy intensity of at least 10% by 2030, compared to 2019; It also stipulates that homes, buildings for public use, commercial buildings and office buildings must have an energy rating to obtain final or final reception by the respective Municipal Works Directorate, among others.
Law No. 21.364/2021 Establishes the National System for Disaster Prevention and Response	This standard establishes the National System for Disaster Prevention and Response and regulates a series of disaster risk management instruments
Decree No. 1.434/2021 Exempt. Approves National Emergency Plan 2020 - 2030 of the Ministry of the Interior and Public Security	This Plan is an instrument for disaster risk management that aims to establish response actions in the different operational phases, in situations of emergency, disaster or catastrophe, with the aim of providing protection to people, their property and environment, in the national territory, through the coordination of the National Civil Protection System.

Board 5 Specific environmental regulations

Law/regulation	Description
Air quality and air emissions	

Decree No. 138 of the Ministry of Health establishes the obligation of the owners of stationary sources of emission of atmospheric pollutants to deliver to the respective SEREMI of Health the necessary background to estimate the emissions from each of their sources	It regulates the emission declarations of all economic activities. Emissions declarations must be made by those who work in agriculture, companies in trade services, tourism, industries, transport and telecommunications, real estate, health, education, social and community, among others that have hot water or steam boilers or occupy generators. The regulated must annually deliver information to the Health Authority so that the State estimates the emissions of atmospheric pollutants on an annual basis. This regulation does not establish emission limits, only the obligation to provide background information to calculate emissions.
Emission standards established by the Atmospheric Decontamination Plans (PDA) and that must be met by all sources located where a PDA exists.	They are environmental management instruments that, through the definition and implementation of specific measures and actions, aim to reduce air pollution levels in a saturated area, in order to protect the health of the population.
Supreme Decree No. 144/1961. Establishes Rules to Avoid Emissions or Air Pollutants of Any Nature. Ministry of Health.	It establishes that gases, vapors, fumes, dust, fumes or pollutants of any nature, produced in any factory establishment or workplace, must be captured or disposed of in such a way that they do not cause danger, damage or nuisance to the neighborhood.
Supreme Decree No. 279/1983. Approves Regulation for the Control of the Emission of Pollutants from Internal Combustion Motor Vehicles. Ministry of Health.	Establishes the regulatory and technical aspects for the control of the emission of pollutants evacuated by the exhaust pipe of internal combustion motor vehicles
Supreme Decree No. 75/1987, as amended by Supreme Decree No. 78/1997. It establishes Conditions for the Transportation of Loads that it indicates. Ministry of Transport and Telecommunications.	Establishes the conditions for the transport of cargo
Supreme Decree No. 38/2011. Establishes Standard for Emission of Noise Generated by Sources Indicated. Ministry of the Environment.	Levels generated by noise sources shall comply with the maximum permissible sound pressure levels
Road works	
Decree No. 90/2003 Approves New Text and Annexes to Chapter Five of the "Traffic Signaling Manual" Establishing Transitory Signaling and Safety Measures for Road Works	Chapter 5 of the Traffic Signaling Manual addresses the signals, devices, safety measures and signaling schemes that must be used when carrying out road works, understanding as such any work or temporary restriction that causes partial or total obstruction of it.
Solid waste	
DS 6/2009 Regulation on Waste Management of Health Care Establishment (REAS). MINSAL	Establishes standards for the management of "solid" waste generated in health facilities
Law No. 20.920/2016. Establishes Framework for Waste Management, Extended Producer Responsibility and Promotion of Recycling. Ministry of Environment (MMA)	This law aims to incorporate the recovery of waste as a primary element in the management of solid waste and introduce into the existing regulation on the subject, an economic instrument that seeks to generate mechanisms that allow increasing the levels of recycling of waste that is currently disposed of in landfills or are deposited in illegal landfills.

Hazardous waste	
Supreme Decree No. 148/2003. Approves Sanitary Regulations on Hazardous Waste Management. MINSAL	It establishes minimum health and safety conditions relating to the generation, holding, storage, transport, treatment, reuse, recycling, final disposal and other forms of disposal of hazardous waste.
D.S. 43/15, Regulation on the storage of dangerous substances. MINSAL	It establishes the storage conditions for classified hazardous substances in accordance with the provisions of NCh382:2013. The substances to which this regulation applies are compressed gases, flammable liquids, flammable solids, oxidizing and organic peroxides, acute toxic, corrosive and various dangerous.
Basic Health Services	
Decree with Force of Law (D.F.L.) No. 382 of 1988, General Law on Health Services, and its regulations D.S. No 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.
Articles 71 and 72 of the Ministry of Health Code, as well as Official Decree No. 1 of 1989, also of the MINSAL, which determines the matters requiring sanitary authorization. Express to work	In the case of health facilities that are located outside the operational areas of health companies, the provision of basic services is through particular drinking water supply and sewage disposal systems. The responsibility for building, operating and maintaining these particular systems rests with the property owners. Any particular system of drinking water supply and sewage disposal must have project approval and operating authorization from the respective Regional Ministerial Secretariat of Health.
D.S. 735 of 1969 of the MINSAL Regulation of water supplies intended for human consumption.	It regulates the quality of drinking water, both in urban and rural areas.
D.S. 236 of 1926 of the MINSAL, General Regulation of Private Sewers	It regulates the basic sanitary conditions of the particular sewage disposal systems.
Water Code Law No. 21.435 Reform of the Water Code of the Ministry of Public Works. Posted on April 6, 2022	This set of codified rules regulates the use of the country's water resources, establishing, among other figures, the right to use water. This Law amends 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 good for public use, whose domain and use belong to all the inhabitants of the nation.
Occupational Health and Safety	
D.S. 594, Regulations on Basic Sanitary and Environmental Conditions in the Workplace	It establishes the basic sanitary and environmental conditions that every workplace must meet, without prejudice to the specific regulations that have been issued 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 Welfare	Codified body of rules governing 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); protection of workers (social insurance against risks and accidents, against sexual harassment); trade unions and collective bargaining; and, labor jurisdiction.
Law No. 16.744/1968 establishing rules on accidents at work and occupational diseases. Ministry of Labor and Social Welfare	Norm that regulates the obligatory nature of insurance against risks of accidents at work and occupational diseases for both dependent and independent workers who contribute to the social security system. The insurance protects in the event of accidents at work, commuting accidents, accidents suffered by trade union leaders and occupational diseases.
Decree No. 40/69 of the Ministry of Labor and Social Welfare approving the Regulation on the Prevention of Occupational Risks	It 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 or keep updated a safety and hygiene regulation, inform workers of the risks they run and train them to deal with them adequately. It also states that statistics on occupational accidents and diseases should be kept.
D.S. No 76/2007, Ministry of Labor and Social Security. Approves Regulation for the Application of Article 66 Bis of Law No. 16,744, on the management of Safety and Health at Work in works, tasks or services indicated.	Article 66 bis of Law 16,744 establishes the obligation of the main company to monitor that both contractors and subcontractors comply with hygiene and safety standards. In addition, among others, it establishes that the main company, for the purposes of planning and fulfilling its obligations in terms of health and safety, must maintain at the site, work or service, an updated Record of Background, either on paper or digital, constituted, among others, by a history of accidents and occupational diseases of the work.
Decree 157/2007 Regulation of pesticides for sanitary and domestic use. MINSAL	It regulates the conditions of import, storage, possession, transport, distribution, application and disposal of pesticides for sanitary and domestic use, which includes a wide range of disinfectants and antiseptics.
Biodiversity, protected natural areas	
Convention on Biological Diversity. Decree No. 1963/1995 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 benefits arising from the utilization of genetic resources.
Decree No. 14/2008 National Biodiversity Strategy 2017-2030 of the Ministry of the 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 robust institutions, good governance and fair and equitable distribution of biodiversity benefits; (4) Embed biodiversity

	objectives in public and private sector policies, plans and programs; and (5) Protect and restore biodiversity and its ecosystem services.
Convention on Wetlands of International Importance, especially as Waterfowl Habitat. Decree No. 771/1981 of the Ministry of Foreign Affairs	The purpose of this Convention is the conservation and rational use of wetlands, carrying out actions at the local, regional, national and international cooperation levels. Among its provisions, it establishes that States must draw up a list of wetlands or implement plans for the conservation of wetlands and waterbirds.
Law No. 18.362/1984. Creates a National System of Protected Wild Areas of the State	This Law creates a National System of Protected Wild Areas of the State, including regulations for its management, creation, administration and disaffection, as well as prohibitions and sanctions in case of non-compliance with this regulation.
Law No. 20.283/2008. On Native Forest Recovery and Forestry Development and its Regulation (D.S. 93/2009 of the Ministry of Agriculture)	This Law aims to protect, recover and improve the native species of the country, ensuring their forest sustainability, through management and preservation plans.
Law No. 21.202/2020 of the MMA Modifies several legal bodies with the aim of protecting wetlands	Its objective 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 the great importance they have 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 Prospections.	Legislates on National Monuments.

4.1.2 Institutional framework for the environmental management of the Program

The main potential environmental and health and safety risks of this PforR are associated with the construction and operation of a new type of PHC establishments with the credit of the WB.

Based on information provided by MINSAL, those responsible for managing the construction of the new PHC establishments will be the **Health Services** and these will be in charge:

i) the contracting of the works by tender, through the Public Procurement system, which will be [20]carried out according to bankruptcy type bases established by the Comptroller[21] for this type of works (it is expected that the same bases will be used as for the construction of rural posts -smaller APS establishments, of about 400-500 m2). The standard bidding rules consider the legal framework that must be applied when building infrastructure, including socio-environmental. The tender documents also include specifications with specific technical specifications 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 regulations and mitigation A & S specific to the work in question, for which the **Directorate** of the corresponding Health Service must hire a **Technical Works Inspector** (ITO), registered in the National Registry of ITO of the Ministry of Housing and Urbanism.

The Technical Inspector of the work will depend on the SS Directorate and has administrative, civil and criminal responsibility. You must verify that the work complies with the conditions of the contract and all applicable legal framework, including environmental, health and safety, and social.

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

The budget of the work dedicated to the implementation of environmental and social prevention, mitigation and control measures is not included as a specific item, but is included in the general expenses of the work item that considers the administration of the work, and includes all the personnel of the company that will work on the work, which must include the risk prevention officer and the specific specialists who 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 breach (technical, environmental, safety and health, others) to cover the cost of what is meant. These guarantees are established based on the total cost of the work.

To start a work, the building permit **must be requested** from the corresponding municipality, through its **Municipal Works Directorate (DOM),** the governing body responsible for verifying that the contractor company complies with all the necessary regulations to start the execution of a work, including urban, environmental, social regulations, among others. Before applying for this permit, the contractor must have all the feasibility resolved, for example, the connection of the new APS center to the supply of drinking water and sewerage, the connection to the electrical system, when necessary, a preliminary topography, a preliminary soil mechanics, the land where it is going to be built, among others. The bidding file of the work is assembled, by the corresponding Health Service, with all these antecedents resolved and feasibility to execute the work.

The DOM also supervises the works under construction, can visit the work and verify that it is complying with all the applicable regulatory framework, including environmental and social. In addition, these works are also supervised by the ITO, the Directorate of Labor and the corresponding SEREMI of Health.

The complaints and claims that may be presented by the work are handled by the DOM, in conjunction with the SS Directorate and the ITO. The claim of an affected by the work can reach the DOM and from there the company is required to resolve the complaint or claim.

[20] Mercado público is a platform for public procurement of products, works and services in Chile, available in 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 vis-à-vis the Executive Power 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 contemplated by law.

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

Once the work is finished, the municipal reception **must be requested from the municipality**, this is the last verification that the work was executed in accordance with what was requested and with the applicable legal framework, including A & S aspects.

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

According to information provided by MINSAL, the new PHC establishments that are built with the WB credit will be operated and managed by the municipalities, through their Municipal Health Directorates, or Primary Health, or PHC Corporations. Therefore, the environmental and social management of these centers will be supervised by the municipality where the new PHC establishment is established and the corresponding SEREMIS. For example, for the management of hazardous waste, municipalities have contracts with companies that are supervised by the SEREMIS for the disposal of hazardous waste in accordance with the regulations of the Regulations on the Management of Waste in Primary Care Establishments (REAS). In addition, each municipal health directorate and each establishment must register, through the SEREMIS where they must declare how they manage their waste.

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

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

Board 6 Institutional Framework for Environmental Regulation, Control and Oversight of the Program

National Environmental Authorities	
Ministry of Environment (MMA)	The MMA is responsible for the coordination of environmental matters and in the design and proposals of environmental policies that strengthen sectoral regulatory frameworks in environmental matters, including the health sector, as well as in the protection and conservation of biological diversity and renewable natural resources and water, promoting sustainable development. the integrity of environmental policy and its normative regulation. The Ministry has a National Advisory Council and Regional Advisory Councils in each region of the country, created by Law No. 19,300 on the General Bases of the Environment, as mechanisms for citizen participation in environmental issues. In addition, the Minister of the Environment chairs the Council of Ministers for Sustainability and Climate Change.
Environmental Assessment Service (SEA)	The main function of the SEA is to administer the Environmental Impact Assessment System (SEIA), which regulates the evaluation process of projects that may generate significant impacts on the environment. The decision of the SEA on the environmental assessment 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. Against this resolution, in certain cases, a complaint may be lodged with the Committee of Ministers. In addition, the Service has the task of standardizing the criteria, requirements, conditions, background, certificates, procedures, technical requirements and procedures of an environmental nature established by the ministries and other competent State agencies, through the establishment, inter alia, of procedural guides. In the event that any of the infrastructure works of the Program must be submitted to the SEIA, it must follow the process provided in the LBGMA and RSEIA for the evaluation of its risks and environmental impacts and obtain the respective RCA. According to the Program's exclusion list, interventions requiring an EIA will be excluded from funding.
Superintendence of the Environment (SMA)	The SMA is the body with exclusive authority to execute, organize and coordinate the monitoring and supervision of the Environmental Qualification Resolutions (RCA), the measures of the Prevention and / or Environmental Decontamination Plans, the content of the Environmental Quality Standards and Emission Standards, and the Management Plans, when appropriate. and all other environmental instruments established by law. The SMA fulfils its function through three types of control: direct, by its officials; by other sectoral agencies, entrusting it with monitoring tasks on the basis of specific programs and subprograms; and, through third parties accredited by the Superintendence. 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 inspection by the SMA.
Organs of the State Administration with Environmental Competence (OAECA)	The OAECA are the organs of the State that participate in the Environmental Impact Assessment of the project or activity. Article 24 of the RSEIA defines them as those that have attributions in terms of permits or sectoral environmental pronouncements regarding

	the particular project or activity. In the event that any infrastructure work included in the Program requires submission to the SEIA through an EIS, these bodies will rule on the EIS of the work.
Directorate of Labour, Safety and Health	The Directorate of Labour is a decentralized public service, supervised by the President of the Republic through the Ministry of Labour and Social Security. Among its roles are to monitor compliance with labor, social security and occupational health and safety standards, and to carry out actions aimed at preventing and resolving labor disputes.
Regional Governments	Law No. 19.300 establishes the obligation of regional governments to decide on the territorial compatibility of projects submitted in the region under their competence (Article 8). In the event that any of the infrastructure works included in the Program must be submitted to the SEIA through an EIS, the work must obtain the report of the Regional Government, the respective Municipality and the competent maritime authority, when appropriate, on the territorial compatibility of the project presented.
Municipalities	The functioning of municipalities in Chile is governed by Law No. 18.695, the Constitutional Organic Law on Municipalities. The management of PHC establishments at the communal level depends on the municipality in 321 of the 345 communes of the country. In these cases, each manages human and financial resources, makes purchases of goods and services, and is responsible for maintaining infrastructure and equipment. The Municipalities have among their functions and responsibilities the management of the [23] environment and public safety and health in their municipality and develop mechanisms to comply with the responsibilities granted by the Constitution of the Republic on these issues, the LBGMA in matters of environmental management (control of environmental quality, represent the complaints of the community in environmental matters, implement decontamination plans, among others) and the Sanitary Code (ensure compliance with the hygiene and safety provisions established in the General Ordinance on construction and urbanization. The municipalities are responsible for issuing the building permit to start a civil work in their territory and for granting the reception of the work once it is finished, it also supervises the compliance of the work with the applicable legal framework, during construction, as well as during its operation. The construction and operation of the new APS infrastructure will be subject to compliance with relevant municipal environmental and social standards, acts and ordinances. The municipalities that are in charge of PHC establishments have well-standardized toilet and ornamental directorates that are responsible for environmental management, or there are municipalities that call them environmental management directorate.
Sectoral environmental authority (Health Authority)	
MINSAL	MINSAL is responsible for formulating and establishing health policies within the national territory. Having, among others, the following functions and objectives: - Exercise the stewardship of the health sector - Ensure due compliance with health regulations, through the Regional Ministerial Secretariats of Health, without prejudice to the competence that the law assigns to other agencies. - Carry out public health surveillance and evaluate the health situation of the population.

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

	- At the national policy 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 Care Division (DIVAP), under the Undersecretariat for Care Networks.
Department of Risk Management in Emergencies and Disasters (DGREYD)	Inserted in the Chief of Staff of MINSAL, the DGREYD's mission is to promote comprehensive risk management in emergencies and disasters in the health sector, considering the guidelines of the National Disaster Prevention and Response System (SINAPRED) and sectoral agreements in the international framework of disaster risk reduction. Among its objectives are: • Prepare the necessary technical guidelines for the implementation of the Sectoral Policy on Risk Management in Emergencies and Disasters, as well as the necessary protocols for the formulation of plans, to monitor the implementation of said policy in the MINSAL, in the SEREMIS, in the Health Services and in the establishments of the network. • Coordinate and monitor 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 the monitoring and reporting of RA2 activities related to emergency preparedness, surveillance and climate change resilience of PHC.
Department of Environmental Health (Undersecretary of Public Health)	It is part of the Division of Healthy Policies and Promotion, which in turn depends on the Undersecretariat of Public Health. Responsible for ensuring that all factors, elements or agents of the environment that affect the health, safety and well-being of the inhabitants of the country 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 that are built with the Program's credit.
Department of Occupational Health (Undersecretary of Public Health)	Also under the Division of Healthy Public Policy and Advocacy. Its main objective is to promote the development of healthy work environments that improve the quality of life of workers, therefore, it fulfills normative, 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 the new PHC facilities that are built with the Program's credit.
Regional environmental management	

Regional Ministerial Secretariats of Health (SEREMIS)	The regional health authority must supervise and sanction provisions of the Health Code and other regulations. In addition, the SEREMI of Health supervises matters such as hygiene and safety of the environment and workplaces; foods; laboratories; pharmacies; burials; exhumations and transfer of bodies. In the area of occupational health, supervision is the responsibility of the SEREMIS Occupational Health Units or Sub-Departments in each region. In the area of environmental health, at the regional level, supervision is the responsibility of the Department of Sanitary Action of the SEREMIS, which may have a different configuration in each region. The SEREMIS will be responsible for supervising and sanctioning provisions of the Sanitary Code and other regulations in the new PHC establishments that are built with the credit of the WB, during their construction and operation, related to factors of environmental quality, emissions, waste, drinking water, sewerage, safety and hygiene in PHC establishments, among others. It is the regional authority that issues the sanitary authorization for the start of operation of a health establishment.
Local environmental management	
Health Services (SS)	The SS report to the Undersecretary of Assistance Networks of MINSAL. Regulated by Law No. 19.937 on the Health Authority and the Health Services Regulations (Decree No. 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 SS, 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 (SS) with jurisdiction in the communes where the new PHC facilities included in the PforR are 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 Works Inspector who will be hired by the SS for the tasks of supervising compliance of the execution of the work with the conditions of the contract and the legal framework applicable to the specific work.
Municipalities	The municipal governments have among their responsibilities, to ensure the protection of the environment and guarantee the safety and public health of their territory, to supervise compliance with environmental legislation and public health and safety of civil works in their municipality, to grant building permits, to facilitate proper waste management, to provide sanitary services to their commune, control air pollution, among others. This is done in collaboration with the regional ministerial secretariats of environment and health of the region where they are located, among other relevant public institutions. The municipal government will apply its relevant rules 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 discussed in the previous sections.

First, the main regulation that regulates environmental aspects in Chile is Law No. 19,300 LBGMA. This law establishes the basic principles and standards for the protection, conservation and recovery of the environment, and establishes the Environmental Impact Assessment System (SEIA) and its regulations (RSEIA). The SEIA is an environmental management instrument that allows evaluating and predicting 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 are the projects or activities that must be submitted to the SEIA and Article 3 of the RSEIA, specifies these projects.

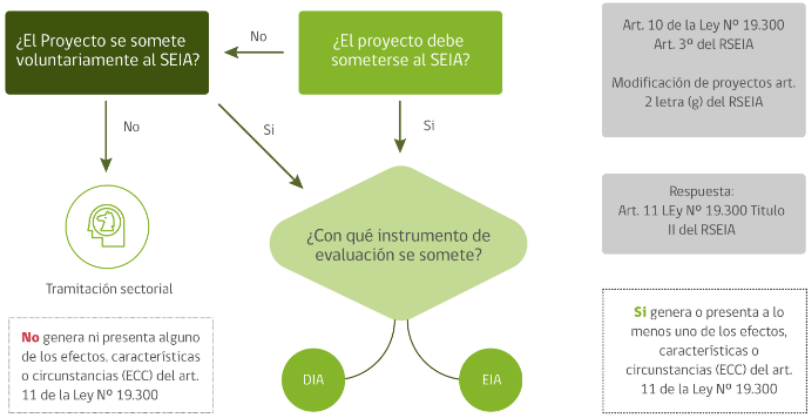
Law No. 19,300 also distinguishes between projects that must submit an Environmental Impact Statement (EIS) and those that must submit an Environmental Impact Assessment (EIA). The projects and activities that must submit an EIA are regulated in article 11 of the same law and, in general, refer to those that have significant impacts. The minimum contents of EIAs and EIAs are set out in Articles 18 and 19 of the ETIAS Regulation, respectively.

Therefore, in order to manage and supervise the environmental aspects of the civil works executed by the Health Services in Chile, the procedures established in Law No. 19,300 must be followed and the projects submitted to the SEIA, obtain the corresponding RCA and comply with the established environmental mitigation and monitoring measures. The SMA is responsible for monitoring compliance with these provisions and applying sanctions in case of non-compliance.

It is emphasized 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, in accordance with the LBGMA and its regulations, an Environmental Impact Study. Interventions that could require an EIS are not excluded, for example, in the case of the construction of the new model of establishment of PHC that includes the Program, which would be works of small magnitude, they could require an EIS if the work had 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, in accordance with 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 this, one of the following specific criteria must be met (RSEIA, Article 3, letter g.1.2 and literal h.1):

- This is located in an undeclared saturated or latent area and has a constructed area equal to or greater than 5,000 m2;
- with property area equal to or greater than twenty thousand square meters (20,000 m2);
- a capacity for attention, influx or simultaneous stay equal to or greater than 800 people;
- or has 200 or more vehicle parking spots.
- This is located in an area declared saturated or latent and requires its own systems of production and distribution of drinking water or collection, treatment and disposal of wastewater;
- or has capacity for 5,000 or more people;
- or has 1,000 or more parking spaces

In view of these criteria (previous paragraph), in the case of the new infrastructure that is planned to be built with credit from the WB, due to its typology and scope, described in section 2.2.5 of this document, these will not be required to submit 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 change of land use for its construction, as previously mentioned . If a project does not meet the criteria established to undergo the SEIA and obtain an RCA, it is considered a smaller project or with environmental impacts of lesser magnitude. However, although the RCA is not required, it is important that the works under the responsibility of the Health Services 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, mitigation and environmental, safety and health and social control that must be specified in the bidding documents of the work and contract for construction, as explained in section 4.1.2 of this document.

Some of the actions carried out to manage the environmental aspects of these projects that do not require undergoing the SEIA are at least:

- **Identification of environmental aspects:** Carry out an initial evaluation to identify the possible environmental and social aspects associated with the work. This involves analyzing the possible risks and impacts on the natural and social environment, such as waste generation, emissions, noise, use of natural resources, risks to natural disasters, among others.
- **Planning and design:** Consider from the initial stages of the works measures of prevention, mitigation and control of environmental risks. This involves designing and planning the work in a way that minimizes negative effects on the environment 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, protection of natural resources, road safety, among others.
- **Monitoring and follow-up:** Establish a monitoring and follow-up program to evaluate the environmental performance of the works during their execution. This involves making periodic measurements of relevant environmental variables and assessing compliance with established limits and standards.

- **Training** and awareness: Promote the training and awareness of the personnel involved in the works (contractors, subcontractors, supervisory firms, among others) regarding the relevant environmental aspects and the mitigation and control measures to be implemented. This ensures that all managers are familiar with good environmental practices.

4.2 Social management systems relevant to the PforR

4.2.1 Legal and regulatory framework for the social management of the Program

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 correct the inequalities, discriminatory practices and unfair power relations that are often central to inequity in health outcomes."[25]

In the area of human rights, Chile has signed all the substantial 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 Evaluation Annex of this document. In addition, in the area of Primary Health Care, Chile has signed the Declaration of Alma Ata. (1978) and the Astana Declaration (2018).

At the national level, the current Political Constitution[29] of the Republic of Chile guarantees all persons 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 will also be responsible for the coordination and control of health-related actions. It is the preferential duty of the State to guarantee the execution of health actions, whether they are provided through public or private institutions, in the form and conditions determined by law, which may establish compulsory contributions."

[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] At the time of this report, ratifications are still pending: 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 Treaties Signed and Ratified by Chile on Human Rights. International recommendations with constitutional impact. 2020. Parliamentary Technical Advice. Area of Government, Defense and International Relations. 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 Evaluation: international legislative framework on human rights and health.

[29] Decree No. 100 establishing 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 made progressive progress in recognizing, promoting and guaranteeing human rights, non-discrimination, citizen participation and the resolution of complaints addressed to the State Administration, through a set of laws, regulations, institutions and mechanisms that provide guarantees in State actions and benefits aimed at all citizens. but also towards some Special Attention Groups (GEA).[30]

The Ministry of Health, like the rest of the State departments, must consider this legal framework in its procedure, which establishes acceptable degrees in terms 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:

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

Matter	Population Group	Guy	Number	Name	Ministry	Year	Detail	Fountain
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 respect for the essential rights that emanate from human nature. It is the duty of the organs of the State to respect and promote these rights, guaranteed by this Constitution, as well as by the international treaties ratified by Chile and that are in force.	https://bcn.cl/2f6sk
	All	Law	20.405	Creates the National Institute of Human Rights (INDH)	Autonomous entity	2009	It creates the INDH as an autonomous corporation of public law responsible for ensuring respect for human rights.	https://bcn.cl/2kdph
	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 of promoting and protecting human rights.	https://bcn.cl/2lo15

[30] Special Care Groups (GEA) are 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 action on the part of the State to make up for this disadvantage. such as: Children and adolescents (NNA); victims of human rights violations by the State; women; population of gender diversities; people living in poverty; migrants and refugees; Elderly; persons 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 Human Rights Instruments, Observations and General 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

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 civil society partnership initiatives, as well as to encourage citizen participation.	https://bcn.cl/2f7nb
	All	Res. Ex.	1.757	Creates Observatory of Citizen Participation and Non-Discrimination	Ministry General Secretariat of Government	2018	Its purpose is to contribute to making more efficient the mechanisms of linkage, dialogue and communication between the government and social organizations, favoring associations and the strengthening of civil society, promoting the participation of citizens in the management of public policies.	https://bcn.cl/2o81c
	All	Law	21.445	Framework Law on Climate Change	Ministry of Environment	2022	In order to grant the country a legal framework that allows it to adapt to climate change, reducing vulnerability and increasing resilience to the adverse effects of climate change, and comply with the international commitments assumed by the State of Chile in the matter. This Law establishes, among other matters, the creation of a National System of 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.	https://bcn.cl/30fwi
	All	Law	19.602	Modifies Law No. 18,695 Constitutional Organic of Municipalities, in matters of Municipal Management	Ministry of the Interior and Public Security		It empowers the mayor to carry out Communal Plebiscites and Non-Binding Consultations in matters of local administration relating to specific investments in communal development, 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 are within the sphere of their competence.	https://bcn.cl/2qhhz
Claims	All	Decree	680	Approves Instructions for the Establishment of Information Offices for the User Public in the State Administration	Ministry of the Interior and Public Security	1990	It establishes the right that any person who turns to the State Administration must find guiding information, timely and prompt attention, and the possibility of collaborating to a better service through the complaint or suggestion.	https://bcn.cl/2lyf0

Access to Information	All	Law	20.285	On Access to Public Information	Ministry General Secretariat of the Republic	2008	It regulates the principle of transparency of the public function, 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 publication of information.	https://bcn.cl/2f8ep
Discrimination	All	Law	20.609	Establishes anti-discrimination measures	Ministry General Secretariat of Government	2012	Defines the concept of arbitrary discrimination; establishes a judicial procedure to re-establish 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 to all persons, without arbitrary discrimination, the enjoyment and exercise of rights and freedoms.	https://bcn.cl/2g7mr
	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 their sex and registered name, to request the rectification of these. It prohibits arbitrary discrimination and that causes deprivation, disturbance or threat to people and their rights, because of their gender identity and expression, as established in Law 20,609.	https://bcn.cl/2f8z8
Indigenous Peoples	Indigenous Peoples	Law	19.253	Establishes standards for the protection, promotion and development of indigenous peoples and establishes the National Indigenous Development Corporation (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 the services of the State administration and regional organizations to listen to and consider the opinion of indigenous organizations in those matters. that have interference or relationship with indigenous issues, among others.	https://bcn.cl/2f7n5
Indigenous and Tribal Peoples	Indigenous and Tribal Peoples	Decree	236	Promulgates Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries of the International Labour Organization	Ministry of Foreign Affairs	2008	Promulgates ILO Convention No. 169	https://bcn.cl/2fx8e

	Indigenous and Tribal Peoples	Decree	66	Approves Regulation Regulating the Indigenous Consultation Procedure under Article 6 No. 1 Letter a) and No. 1 of Convention No. 169 of the International Labour Organization and Repeals Regulations Indicating	Ministry of Social Development and Family. Undersecretariat of Social Services	2013	It describes the regulations that will govern the processes of indigenous consultation in the State Administration.	https://bcn.cl/2lp47
	Chilean Tribal People	Law	21.151	Grants legal recognition to the Chilean Afro-descendant 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	https://bcn.cl/2f9j2
Inclusion of People with Disabilities	Disabled	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 of the full social inclusion of persons with disabilities: the National Disability Service; a Committee of Ministers on Disability 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.	https://bcn.cl/2irkh
	Disabled	Law	21.015	Encourages the Inclusion of People with Disabilities in the World of Work	Ministry of Social Development and Family	2017	It encourages, both in State agencies and in private companies, the labor inclusion of people with disabilities under equal conditions, prohibiting any discriminatory act based on their condition.	https://bcn.cl/2f9hw
Children's Rights	Children and adolescents	Law	21.067	Creates the Office of the Ombudsman for Children	Autonomous entity	2018	It establishes the Office of the Ombudsman for Children as an autonomous body whose mission is to promote and protect the rights of children.	https://bcn.cl/2fl6e
	Children and adolescents	Law	21.430	On guarantees and comprehensive protection of the rights of children and adolescents	Ministry of Social Development and Family	2022	Its purpose is the guarantee and comprehensive protection, effective exercise and full enjoyment of the rights of children and adolescents, in particular 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	https://bcn.cl/2yieq

Migration	Migrants	Law	21.325	Migration and aliens	Ministry of the Interior and Public Security	2021	It establishes rules on migration and aliens with a view to regulating the entry, stay, residence and departure of foreigners from the country, and the exercise of rights and duties, and establishes the National Migration Service.	https://bcn.cl/2oodq
Gender Violence	All	Law	20.005	Criminalizes and punishes sexual harassment	Ministry of Labour and Social Welfare	2005	It establishes standards to ensure a decent work environment free of sexual harassment.	https://bcn.cl/2i4ie
	All	law	21.153	Modifies the Penal Code to typify the crime of sexual harassment in public spaces	Ministry of Justice and Human Rights	2019	It establishes penalties for the crime of sexual harassment in public spaces.	https://bcn.cl/2ffd3

In addition, Chile has a solid track record in public health, its origins date back to the nineteenth century and the Primary Health Care Network has played a fundamental role in the prevention and promotion of health over the years.

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

The following describes the legal and regulatory framework that governs the Ministry of Health with regard to the administrative aspects governing the Primary Care Network, its coordination, the rights and duties explicitly guaranteed and the mechanisms for citizen participation.

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

Guy	Number	Name	Ministry	Date of Enactment	Matter	Detail	Fountain
Decree	602	Create Local Health Councils	Bless you	01-09-71	Participation	Article 3. - It will be up to the Local Councils to examine health problems affecting the community; promote its solution through rapid and effective actions; promote the interest of the inhabitants to participate actively in solving them; Collaborate in the dissemination of health action plans, and represent anomalies that appear in the execution of these actions. Article 5. - The Local Councils of Health Establishments shall be composed of: 1.- The head of the establishment of the National Health Service, which serves as the local base of 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 Establishment. 3.- A representative of each of the urban workers' organizations and/or peasant councils constituted in the sector. 4.- A number of representatives, distributed in equal proportionality, 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 officials subject to Law No. 15,076. This number shall be determined jointly by the above-mentioned organizations and may not be greater than the sum of the representatives of the population organizations of urban workers and/or peasant councils. 5.- A representative of the Interior Government Service. 6.- A municipal representative. 7.- A representative of local education.	https://bcn.cl/2xybo

						ANNEX: However, and in relation to the functions foreseen for these Councils in the document under review and, in particular, with the provisions of articles 6 and 9 in order that the Joint Councils referred to in these 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 health programs", it is appropriate, in the opinion of the Office of the Comptroller General, to point out that this can only be understood in the sense that the aforementioned Councils must act as mere advisory or consultative bodies, without, therefore, it being possible to consider that those norms would allow the development of functions of a decision-making or executive nature, which are exclusive of the public departments that must be created by law.	
DFL	36	Rules to be Applied in Agreements Concluded by Health Services	Bless you	10-07-80	Execution	It describes the provisions governing the agreements concluded between the Health Services and the persons, natural or legal, who are entrusted with carrying out health actions through said agreements.	https://bcn.cl/2n1dj
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.	https://bcn.cl/2fxvv
DFL	4	Adapts Plants and Ranks of the National Health Fund to Article No. 5 of Law 18,834 on Administrative Statute	Bless you	28-02-90	Public administration	Describes the plant and ranks of health personnel	https://bcn.cl/3dzan
Law	19378	Establishes Municipal Primary Health Care Statute	Bless you	24-03-95	APS Staff	It regulates the administration, financing regime and coordination of primary health care, whose management is transferred to the municipalities.	https://bcn.cl/2f8iv
Law	19490	Establishes Assignments and Bonuses that Indicates for Health Sector Personnel	Bless you	03-01-97	Public administration	Establishes the annual creation of Improvement Programs associated with goals of efficiency and quality of services that will accrue monetary incentives for health officials.	https://bcn.cl/2ga62
Law	19602	Modifies Law No. 19695, Constitutional Organization of Municipalities, in	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 for each municipality to have an ordinance for the modalities of citizen participation at the local level.	https://bcn.cl/2qhhz

		matters of Municipal Management					
Law	19813	Provides Primary Health Benefits	Bless you	18-06-02	APS Staff	Article 1º.- Establishes for the personnel governed by the Statute of Primary Care of Law No. 19,378, an allocation of development and encouragement to collective performance...	https://bcn.cl/2m8lz
Law	19937	Modifies D.L. No. 2763, of 1979, in order to establish a new conception of the health authority, different management modalities and strengthen Citizen Participation	Bless you	30-01-04	Reform	It transforms the previous Undersecretariat of Health into two Undersecretariats: an Undersecretariat of Public Health and an Undersecretariat of Assistance Networks. In addition, it transforms the former Superintendence of ISAPRE into Superintendence of Health, with powers to supervise not only the IISAPRE but also the National Health Fund (FONASA) and public and private health providers.	https://bcn.cl/2f7j5
Law	19966	Establishes the Health Guarantees Regime	Bless you	25-08-04	Rights and Duties in Health	It establishes explicit guarantees in Health regarding access, quality, financial protection and opportunity with which the benefits associated with a prioritized set of programs, diseases or health conditions indicated by the corresponding decree must be granted. The National Health Fund and the Social Security Health Institutions must obligatorily ensure these guarantees to their respective beneficiaries.	https://bcn.cl/2fckl
Decree	136	Organic Regulation of the Ministry of Health	Bless you	08-09-04	Public administration	It describes the functions of the Ministry of Health. Article 15.- The Ministry of Health shall ensure the effective coordination of care networks, at all levels of complexity, articulating the entities of the system that provide promotion, prevention, protection, recovery, rehabilitation, palliative care services, in order to obtain the maximum efficiency and effectiveness in the development of these actions and the best use of available resources. For the fulfillment of this function, it will issue the resolutions and adopt the necessary measures conducive to obtaining an adequate and expeditious collaboration between said entities.	https://bcn.cl/3dzap
DFL	1	Establishes the Consolidated, Coordinated and Systematized Text of Decree Law No. 2.763	Bless you	23-09-05	Equal access Free access Participation	Art 1: The Ministry of Health and the other bodies contemplated in this Book, are responsible for exercising the function that corresponds to the State to guarantee free and equal access to actions for the promotion, protection and recovery of health and rehabilitation of the sick person ...	https://bcn.cl/2qjwe

		of 1979 and Laws Nos. 18.933 and 18.469				Article 18: ... The beneficiaries referred to in Book II of this Law must register in a primary care establishment that is part of the Health Service Assistance Network in which their home or place of work is located. Article 34.- There will be a User Advisory Council, which will be composed of 5 representatives of the neighborhood community and 2 representatives of the workers of the Establishment. Article 40.- By resolution of the Undersecretary of Assistance Networks, the way in which the user population of the Establishment may express their requests, criticisms and suggestions shall be regulated. Article 131.- The exercise of the constitutional right to health protection includes free and equal access to actions for the promotion, protection and recovery of health 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 benefit.	
Law	20548	Regulates the Rights and Duties that People Have in Relation to Actions Related to their Health Care	Bless you	13-04-12	Rights and Duties in Health	Article 2.- Every person has the right, regardless of the provider who carries out the actions of promotion, protection and recovery of his health and rehabilitation, to have them given in a timely manner and without arbitrary discrimination, in the forms and conditions determined by the Constitution and the laws.	https://bcn.cl/2f7cj
Supreme Decree	23	Creates National Commission for the Protection of the Rights of Persons with Mental Illness	Bless you	12/06/2012	Rights and Duties in Mental Health	It creates the National Commission for the Protection of the Rights of Persons with Mental Illnesses, whose main function will be to ensure the protection of the rights of persons with mental or intellectual disabilities, assuming their defense with regard to the health care provided to them by public or private providers.	https://bcn.cl/2mbki
Law	20645	Creates Assignment Associated with the Improvement of the Quality of User Treatment, for Officials Governed by the Municipal Primary Health Care Statute	Bless you	14-12-12	APS Staff	Assignment to Municipal APS officials associated with user treatment	https://bcn.cl/2k2lt
Law	20646	Creates Assignment Associated with the	Bless you	14-12-12	APS Staff	Assignment to Health Services officials associated with user treatment	https://bcn.cl/2m3ei

		Improvement of the Quality of User Treatment, for Officials Belonging to the Technical, Administrative and Auxiliary Plants of the Health Services Establishments					
Norm		Methodology for Preparation, Evaluation and Prioritization of Primary Care Projects in the Health Sector	Ministry of Social Development and Family (MIDESO)	2013	Social variables to consider	Page 70 Considers the variables of:Gender approach (not detailed)Environment (does detail)Intercultural and Heritage Relevance (does detail)	https://sni.gob.cl/storage/docs/Atencio%CC%81n-Primaria-Salud-2013.pdf
Law	20850	Create a Financial Protection System for High-Cost Diagnostics and Treatments	Bless you	01-06-15	Rights and Duties in Health	Creates a Financial Protection System for Diagnosis and Treatment of High-Cost Diseases, insured by the National Health Fund for beneficiaries of Chile's health pension systems.	https://bcn.cl/2fpjz
Exempt Resolution	31	Establishes the General Standard of Citizen Participation in Public Health Management	Bless you	2015	Citizen Participation	It understands citizen participation as an active relationship between citizens and the State, being oriented to 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.	http://transparencia.redsalud.gob.cl/transparencia/public/ssp/2015/res31.pdf

4.2.2 Institutional framework for the social management of the Program

Currently, the system of pension health insurers 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 national territory is affiliated to FONASA; on the other hand, private health insurance (ISAPRE) covers 17% of the population.

Governance of the Health System: The Ministry of Health (MINSAL) is responsible for: (i) formulating, creating and coordinating health plans at the sectoral and intersectoral levels (public and private) and with national and international coverage; (ii) dictate and ensure compliance with general and specific rules on health issues; (iii) conduct health surveillance and assess the health of the population; (iv) formulate and execute the annual sectoral budget; and (v) coordinate care networks at all levels.

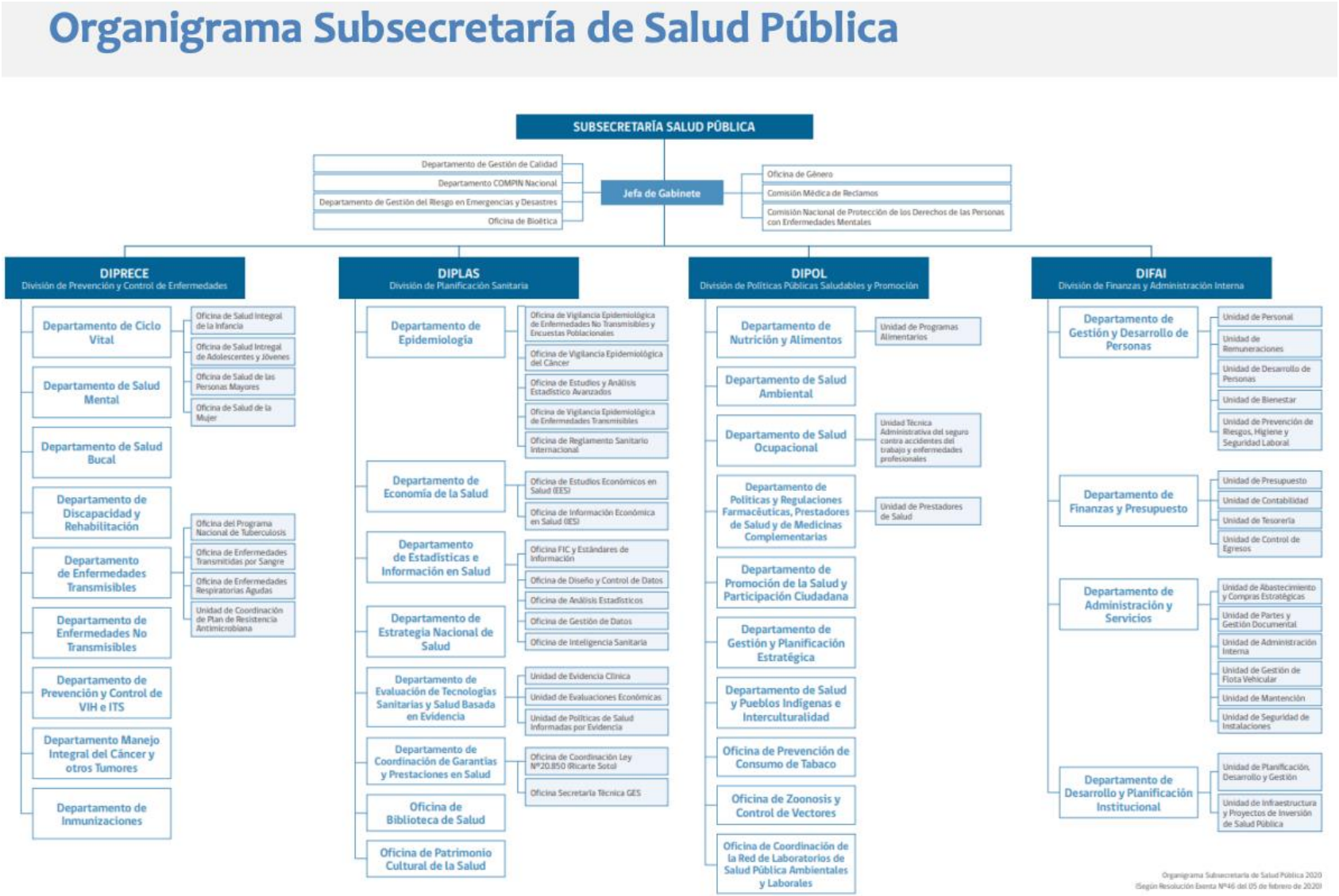
The Ministry is composed of two undersecretariats:

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

Figure 2 Compact Organization Chart of the Ministry of Public Health

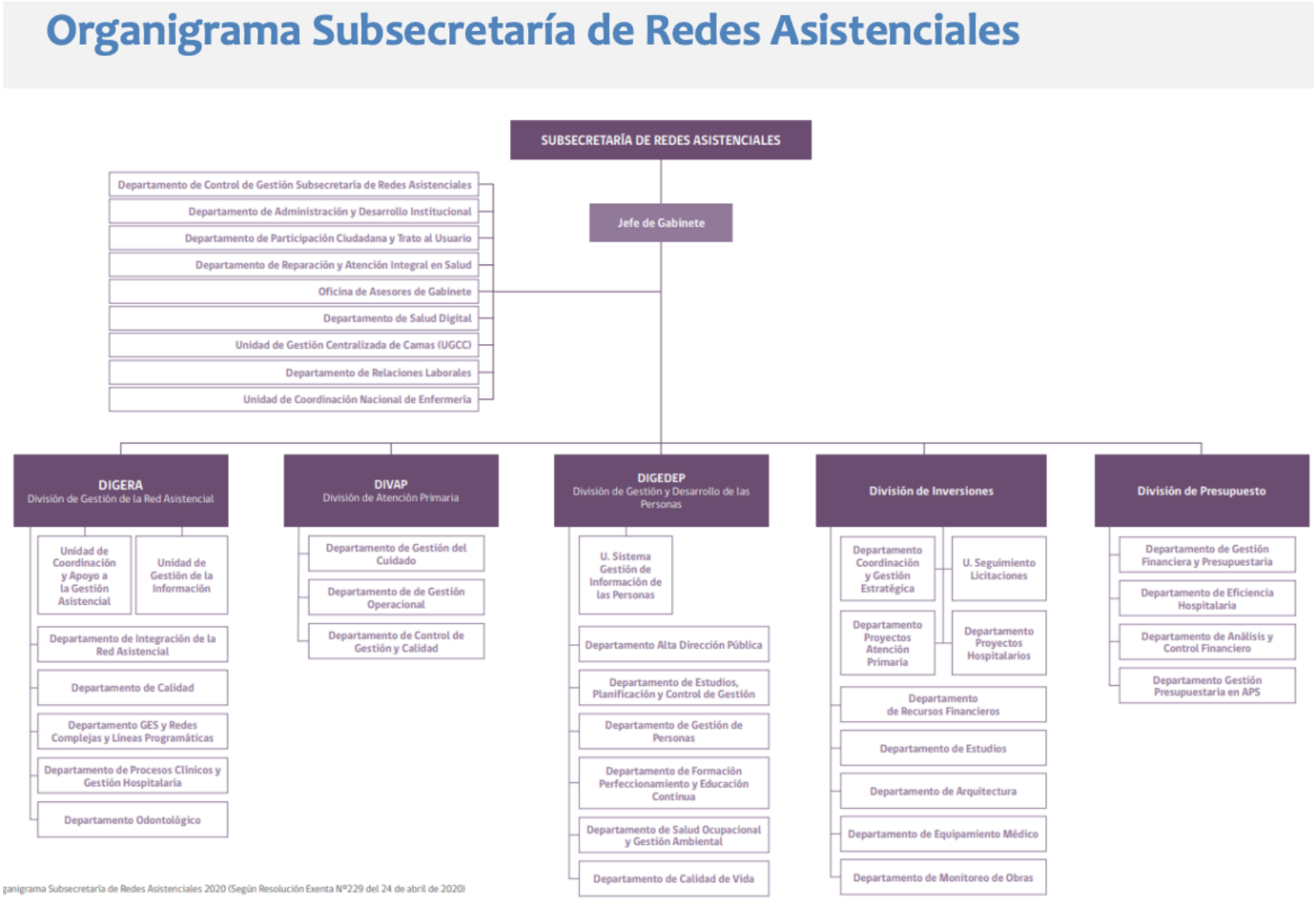
Source: MINSAL presentation. 2020. Link: https://saludresponde.minsal.cl/wp-content/uploads/2020/11/Presentacion-estructura-minsal.pdf

Figure 3 Organization chart Undersecretariat of Public Health



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

Figure 4 Organization chart Undersecretariat of Assistance Networks



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

The governance, regulation and other functions of the health system in Chile is 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 care, which puts the patient at the center, with emphasis on the care of populations throughout the life cycle, and also stimulates health promotion and prevention, as well as follow-up, Traceability and financial coverage.

Organs dependent on MINSAL:

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

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

1. The 29 Health Services, responsible for managing the health care networks of their districts (region, province or other, depending on the extension of the territory).
2. The National Health Fund (FONASA), which is responsible for collecting, administering and distributing the financial resources of the health sector, financing the health benefits granted to its users, characterizing the beneficiaries of this Fund and administering public health insurance.
3. Institute of Public Health (ISP), which has the function of regulating medicines and medical supplies, in addition to acting as a national reference laboratory and producing vaccines and reagents.
4. Superintendence of Health, responsible for protecting ISAPRE 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 Healthcare Network: In order to properly manage the public health care network, MINSAL has 29 Health Services throughout the country that are related to MINSAL through the Undersecretariat of Healthcare Networks, which exercises, among other functions, the role of coordination between the Health Services and the Ministry. In addition, PHC service providers interact with MINSAL through Health Services.

The Health Services are functionally decentralized State bodies, endowed with legal personality and their own assets. They are administratively related to the health authority through the Undersecretariat of Assistance Networks.

The healthcare network of each Health Service is composed of three levels of care: primary, secondary and tertiary, differing from each other by the level of complexity in the care they provide and in 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 less complex services aimed at health promotion and prevention, the secondary level is aimed at providing specialized benefits to those who have been referred from the primary level or an emergency unit. The tertiary level is mainly oriented to highly complex services.

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

a. Municipal Primary Health Care, whose administration is located in the municipal health administration entities and their network of establishments. According to the Department of Statistics and Health Information (DEIS), 92% of the establishments in the PHC Network are managed by municipalities.
b. Primary Care, dependent on the Health Services themselves, whose administration is the corresponding Health Service, with its establishments, rural and urban general clinics, attached or not. According to the DEIS, about 7% of PHC establishments are managed under this modality.
c. Non-governmental organizations (NGOs), which through DFL 36/80 agreements signed with the respective health services, carry out actions at the primary level of care. It corresponds to 1% of the total.

PHC establishments are typified as follows:

Community Mental Health Center (CECOSAM);

Family Health Center (CESFAM);

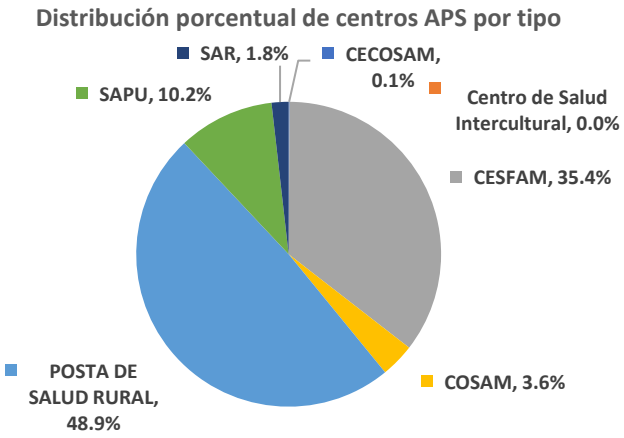
Intercultural Health Center;

Mental Health Center (COSAM);

Rural Health Post;

Emergency Primary Care Service (SAPU);

High Resolution Emergency Primary Care (SAR) Services.



Source: Based on information published by the Department of Health Studies and Information [29]

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

Health Information Systems: The most solid element of the information system is represented by the certificates of vital facts (births and deaths), whose coverage reaches almost 100% and allows to calculate mortality rates and disease burdens. The communicable disease surveillance system is also functional and universal. The scarcest data are those that refer to other diseases that are not included in the surveillance system, as well as to financing and provision of services, particularly in the private sector. During the COVID-19 Pandemic, MINSAL information systems were strengthened.

Organization of health regulatory actions: Health care is regulated by regulations within the framework of health programs established by the Ministry of Health. These programs define coverage, frequency or

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

periodicity of contacts between users and care providers, as well as responsibilities by level of care of the system.

Health regulation of public sector health facilities is the responsibility of the Health SEREMI of each Region.

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 title of Surgeon. Under the changes resulting from the 2004 health reform (Law 19,937), the Ministry of Health, in conjunction with the Ministry of Education, is assigned the responsibility of establishing a system of certification of specialties and subspecialties of individual professional providers as natural persons. The Superintendence of Health is responsible for supervising all public and private health providers, as natural persons, with respect to their certification.

Organization of public health services, in the context of a National Health Plan, general objectives are established aimed at promoting healthy lifestyles and environments, increasing knowledge and individual and community capacity for self-care, and strengthening the regulatory role of the State on the determinants of health.

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

In accordance with the regulatory framework described in tables No. 7 and No. 8 of this document, which describe citizen rights and institutional duties in terms of guaranteeing health care, citizen participation, access to information, resolution of claims and conflicts, as well as consultations with indigenous and tribal peoples on the issues that concern them, The Ministry of Health has in its two Undersecretariats divisions, departments and units aimed at designing, disseminating and supervising public policies aimed at safeguarding the universal right to health, access to decent and quality benefits and the right of access to information and citizen participation

In terms of citizen participation in PHC, the Primary Care Division of the Undersecretariat of Healthcare 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 people and users to directly influence decision-making in health matters that directly affect their communities.

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

- Formal instances: Development Councils, Advisory Councils, Youth Advisory Councils and Local Committees, composed of representatives of organized users, neighborhood organizations and functional health organizations, among others.
- Regular processes of citizen consultation, in order to provide inputs for the design, execution and evaluation of health policies. For example, through the development of the Community Health Plan (PSC)[33]
- Participatory budgets, participatory public accounts.
- Letters of Rights and Duties.

[32] Citizen participation in primary care. A contribution to the development of the Model of Comprehensive 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 in the technical standards and the care model 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

- Information, Complaints and Suggestions Offices (OIRS) available in all health centers and remotely through the Integral System of Information and Citizen Attention (SIAC).

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

Board 9 Dimensions and Actions for Citizen Participation and Grievance Management

Dimensions	Actions
User satisfaction and humanization of care	Volunteer network functioning. Regular functioning of the OIRS Management Committee (Information, Complaints, Suggestions, Congratulations).
Communication and community strategies	Information, consultative campaigns regarding family and community self-care issues.
Participatory Diagnosis	Participatory local planning. Work tables.
Participation and Social Control	Development Council. Advisory Councils. Local Health Councils. Councils of Civil Society (CESOC). School of Social Leaders.
Intersectoriality	Chile grows with you. Health Promotion Plans.
Human Resources Enablement	Training of local leaders. Training of local health teams.

Source: Citizen Participation in Primary Care. A contribution to the development of the Model of Comprehensive Family and Community Health Care and user satisfaction. 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) that contains the Offices of Information, Claims and Suggestions lacks a system for the management of the knowledge that is generated from citizen requests at the national level, because the detail of the requests is only known at the regional level. Because only statistical data on applications reach the central level. With regard to the evaluation of public policy, the Ministry of Social Development and the Family (MIDESO), through its Undersecretariat for Social Evaluation, has developed a solid framework for evaluating social policies aimed at the ongoing evaluation of the social programs implemented by the State, including the programs of the Ministry of Health. through the Ex-Ante and Ex-Post evaluations, whose objective is to evaluate the consistency of the design of the programs, in order to resolve situations of fragmentation and eventual duplication of programs, that is: interventions aimed at solving similar problems to very similar populations.

Ex-Ante evaluation is the first step in the life cycle of public, social and non-social programs. The Directorate of Budgets (DIPRES), under the Ministry of Finance, and the Undersecretariat for Social Evaluation, under the Ministry of Social Development and Family, verify that there is coherence between the public problem to be addressed, the population affected, the objectives defined and the measurement of results. This allows the subsequent ex-post monitoring and evaluation of the initiative, which

contributes to greater efficiency and transparency in the use of public resources. The results of the evaluations, ex-ante and ex-post, can be reviewed in the Integrated Bank of Social Programs[34].

These evaluations also generate inputs to the budget formulation process, contributing to greater transparency of public spending and facilitating monitoring and subsequent evaluation of public bid performance.

In general, the evaluations carried out by the Undersecretariat for Social Evaluation make recommendations that the departments should adopt in the shortest possible time.

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 ASSL systems applicable to the Program, it is concluded that in general, the legal and regulatory framework in Chile are 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 aspects. The country's legal framework, in general, provides a reasonable basis for addressing the environmental, health and safety 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:

Board 10 Result of the Environmental and Social Assessment by Basic Principles of the PforR

Basic 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 impacts of the Program.

Overall, there is a well-developed general and sectoral E&S legal and regulatory framework, as well as an institutional framework at national and regional levels with clear and delimited functions, as detailed in section 4.1 and 4.2 of this document. Based on the information provided to date, the Health Services (SS) will be responsible for bidding and supervising the execution of the 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 that include the requirement that the works comply with the applicable legal framework, including that referring to environmental and social. Tender documents must also include technical specifications including the requirements to plan environmental, health and safety and social prevention, mitigation and control, based on the complexity of the work in question that the contractor must implement. The SS 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 with the competencies and accreditations validated by the State to perform that task. The contractor of the works must also have among its personnel a risk prevention specialist responsible for supervising and enforcing the requirements of the work in environmental, safety and health and social matters. The works are permanently supervised by different competent bodies. There is a grievance mechanism that works in this type of works, where the DOM and the ITO receive the complaint or claim and must seek that the contractor resolves 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

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

to this principle and the processes for environmental and social management and oversight of the Program.

Basic 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 the conversion or significant degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR funding.

It is specified that the Program includes a list of exclusion of activities as detailed in section 2.2.8, among which are, among others, those associated with construction in protected areas or priority areas for the conservation of biodiversity, 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 lead to adverse impacts on these habitats, including urban or rural wetlands; and any activity affecting 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 with the Program, they will not have to undergo the SEIA, however, they will also have to comply with the applicable environmental and social legislation, regarding the identification and management of E&S risks, related, for example, to environmental quality, management of natural resources, management of hazardous and non-hazardous waste, land use, among others. This will be addressed by the corresponding SS when assembling the bidding file of the work with all the technical and regulatory issues resolved and feasibility to execute the work, including the aspects of prevention, mitigation and environmental control, 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 the environmental and social management and oversight of the Program.

Basic Principle 3: The Program's environmental and social management systems are designed to protect the safety of the public and workers against potential risks associated with (a) the construction and/or operation of facilities or other operating 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, but is not limited to, activities that involve: (i) air, water, or land pollution that causes significant adverse impacts on the health or safety of individuals, communities, or ecosystems; (ii) working conditions which expose workers to significant risks to personal safety and health; iii) activities that may cause or lead to forced labor or child abuse, child labor exploitation or employing or involving children, over the age of 14 and 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 trafficking in persons in relation to the Program; (v)

construction in areas at high risk from natural hazards (floods, landslides, 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 for the protection of the safety and health of workers and the community against risks associated with the construction and operation of PHC establishments (as detailed in Tables 5 and 6). The corresponding SS Management, through the ITO will supervise the implementation in the work of the prevention and control of potential risks related to the conditions of safety and health at work and in the community where the work is built, in addition the contracting companies that execute the works are obliged by law to have a professional in risk prevention in the work to guarantee the application of the relevant regulations and manage environmental, safety and health and social risks that may arise, including those related to gender-based violence (including sexual harassment and sexual abuse and exploitation) both in the work environment, and that which may occur in the commune where the work is built due to the arrival of external labor. Likewise, during the operation of the new PHC establishments, they must apply the relevant 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 the environmental and social management and oversight 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 living standards**.*

It is not clear whether or not the Program contemplates the acquisition of land and whether this may lead to the loss of access to natural resources of 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 do not see their livelihoods and living standards 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 adequacy of and equitable access to the benefits of the Program, paying particular attention to the rights and interests of historically neglected indigenous peoples/traditional local communities in sub-Saharan Africa, and to the needs or concerns of vulnerable groups.

One of the main axes of the Program is to strengthen the cultural adequacy of benefits 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 indicated in the RA1. In addition, MINSAL has the legal obligation to apply an intercultural health model in those territories with a high concentration of indigenous population, thereby guaranteeing cultural adequacy for these communities.

Basic 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 actions of the Program can cause social conflicts.

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5. RECOMMENDATIONS AND ACTIONS FOR PROGRAM E&S SYSTEMS

Based on the evaluation 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 the environment, health and safety, as well as land acquisition and the concerns of indigenous peoples and other vulnerable groups related to the activities proposed under the PforR. These systems are in line with the basic principles and key planning elements defined in the Bank's Policy for PforR. The potential overall 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 the implementation of the Program.

5.1 Actions to be included in the Program Action Plan (PAP)

Actions proposed for inclusion in the PAP:

1. **Designate within the IPU an environmental specialist**, with expertise in occupational health and safety, as focal point for Results Area 2 to facilitate inter-agency coordination. This specialist would have among his responsibilities:
    - Coordinate and implement programs for capacity building in E&S management of the executing agencies of the Program;
    - Supervise the performance of the E&S management of the Program, including compliance with the E&S strengthening measures agreed in the PAP;
    - Support in the preparation of the Program Operational Manual (MOP) and monitor its compliance;
    - Implement an adaptive E&S management approach to the Program (identify changes in the E&S risks and impacts assessed in ESSA, as well as changes in the E&S systems of application to the Program that may require further measures to be adopted);
    - Monitor the application of the activity exclusion criteria defined in section 2.2.8.
    - Prepare reports and report to the IPU coordinator on accidents occurring during the 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 MOP, as well as other reports that are agreed, to be presented to the WB; others to be determined.
2. **Designate within the IPU a social specialist**, with experience in public policies with a human rights approach and a gender perspective and inclusion, as focal point for Results Areas 1 and 3 to facilitate inter-institutional coordination. This specialist would have among his responsibilities:

- Coordinate and implement programs for capacity building in social management of the executing agencies of the Program;
- Supervise the performance of the E&S management of the Program, including compliance with the E&S strengthening measures agreed in the PAP;
- Support in the preparation of the Program Operational Manual (MOP) and monitor its compliance;
- Supervise the performance of the Complaint and Grievance Mechanisms and the Program's response capacity to complaints received and propose necessary improvements;
- Implement an adaptive E&S management approach to the Program (identify changes in the E&S risks and impacts assessed in ESSA, as well as changes in the E&S systems of application to the Program that may require further 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 MOP, as well as other reports that are agreed, to be presented to the WB; others to be determined.

5.2 Processes to include in the Program Operations Manual (MOP)

Processes proposed for inclusion in the MOP include:

1. **Definition of the human resources that will be in charge of environmental and social management in the agencies responsible for the execution of the new PHC infrastructure that is financed with the WB loan.** Define their roles, responsibilities and professional profile. At a minimum, these professionals must have experience in the application of the national legal framework and the environmental and social management systems relevant to the works to be built with the WB loan.
2. **Checklist to identify activities that meet the exclusion criteria** defined in the ESSA and therefore cannot be funded by the Program. This checklist shall correspond to that included in section 2.2.8.
3. **Minimum technical specifications to be included in tender documents for the environmental and social management of civil works to** be implemented by contractors, as well as ASSL management guidelines to be applied during the construction and operation of new APS facilities, consistent with national regulations, relevant international good practices and the basic principles and key planning elements set out in the PforR Financing Policy and Directive;
4. **Template for the preparation of semi-annual environmental and social monitoring reports to** be submitted to the WB, and will include, at least, the minimum contents of the reports on E&S matters, including the report on the resolution of complaints and claims, as well as the responsibilities and procedure for their preparation.
5. **Procedure for reporting incidents and accidents to the WB**. It will include, at least, the deadlines, procedure, relevant information to be included in the report, such as: details of the incident (date, time, responsible for the report), type and description of the incident, actions developed to address the incident, support provided to the affected person.
6. **Procedure/mechanism for dealing with complaints and grievances.** It will include, at least: process for the registration of complaints or claims, the process and deadlines to address and

follow them up, measures implemented to prevent the recurrence of the causes of the claims, responsible for the implementation of the grievance and grievance mechanism.

7. Others to be determined.

5.3 Recommendations

The following recommendations are proposed based on the information available to date. The proposed recommendations will be fleshed out in the final version of the Report for ESSA.

- Design and implement training and certification programs to strengthen the capacities in environmental and social management of the Health Services and / or other agencies that participate, both in the execution of the infrastructure works included in the Program, and in the operation of the new PHC centers that are built with financing from the Program.
- Rescue the experience and strengthening of capacities in the management of E&S for the execution of infrastructure acquired by the SS involved in the PforR to replicate it in the operation of other SS 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 establishments 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 establishments.
- Incorporate sociodemographic, accessibility and connectivity criteria in the selection of territories where new PHC enclosures will be built, in which a prospection of the population, especially migrants, is considered, both nationally and internationally.
- Delink the evaluation of user experience to the performance goals of PHC officials.
- Strengthen citizen and indigenous consultation mechanisms through mechanisms for returning the results of consultations, in which the reasons that led the institutional framework to decision-making are explained to the communities.

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7. SOCIAL EVALUATION ANNEX

Program by Results

Chile: Program for Universal Primary Healthcare Coverage and Resilience

(P179785)

Table of Contents

Brief History of the Public Health System in Chile

Chile has a long history in public health.

In 1833 the first Medical School was founded, and in 1840 some groups of workers organized groups called Mutual Relief Societies (SSM) to provide protection against accident, illness, disability or death of their members. On the other hand, in 1891 the Superior Council of Public Hygiene and the Institute of Hygiene were created by law, in addition to making the municipalities responsible for public hygiene and the sanitary status of their communes.

In 1918 the first Sanitary Code was issued and in 1924 the Ministry of Hygiene, Assistance and Social Welfare and the [35] Compulsory Workers' Insurance[36] were created by law, both legal frameworks established the mandatory monthly contribution by workers and employers in order to contribute to a solidarity fund for illness and disability, in addition to involving the State in the provision of health care and social security for workers.

In 1938 the Law on Preventive Medicine was passed. In 1942, the National Medical Service for Employees (SERMENA) and the General Directorate for the Protection of Children and Adolescents (PROTFINA) were created.

In 1952, Law No. 10,383[37] created the National Health Service (SNS) whose responsibility was to carry out all health actions for the promotion of health, disease prevention, cure and rehabilitation. In the SNS, the Caja del Seguro Obrero, PROTFINA and the Municipal Medical Services were merged.

In 1959 the Ministry of Hygiene, Assistance and Social Welfare was divided into two ministries through Decree with Force of Law No. 25[38] that created the Ministry of Labor and Social Welfare and the Ministry of Public Health with its corresponding undersecretariat. The new Ministry of Health was in charge of carrying out the functions of programming, coordination and control in matters of public health, and in its dependence were the following entities: (i) The National Health Service; (ii) The National Medical Service for Employees; (iii) The Sociedad Constructora de Establecimientos Hospitalarios; and (iv) La Polla Chilena de Beneficencia.

During the decade of the 60s, important social reforms were carried out aimed at investments in health centers, the increase of the civil service in public health and the extension of the geographical coverage of the National Health Service.

Between 1970 and 1973, state health services were improved and a single social security system was created. However, the sustained progress of public policy in health was abruptly interrupted by the civic-military dictatorship (1973 and 1988), causing an institutional breakdown that weakened public health policies. In counterbalance, non-governmental organizations emerged that responded to the health needs of the population not covered by the State, in addition to promoting the adoption of the Alma Ata

[35] Decree Law No. 131 establishing the Ministry of Hygiene, Assistance and Social Welfare. Source: https://bcn.cl/3dwzb

[36] Law No. 4.054 creating the Workers' Insurance. Source: https://bcn.cl/2ngaz

[37] Law No. 10.383 amending Law No. 4.054 relating to compulsory insurance and creating the National Health Service. Source: https://bcn.cl/2lpr3

[38] Decree with Force of Law (DFL) No. 25 creating the Ministry of Labor and Social Welfare with two undersecretaries and the Ministry of Public Health. Source: https://bcn.cl/2map9

Declaration that in 1978[39] urged all governments, health workers and the international community to promote actions aimed at protecting and promoting the primary health care model as a primary strategy to achieve a better level of health of the population. Peoples.

In 1979, the National Health Services System (SNSS), the National Health Fund (FONASA), the Public Health Institute (ISP) and the National Supply Center (CENABAST) were created. In addition, the administration of health facilities was decentralized and care was organized according to levels of complexity and coverage, through the municipalization of primary care.

A year later, in 1980, the administration and management of the PHC clinics was transferred to the municipalities and the reform of the pension and health system was carried out, which allowed the entry of private insurers into both systems[40]: The Social Security Health Institutions (ISAPRE) and the Pension Fund Administrators (AFP). that survive to this day.

In 1985, Law No. 18,469 was enacted[41], regulating the exercise of the constitutional right to health protection and creating a health benefits system that obliges the health care establishments of the National Health Services System to provide care to those who require it, without payment condition, with some exceptions.

At the same time, during the 80s state universities began the professional training of family doctors for teaching in PHC and there was a growing academic development in family medicine. The universities also supported the creation of Urban General Clinics based on a family health model strategy. In 1989, the National Coordinator of Primary Care Workers in Municipal Health was established.

During the 90s with the recovery of democracy, the Superintendence of Isapre, the [42]Chilean Association of Municipalities (AChM) and the National Confederation of Municipal Health Officials (CONFUSAM) were created. Within this framework, the Primary Care Statute was issued through Law 19,378 and [43] the permanent working group "Tripartite Commission" composed of municipalities, workers and MINSAL was established by Exempt Resolution.

Henceforth, the State adopted the principles of Alma Ata. and made progress in establishing specific objectives for the health system, such as: improving access to the primary level of care; free of charge for the PHC beneficiary population (FONASA); and strengthening actions for health prevention and protection. A new model of care based on the principles of family medicine was conceptualized and universities

[39] In 1978, the World Health Organization (WHO), the Pan American Health Organization (PAHO) and the United Nations Children's Fund (UNICEF) organized the International Conference on Primary Health Care, in which 134 countries and 67 international organizations participated. It established the Declaration of Alma Ata. which points out the importance of primary health care as a strategy to achieve a better level of health for peoples and urges all governments, health workers and the international community to promote actions to protect and promote the primary health care model. Its motto was "Health for All by the Year 2000". Twenty-five years later, PAHO adopted a Renewed Strategy for Primary Care in which it recognizes that PHC is a strategy that significantly reduces health inequities. Then, in 2008, WHO published the report On Health in the World "Primary Health Care, more necessary than ever" where it proposes four normative orientations for PHC: (i) Universal coverage; (ii) People-centered services; (iii) Healthy public policies; and (iv) leadership. September 1978. Source: https://www.paho.org/hq/dmdocuments/2012/Alma-Ata-1978Declaracion.pdf

[40] Decree Law No. 3.626. 1981. From the Ministry of Labor and Social Welfare. Source: https://bcn.cl/3dxqw

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[43] Law No. 19.378 establishing the Municipal Primary Health Care Statute. 1995. Ministry of Health. Source: https://bcn.cl/2f8iv

incorporated curricular innovations to strengthen family medicine training with a focus on PHC, both in undergraduate and graduate training.

With regard to the resolution of complaints and citizen participation, in 1990 through Decree No. 680[44] the Ministry of the Interior approved the establishment of information offices for the user public in the State Administration, including MINSAL. In 1995, the Ministry of Health instructed the creation of Local Development Councils (CDLs) composed of both users and health officials, with the aim of formalizing the participation of communities in the local management of services at all levels of health care.

In 1999, Law No. 19,650 was enacted,[45] which perfected health regulations and guaranteed that persons suffering from serious or vital health emergencies could be treated in any public or private health establishment without being denied care or demanding any payment. This law also establishes a legal loan that allows beneficiaries to finance the vital emergency care received in the health center from admission until its stabilization.

In the 2000s, a reform of the health system was carried out that established the responsibility of the State to guarantee equitable access to health, of high quality and resolutiveness, financial protection in events of illness and greater citizen participation for the population, incorporating the concept of quality as an axis associated with results.

In the legal framework, this reform considered:

1. A law that allows the financing of social policies through the increase of the Sales and Services Tax (VAT) and other specific taxes, and that in the case of Health guarantees the financing of the Health Plan with Explicit Guarantees (AUGE) for FONASA beneficiaries[46];
2. A law that establishes various rules of solvency and protection of persons incorporated into social security health institutions, pension fund administrators and insurance companies[47];
3. A law that creates the Superintendence of Health and the Undersecretariat of Healthcare Networks, and that creates new management instruments for the Care Network, with greater powers for the managers of health facilities, as well as financial incentives for staff[48];
4. A law that establishes a mandatory health plan for FONASA and the ISAPRE (the Guarantee Regime or AUGE Plan), consisting of diagnostic confirmation benefits and standardized treatments for a set of diseases prioritized for their high health and social impact, and that defines explicit and enforceable guarantees of access, opportunity, quality and financial coverage (GES)[49]; and a law that, among other matters related to the operation of the ISISA SystemRegulates the process of

[44] Decree No. 680 Approves Instructions for the Establishment of Information Offices for the Public Users in the State Administration. 1990. Ministry of the Interior. Source: https://bcn.cl/38siw

[45] Law No. 19.650 on Improving Health Regulations. 19 November 1999. Ministry of Public Health. Source: https://bcn.cl/2gwzz

[46] Law No. 19.888 Establishing the Financing Necessary to Ensure the Government's Priority Social Objectives. 2023. Ministry of Finance. Source: https://bcn.cl/3dxrb

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[48] Law No. 19,937 that Establishes a New Conception of the Health Authority, Different Management Modalities and Strengthens Citizen Participation. 2004. Ministry of Health. Source: https://bcn.cl/2f7j5

[49] Law No. 19.966 establishing a Health Guarantee Regime. 2004. Ministry of Health. Source: https://bcn.cl/2fckl

annual adaptation of contracts, price increases, factor tables and establishes the Solidarity Compensation Fund for the GES among the I[50]ISAPRE

In 2012, Law No. 20,584 was enacted[51], which regulates the rights and duties that people have in relation to actions related to their health care, and which establishes the obligation of all health providers, public or private, to inform their patients in a timely manner about their rights and duties; as well as the right of patients to the protection of their medical information, to be treated with dignity, regarding their privacy, to receive quality and safe health care, and to accept or refuse any treatment, among others.

In 2014, the Sanitary Code was modified in terms of regulation of pharmacies and medicines through Law No. 20,724, [52] which establishes that the medical prescription must include the prescription drug and its bioequivalent. In addition, medicines may be sold by unit and their value must be clearly indicated at the points of sale, among other provisions.

In 2015, Law No. 20,850 was enacted,[53] which creates a financial protection system for high-cost diagnoses and treatments and covers all people who contribute to a social security health system.

Some of the public policies on guaranteeing equitable access to health in recent decades include:

1. The guarantee of access in the primary care network to the preventive and curative benefits considered in the Health Code for all persons living in the national territory, regardless of their health insurance system.
2. The Chile Crece Contigo program accompanies children who are treated in the public health system, from the first prenatal check-up, to entering the school system in different areas, such as: health, education, family conditions, neighborhood and community.
3. The Explicit Health Guarantees (AUGE/GES) regime that grants financial protection and guarantees access, opportunity and quality for more than 80 pathologies to patients regardless of their health insurance system.
4. The High-Cost Diseases and Treatments Financial Protection Act that guarantees financial protection for high-cost diagnoses and treatments to patients regardless of their health insurance system.
5. The Special Program for Health and Indigenous Peoples, created in 2000 in order to fulfil the mandate of Law No. 20,584, which regulates the rights and duties of patients and which explicitly states that "public institutional providers must ensure the right of persons belonging to indigenous peoples to receive culturally relevant health care". To this end, MINSAL created intercultural centres with language facilitators and has trained intercultural facilitators in the regions of Arica and Parinacota, Iquique and Antofagasta (for Aymaras), in the Metropolitan Region of Santiago (for migrants), Biobío, Araucanía and Los Lagos (for Mapuche).

[50] Law No. 20.015 amending Law No. 18.933 on Social Security Health Institutions. 2005. Ministry of Health. Source: https://bcn.cl/2hmko

[51] Law No. 20,584 regulating the rights and duties of individuals in relation to actions related to their health care. 23 April 2012. Ministry of Public Health. Source: https://bcn.cl/2f7cj

[52] Law No. 20,724 amending the Health Code on the Regulation of Pharmacies and Medicines. 30 January 2014. Ministry of Public Health. Source: https://bcn.cl/2om64

[53] Law No. 20,850 that creates a financial protection system for high-cost diagnoses and treatments and that pays posthumous tribute to Mr. Luis Ricarte Soto Gallegos. June 1, 2015. Ministry of Public Health. Source: https://bcn.cl/2fpjz

In 2018, Chile signed the Astana Declaration[54], which establishes commitments in four key areas of primary care: (i) making bold policy decisions for health in all sectors; (ii) building sustainable primary health care; (iii) empower individuals and communities; and (iv) align stakeholder support with national policies, strategies and plans.

Currently, the Health Sector faces the challenge of guaranteeing dignified, safe, timely and quality access to the entire population regardless of their health insurance system.

[54] Astana Declaration. 2018. World Health Organization (WHO), United Nations Children's Fund (UNICEF) Source: https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration-sp.pdf?ua=1

Social and Economic Context in Chile: Pre and Post Pandemic by COVID-19

In the last three decades Chile has enjoyed a strong economic dynamism, where poverty measured by income fell precipitously and the country today has one of the lowest poverty rates in Latin America. Similarly, per capita income has more than doubled and is among the highest in the region. In 2013 Chile was the first country in Latin America to reach a high income status.

At the global level, the United Nations Special Report 2022 on New Threats to Human Security [55]points out that even though in 2019 the world had reached unprecedented levels in the Human Development Index, six out of seven people feel insecure in terms of being able to meet their basic needs, protect their physical integrity and their human dignity. This is explained by the fact that in recent decades the approach to development has been oriented towards economic growth and territorial security, instead of focusing on human security that[56] seeks to guarantee a life without fear, without want and with dignity for all.

Paradoxically, despite the fact that economic and welfare indicators point to positive growth rates for the region and for Chile in particular, according to the World Bank report Poverty and Shared Prosperity 2022[57], the income gap between the richest and poorest in the region was 27 times, while in Chile it was 29 times. In addition, the World Bank's 2022 Global Inequality Report[58] notes that economic inequality in Chile has been extreme for the past 120 years. One of its conclusions is that half of the population in Chile earns only 10% of the country's total income, while a tenth of the population receives almost 60%.

According to the Latinobarómetro 2021 Report[59], social demonstrations in Chile in 2019 were triggered, among other factors, by socioeconomic inequality, political discontent with the Government and the citizen demand for greater guarantees in various aspects around social security. In the measurement, Chile was the country in the region with the lowest regional average on perception of social security guarantees, also presenting the highest perception of social inequality.

During the 2010s, health demands were related to unreasonable waiting times in the public system, untimely care, undignified treatment, high costs in health and medicines, as well as with the inequities caused by the coexistence of two health affiliation systems: one public and one private, whose standards of care and infrastructure present differentiating elements.

[55] Special Report 2022 The New Threats to Human Security. UNDP. 2022 Source: https://reliefweb.int/sites/reliefweb.int/files/resources/Informe%20Especial%202022%20-%20Las%20nuevas%20amenazas%20para%20la%20seguridad%20humana%20en%20el%20Antropoceno%20exigen%20una%20mayor%20solidaridad%20%28Panorama%20General%29.pdf

[56] Human Security. Paragraph 143 of the 2005 Summit Outcome, resolution 6'/1. United Nations General Assembly. Source: https://www2.ohchr.org/spanish/bodies/chr/docs/wsoutcome2005_sp.pdf

[57] Poverty and Shared Prosperity. 2022. World Bank. Source: https://www.worldbank.org/en/publication/poverty-and-shared-prosperity

[58] Word Inequality Report 2022. Source: https://wir2022.wid.world/

[59] 2021 Report Corporación Latinobarómetro. Source: https://www.latinobarometro.org/lat.jsp?Idioma=0&Idioma=0#:~:text=Informe%20Latinobar%C3%B3metro%202021

Already in 2015, the Study of Health Users regarding the Law of Rights and Duties[60] of the Superintendence of Health, indicated that the rights of the patient were perceived by the users as an enforceable standard, but that it is usually not fulfilled. 65% of the people interviewed considered that PHC facilities do not contribute positively to the respect of patients' rights, and 64% considered the same in the case of public hospitals. The most important thing for users was to be treated with dignity, in a timely manner, with an understandable language and through safe and quality care. The research also indicates that poor, immigrant, indigenous, rural residents and older people are the worst treated in health care.

The social crisis of October 2019 was followed by the COVID-19 pandemic that forced countries to decree severe measures to control contagion. The social and economic effects of the Pandemic are overwhelming from every point of view: economic, educational, labor, cultural and health, and are palpable to this day.

In Chile, as in other countries, the economic contraction was reflected in the decrease in the Gross Domestic Product, which according to the March 2021 Monetary Policy Report[61] decreased by 5.8% during 2020. Employment levels also fell to levels seen only in the economic crisis of the 80s. According to the first round of the COVID-19 Social Survey of July 2020[62] of the Ministry of Social Development and Family, if in 2019 the percentage of employed people was 57.9% in June 2021 it was 48.6%. The most affected households were those belonging to the two lowest quintiles and those with female heads of household. According to World Bank estimates, the incorporation of women into the labor force fell in 10 years as a result of the Pandemic. On the other hand, the prolonged closure of schools caused a setback equivalent to 1.3 years of schooling.

In addition to the number of people who died from COVID-19, during the first two years of the pandemic thousands of people saw acute or experienced mental health problems for the first time. According to the sixth round of the Mental Health Thermometer in Chile 2022[63], conducted by the Catholic University and the Chilean Security Association, 51% of people thought their life was quite or completely different from what they had before COVID-19. 13.9% had moderate or severe symptoms of depression, and between 20.6% and 21.6% of people with one or more chronic health conditions suspected mental health problems.

In 2020, the expectation of a substantial improvement in the public health system that addressed structural inequities was reflected as one of the main citizen priorities in the public consultation carried out between September and October of the same year by the campaign team of the then candidate for the presidency of Chile, Gabriel Boric Font. who embodied in his Government Program I approve Dignity the intention to carry out four fundamental reforms during his government, including: A health reform that guarantees universal access to public health through the development of an intersectoral health strategy at the local level, based on the primary care system, capable of ensuring universal access and zero discrimination in the public health network, and whose design will be focused on people and communities. To this end, he proposed measures aimed at modernizing health management, improving accessibility to the public health system and the efficiency of public spending in this area.

[60] 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

[61] Monetary Policy Report (IPOM) March 2021. Central bank. Source: https://www.bcentral.cl/contenido/-/detalle/informe-de-politica-monetaria-marzo-2021-1

[62] First round Covid-19 Social Survey. July 2020. Ministry of Social Development and Family. Source: https://observatorio.ministeriodesarrollosocial.gob.cl/encuesta-social-covid19-primera-ronda

[63] Sixth round Mental Health Thermometer in Chile. 2022. UC-ACHS. Source: https://www.achs.cl/docs/librariesprovider2/noticias-2022/achs-149852/tms-rond-6-conferencia.pdf

By 2023, the effects of the Pandemic on public health persist and have deepened the gaps previously detected. The 2020 health crisis led to the suspension of thousands of elective surgeries in order to prioritize the use of beds in COVID-19 patients. According to statements by the Minister of Health, Dr. Ximena Aguilera[64] made almost a year after the administration of President Gabriel Boric, during 2020 and 2021 the average wait, both for surgeries and for consultations with specialists, was 700 days. By the beginning of 2023, that average had dropped to 400 days of waiting. Currently, waiting lists in the public health system remain long and difficult to overcome despite the injection of $35 billion pesos made by the Government between 2022 and 2023 to improve hospital care.

In addition, so far in 2023 the public debate on health has revolved around the mechanism that the Executive must design to comply with the ruling of the Third Chamber of the Supreme Court on[65] the obligation for private health insurers: ISAPRE, to use the table of risk factors prepared by the Superintendence of Health (SS) in 2019 for the collection of their benefits and whose compliance should cause the Return of surpluses charged to its contributors from 2020 onwards.

In this scenario and in response to the short bill presented by the Executive to Congress in May 2023[66], the Association of ISAPRE of Chile (AICH) has declared that the short bill has no feasibility and that its fulfillment will force the transfer of more than three million people to FONASA[67].

In summary, if before the COVID-19 Pandemic Chile already showed high rates of socioeconomic inequality that are complex to overcome, such as access to social security and basic quality benefits in health, education and pensions, during the three years after the Pandemic the social and economic gaps deepened even more, particularly affecting women, children, adolescents, the elderly and, in general, the groups called for special attention (GEA) in addition to people in poverty.

[64] Minister Ximena Aguilera on waiting lists: "We hope to recover the production of a pre-pandemic year this year." February 9, 2023. The counter. Source: https://www.elmostrador.cl/dia/2023/02/09/ministra-ximena-aguilera-sobre-listas-de-espera-esperamos-recuperar-la-produccion-de-un-ano-prepandemico-este-ano/

[65] Ruling of the Third Chamber of the Supreme Court on undue charges by ISAPRE to their members. November 2022. Source: https://www.pjud.cl/prensa-y-comunicaciones/noticias-del-poder-judicial/83477

[66] Timeline of the bill cuts in the Senate. Source: https://www.senado.cl/definen-cronograma-tentativo-para-tramitar-ley-corta-de-ISAPRE

[67] Public statement of the Association of ISAPRE of Chile on the short bill on IsapresISAPRE in May 2023 to the Parliament to comply with the ruling of the Third Chamber of the Supreme Court on charges to ISAPRE affiliates. Source://www.isapre.cl/images/PDF/Declaracion_AGICH_11052023.pdf

Government Program 2022 to 2025: Reform of the National Public Health System

The health reform that guarantees universal access to public health is one of the four structural reforms proposed in President Gabriel Boric's Government Program Apruebo Dignidad[68] for the period 2022 - 2025. Its inclusion in the Government Program is based on the results of a citizen consultation, carried out between September and October 2021 by the citizen participation team of the then candidate, in which 33,728 people participated, in person and remotely, through 603 citizen tables: in 80 communes of the country (21% of the total of communes) and 14 tables abroad. The main categories proposed by citizens to be included in the Program were: Public education (15.5%); public health (11.4%); economic recovery (10.4%); human rights (10%) and climate crisis (8.8%), with Public Health being the programmatic axis that obtained the third place in the programmatic prioritization at the national level, with the exception of the regions: Tarapacá, Antofagasta, Maule, Los Ríos and Los Lagos that did not prioritize this category among the first three places.

The Program 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, and whose design will be centered on people and communities. To this end, it proposes measures aimed at modernizing health management, improving accessibility to the public health system and the efficiency of public spending in this area.

Universalization of Primary Care: In general, the Program recognizes the structural gaps of the public health system: such as waiting lists and number of waiting days, as well as the gaps left by the first two years of the COVID-19 Pandemic, and proposes as one of its public health goals the strengthening of the Primary Care system, which it recognizes as the heart of the public health system, guaranteeing access to PHC to 100% of the population and reactivating the Primary Health Care system through: (i) the implementation of a digital health strategy that integrates all levels of care and that at the primary care level allows virtual scheduling and remote access to PHC benefits through digital tools such as teletriage; (ii) the implementation of a comprehensive care model centered on people in the context of multimorbidity; (iii) updating and strengthening the Family Health Plan as a key element in the prevention, control and early detection of diseases.

This reactivation will be accompanied by a comprehensive strategy in the management of the public health network in order to improve the time spent on waiting lists and to provide people and their families with active accompaniment in the transit from Primary Health Care to the secondary and tertiary levels of care. In addition to establishing public criteria for clinical prioritization and maximum waiting times according to the level of risk of the pathologies, among other measures.

Priority in mental health strategies: The Program contemplates the strengthening of the mental health component in PHC, through the strengthening of the coverage of the Psychosocial Accompaniment Program in PHC. In addition, the Program makes special mention of the inter-institutional strengthening of mental health programs for children and adolescents through: The strengthening and expansion of the Chile Crece Contigo Program of the Ministry of Social Development and Family; A new program in the Ministry of Education called the Social-Emotional Well-Being Program for educational communities; and a Mental Health Training Plan, with a human rights and gender perspective, for health teams with an

[68] 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

emphasis on improving the accessibility and acceptability of mental health services for populations belonging to gender diversities, with a focus on adolescents and young people.

The Program also mentions the design of a communication strategy that tends to reduce the stigma and discrimination that is usually associated with mental health treatment, in addition to strengthening work with the National Care System and designing comprehensive programs that address mental health in women, children and adolescents and gender diversities who suffer gender violence.

Territorial and cultural relevance: rurality and intercultural health:

Based on the National Rural Development Policy 2014 - 2024[69] by the Interministerial Commission on Citizenship, Housing and Territory, the Program proposes to address the historical inequalities faced by those who live in rural territories in terms of guaranteeing access to basic social services, such as: education and health, through the prioritization of investment in equipment and infrastructure to improve accessibility to health services in rural areas. rural areas.

In the area of intercultural health, the Program proposes: (i) The creation of a national system for monitoring health inequities for indigenous and tribal peoples; (ii) The design of a National Plan for Intercultural Education for all workers in the public health system; (iii) The redesign of the Special Program for Health and Indigenous Peoples (PESPI) in accordance with the provisions of Convention No. 169 of the International Labour Organization (ILO) through PHC; (iv) The incorporation of autonomous intercultural health initiatives, going beyond the current funding based on DFL No. 36 of 1980; (v) Guarantee of health care for migrants in an irregular migratory situation, in accordance with Decree No. 67 of the National Health Fund (FONASA) and the Health Policy for International Migrants of MINSAL; and (v) the availability of Creole/Spanish interpreters in those centers with the highest percentage of Haitian population.

Status of progress of the 2023 public health reform project

According to statements by President Boric in December 2022[70], it is estimated that the health reform bill will be presented to Congress in late 2023 or 2024. However, the project addresses the challenge of rethinking the public health care model, strengthening the role and binding participation of the community, putting people and their diversities at the center of the care model, in order to achieve equity in health and universal access, through four axes:

1) Dignification and modernization of the public health system through the use of different digital technologies.
2) Universalization of Primary Care aiming to improve efficiency, equity and health outcomes of the population, establishing PHC as a strategy that accompanies people throughout their lives, expanding access to the population that is not currently a beneficiary of FONASA.
3) Address the social determinants that affect people's health condition.
4) Creation of a Single Health Fund (FUS) in order to generate a universal floor through a fund of all social security resources and from that floor, distribution to providers based on risk.

[69] National Rural Development Policy 2014 – 2024. Source: https://www.odepa.gob.cl/wp-content/uploads/2018/10/Poli%CC%81tica-Nacional-de-Desarrollo-Rural.pdf

[70] Interview with President Gabriel Boric on radio Sonar, minute 19:30. December 19, 2022. Source: https://www.t13.cl/noticia/politica/presidente-boric-reforma-salud-fines-proximo-ano-19-12-2022

Advances in health during the Government of President Gabriel Boric 2023

According to what was reported in the 2023 public account of President Gabriel Boric, some of the advances in public health are:

1) Zero co-payment for FONASA users of sections C and D, which represents around five million people.
2) Development of 76 conservation projects in rural posts of 37 communes of the country.
3) Creation and implementation of the National Registry of Caregivers that grants preferential access to different public services, including health.

Likewise, some of the commitments and announcements in the field of health announced in the public account 2023 are:

1) ISAPRE bill: to find solutions to responsibly comply with the ruling of the Supreme Court, which obliges private health insurers (ISAPREstar their plans to the table of factors and return the surpluses charged to contributors, without jeopardizing the benefits to families or promoting a pardon to the ISAPRE.
2) Investment of seven billion pesos in rural posts, to be executed between 2023 and 2024, which will be extended in the following years.
3) Investment in mental health to build 30 Community Mental Health Centers in the country during the period of President Gabriel Boric's administration (from 38 to 68).

Table of activities defined by the Ministry of Health for the Universalization of Primary Health Care. 2023

The following table describes the activities envisaged by the Ministry of Health for the Universalization of Primary Health Care. These are organized through strategic areas and lines defined by MINSAL and linked to the three result areas proposed by the World Bank in the Program for Results called Chile: Program for Universal Coverage of Primary Health Care and Resilience, which aims to support improvements in three result areas: (i) the coverage and quality of primary health care, (ii) the contribution of primary health care to the resilience of the health system, and (iii) the efficiency of financing primary health care.

Board 11 of Activities for the Universalization of PHC defined by MINSAL by PforR Result Area

Area and Strategic Line Defined in the Government Program	Activities Defined in the Government Program	Results Areas (RA) World Bank Program for Results
Strategic Area 1: Expand effective coverage through PHC optimization		
1: Introduction of digital tools for online appointment management	A. Analysis of technical, clinical and regulatory guidelines in Chile and in the world related to prioritized care. B. Analysis of effective capacity and institutional arrangements for online appointment management C. Development of technical guidelines for health services and primary health care at the municipal level. D. Establishment of registration, monitoring and evaluation of compliance with this guarantee in PHC establishments. E. Design and development of a platform that establishes the prioritization of care based on the characteristics of patients. F. Development and dissemination of protocols for the use of the platform.	**Expand coverage and quality of care at the primary health care (RA 1) level**
2: Expansion of service delivery by extending operating hours	A. Generate new technical guidelines and control tools to define the services provided during extended hours.	Expand coverage and quality of care at the primary health care (RA 1) level
3: Development of a platform for agenda management (optimization of supply and demand)	A. Develop a technical basis to build a platform for agenda management by integrating demand and supply information from APS.B. Call for proposals to develop a platform for agenda management.C. Platform development, including pilot testing. D. Development of guidelines for the use of the visualization and monitoring platform. E. Evaluation of the implementation of the platform.	Expand coverage and quality of care at the primary health care (RA 1) level
4: Developing a communication plan	A. Communication campaign to inform the population about the possibility of registering in PHC establishments.B. Implementation of a multiplatform communication campaign (TV, social networks, internet platforms, etc.)	Expand coverage and quality of care at the primary health care (RA 1) level
5: Expanding service delivery through telemedicine	A. Generation of technical guidelines to implement telemedicine in PHC.	Expand coverage and quality of care at the primary health care (RA 1) level

6: Purchase of mobile clinics	A. Design of technical bases for the tender for the purchase of mobile clinics .B. Management of health services and the Ministry of Health for the purchase of mobile clinics.C. Generate technical guidelines for the use of mobile clinics. D. Review and recording of PHC activities in mobile clinics.	Expand coverage and quality of care at the primary health care (RA 1) level
7: Review and define standards for hours of attendance and non-attendance of primary health care teams to develop technical guidance for other PHC teams	A. Conducting an analytical study on the distribution of hours of professional and non-care care in PHC facilities. B. Development of recommendations based on study findings. C. Dissemination of findings to key stakeholders.D. Generate recommendations for municipalities on the balance between hours of attendance and non-attendance.	Expand coverage and quality of care at the primary health care (RA 1) level
8: Integration of health and social services in a "one-stop-shop" mode	A. Survey on the requirements for integrating health information into a "one-stop-shop" modality. B. Establish a working group with the MDSF to develop the integration of the health module into the "one-stop shop" modality. Implementation of a pilot project of the "one-stop shop" modality. D. Evaluate the pilot process and plan implementation. Implementation at the national level of the "one-stop shop" modality. F. Evaluation of the implementation of the "one-stop shop" modality.	Expand coverage and quality of care at the primary health care (RA 1) level
9: Development of instances of reflection, participation and design of strategies to improve the user experience of PHC (Citizen Dialogue)	A. Design and validation of an instrument to measure user experience. B. Design and testing of the application to measure the user experience. C. Development and dissemination of protocols for the use of the application. D. Generation of a user guide for APS equipment.	Expand coverage and quality of care at the primary health care (RA 1) level
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**
10: Development of a plan to improve the user experience in APS contact channels	A. Generation of technical guidelines to support local teams in the development of plans to improve the multichannel user experience. B. Approval of the plan by the Health Services. C. Preparation of annual evaluation reports of the plan.	Expand coverage and quality of care at the primary health care (RA 1) level
Strategic Area 2: Making PHC more resilient		
11: Trained teams for health emergencies	A. Development of the training program for public health emergencies in primary health care, considering the lessons learned from COVID-19.	Resilient APS (RA 2)

12: Development and implementation of surveillance processes (pandemic, environmental and social surveillance)	A. Design of an epidemiological and environmental surveillance model. B. Development of community policing plans based on the national model. C. Oversee the implementation of community policing plans.	Resilient APS (RA 2)
13: Local strategies for environmental health	A. Generate technical guidelines for local teams to facilitate the development of plans. B. Development of adaptation plans with measures to strengthen the resilience of primary care in municipalities. C. Approval of adaptation plans by the Health Services. D. Implementation of approved adaptation plans. E. Evaluate the implementation of adaptation plans.	Resilient APS (RA 2)
14: Development of APS infrastructure standards (easy to build, maintain, energy efficiency, etc.)	A. Create an intersectoral roundtable with different government agencies to develop a PHC infrastructure in all neighborhoods. B. Study on the state of infrastructure at the national level. C. Development of a professional technical profile for specialization in health infrastructure (Chile Valora)	Resilient APS (RA 2)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**
Strategic Area 3: Improve the health and socio-health model, with dignity and quality for the territory		
15: Strengthening and implementation of the integrated health and social assistance model (ECICEP)	A. Evaluation of the implementation of the ECICEP strategy in pilot centers. B. Publication of a report with recommendations to strengthen the strategy and its implementation. C. Elaborate on the scalability of the ECICEP strategy at the national level. Monitoring and implementation of measures at ministerial level to expand the ECICEP strategy. D. Implementation of the scalability plan: distribution of resources and strengthening of the strategy at the community and health facility levels.	Expand coverage and quality of care at the primary health care (RA 1) level

16: Creation and implementation of a risk stratification strategy for the health of the Chilean population.	A. Study with national clinical and health data to test variables to be considered in the new risk stratification. B. Generation of a mechanism to process data as stratification. C. Evidence of the new stratification with developments of electronic health record providers. D. Start of a scalable implementation of the new stratification in the electronic medical record of primary care.	Expand coverage and quality of care at the primary health care (RA 1) level
17: Development of strategies to promote family and social health (gender approach)	A. Adaptation and validation of a test to detect gender-based violence. B. Development of a test for the detection of gender-based violence. C. Development and dissemination of protocols for an application to detect gender-based violence. D. Generate a guide for use by primary health care teams, available at all levels of governance (Ministry of Health, Health Services, municipalities, facilities). E. Piloting the test for the detection of gender violence.	Expand coverage and quality of care at the primary health care (RA 1) level
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**
18: Development of strategies to promote family and social health	A. Design, adaptation and validation of mental health screening tests. B. Design and test a mobile application for mental health screening. C. Development and dissemination of protocols for such application. D. Generate a guide for use by primary health care teams.	Expand coverage and quality of care at the primary health care (RA 1) level

19: Review and optimization of the family health plan II based on PRAPS	A. Study on the Health Value Benefits of the Family Health Plan II. B. Preparation of a proposal to update the family health plan II. C. Review and propose a modification of the indicators associated with the updated Family Health Plan II. D. Develop a methodological proposal to periodically update the benefits of the family health plan. E. Update of the basket of benefits of the family health plan and publication of the modification (decree per capita)	Expand coverage and quality of care at the primary health care (RA 1) level
20: Integration of social care with other sectors (such as SENAME)	A. Identification of integration possibilities and characterization of the social and health care provided. B. Plan intersectoral work at central and local levels to implement health and social care programs. C. Plan and modify programs implemented in centers that are part of the social network. D. Updating or developing technical guidelines for the integration of health and social care with other sectors. E. Implement new programs or change existing ones. F. Plan the integration of information and health services into the local social management platform. G. Implement the integration of information and health services in the local social management platform.	Expand coverage and quality of care at the primary health care (RA 1) level
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**
21: Development of institutional arrangements/standards for shared network governance	A. Review of models in countries with an integrated health network. B. Propose institutional arrangements for shared governance of the network. C. Regulatory and/or legal modifications of the institutional arrangements for the governance of the shared network. D. Evaluation of institutional arrangements (proposed changes; results).	Expand coverage and quality of care at the primary health care (RA 1) level

22: Design and implementation of patient network navigation offices	A. Planning of the model for the offices of navigation of the patient network based on national and international experiences. B. Modification of platforms and/or information systems to achieve interoperability (must be scalable at national level).	Expand coverage and quality of care at the primary health care (RA 1) level
23: Creation of a network of specialists integrated into the PHC network	A. Development of an integration plan for PHC specialists that includes the technologies necessary for their performance. B. Design of a model for the integration of PHC specialists in the health care network.	Expand coverage and quality of care at the primary health care (RA 1) level
Strategic Area 4: Optimize resources and implement a performance monitoring and evaluation framework that supports the PHC strategy		
24. Ensure connectivity of primary health care	A. Definition of standard requirements (human resources, physical resources, training, equipment) to ensure connectivity in primary care. B. Evaluation of the implementation process and effectiveness of the connectivity plan in pioneering communes.	Efficiency (RA 3)
25. Creation of a technical guideline for data governance to ensure the quality, timeliness and relevance of the data obtained	A. Formation of a working group with key stakeholders involved in electronic health record processes to discuss the objectives, scope, and implementation of data governance policy to ensure data reliability. B. Analysis of existing gaps in data quality in primary care. C. Generation of technical guidelines that constitute the starting point of a data governance policy to be disseminated to primary care teams. D. Evaluation and monitoring of compliance with technical guidelines on data governance in primary care.	Efficiency (RA 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**
26. Development of interoperability between the care levels of the network	A. Develop an interoperability pilot plan. B. Definition of the conditions (human resources, physical resources, etc.) necessary for the development of interoperability in the pilot communities. C. Implementation and evaluation of an interoperability pilot plan. D. Development and implementation of an interoperability plan at the national level, incorporating the lessons learned from the pilot phase. E. Evaluation of the implementation process and the effectiveness of the interoperability plan at the national level.	Efficiency (RA 3)

27. Implementation of an M&E system of social determinants of health	A. Study of available and relevant information for the evaluation of social determinants. B. Generate a technical basis for the construction of a platform for visualization and monitoring of social determinants. C. Development of the platform for visualization and integration of databases for the monitoring system of social determinants. D. Development of user guidelines for the platform for visualization and monitoring of social determinants. E. Training of teams in the use of the platform for visualization and monitoring of social determinants.	Efficiency (RA 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**

28. Development of a framework for monitoring PHC results	A. Analysis of the indicators available in the PHC and selection of those that allow an exhaustive evaluation and monitoring of PHC performance. B. Generate the technical basis to build a database visualization and integration platform for the PHC monitoring framework. C. Development of the database visualization and integration platform for the APS performance results monitoring framework. D. Drafting guidelines for the primary care performance results framework visualization platform. E. Training of teams to use the visualization platform of the primary care performance monitoring framework.	Efficiency (RA 3)
29. Creation and implementation of an entity to safeguard the quality of PHC performance	A. Establish the basis and structure of an institution that guarantees quality in primary care. B. Determine the financing of this action and define what costs are covered by which institutions. C. Prepare the bill for the formation of an institution that ensures the quality of primary care.	Efficiency (RA 3)
30. Development and definition of clinical HR standards and general management for PHC establishments.	A. Proposal to adjust PHC funding based on human resource needs and gap reduction. B. Financial impact study for compliance with PHC human resources standards C. Formation of a working group with intra and extra MoH actors for the review and validation of the standards. D. Development of recommendations for human resources standards in clinical functions. Analysis of the status of existing human resources regulations.	Efficiency (RA 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**

31. Development and definition of equipment standards for APS installations.	A. Analysis of the status of current equipment standards. B. Development of team recommendations based on the findings of the analysis. C. Generation of guidelines for the design and maintenance of equipment, based on the findings of the analysis. D. Dissemination of the guidelines for the provision and maintenance of equipment in the different lines of governance. E. Facility standardization plan for compliance with equipment maintenance standards F. Execution of the equipment maintenance standardization plan. G. Evaluation of the equipment maintenance standardization plan.	Efficiency (RA 3)
32. Development and definition of infrastructure maintenance standards for APS facilities.	A. Infrastructure maintenance generation guide. B. Dissemination of infrastructure maintenance guidelines in the different lines of governance. C. Standardization plan of facilities for compliance with infrastructure maintenance standards. D. Evaluation of the infrastructure maintenance standardization plan.	Efficiency (RA 3)
33. Redesign of per capita payments and payment mechanism based on health risk	A. Analysis of the per capita payment mechanism. B. Proposal for a per capita payment plan and associated institutional framework. C. Preparation of a new per capita decree incorporating the findings of the analysis	Efficiency (RA 3)
34. Analysis and reconfiguration of health care delivery	A. Analytical study on resource delivery processes in PHC. B. Redesign of the resource allocation process in PHC. C. Implementation of the redesign of the PHC accountability process. D. Evaluation of the implementation of the redesign of the resource accountability process in PHC.	Efficiency (RA 3)
Area and Strategic Line Defined in the Government Program	**Activities Defined in the Government Program**	**Results Areas (RA) World Bank Program for Results**

35. Analysis of the municipal contribution to the financing of primary care in the territories	A. Analytical study on the municipal contribution to PHC financing. B. Preparation of suggestions and recommendations based on the results of the analytical study. C. Dissemination of the results of the study and suggestions generated on the municipal contribution to primary care among stakeholders. D. Generation of recommendations for municipalities	Efficiency (RA 3)
36. Review, analysis and redesign of payments associated with human resources in PHC (Article 45, Law 19,378)	A. Analytical study on payments associated with human resources within the framework of Law 19.378 B. Preparation of suggestions and recommendations based on findings. C. Dissemination of the results of the study and suggestions generated on the municipal contribution to primary care among the actors D. Analysis of possible legislative and regulatory changes related to the payment associated with human resources. E. Implementation of the necessary legislative and regulatory modifications to adjust the payments associated with human resources.	Efficiency (RA 3)
37. Establishment of a leadership school for managerial and budget execution skills	A. Identification of specific contents for the training of municipal managers. B. Creation of a high-level leadership program for primary care. C. Establishment of the training procurement mechanism. D. Implementation of the High Level Leadership School for Primary Care	Efficiency (RA 3)
38. Development of standards for PHC facility infrastructure that should be in place to achieve progressive health care for the population and reduce the health care gap.	A. Analysis of the state of current infrastructure and sustainability standards B. Creation of an intersectoral technical working group. C. Preparation of recommendations based on the results of the analysis and the working group. D. Generation of a proposal for a new Medical Architecture Program.	Resilient APS (RA 2)
39. Development and definition of infrastructure maintenance standards for APS facilities.	A. Analysis of the status of current infrastructure maintenance standards. B. Development of infrastructure maintenance recommendations based on the findings.	Efficiency (RA 3)

International Standards on Human Rights, Health and Primary Health Care that Chile has signed

Board 12 Treaties and other international standards signed by Chile in the area of human rights and health

Guy	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 5In fulfilment of the fundamental obligations set forth in article 2 of the present Convention, States Parties undertake to prohibit and eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, particularly in the enjoyment of the following rights:[...] (e) Economic, social and cultural rights, in particular:[...] (iv) **The right to public health, medical care, social security and social services**; [...]
International Treaty	International Covenant on Civil and Political Rights	1969	1972	
International Treaty	International Covenant on Economic, Social and Cultural Rights	1969	1972	Article 121. 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.** 2. The measures to be taken by States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) Provision for the reduction of the stillbirth rate and infant mortality and for the healthy development of the child;(b) The improvement of all aspects of environmental and industrial hygiene;(c) Prevention, the treatment and control of epidemic, endemic, occupational and other diseases; (d) **The creation of conditions that ensure medical service and medical care for all in case of illness.**
International Treaty	Convention on the Elimination of All Forms of Discrimination against Women	1980	1989	Article 121. 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.2. Notwithstanding paragraph I of this article, States Parties **shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period**, providing free services where necessary, as well as adequate nutrition during pregnancy and lactation.
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in Health**
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	Article 241. States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to services for the treatment of illness and rehabilitation of health. States Parties shall endeavour to **ensure that no child is deprived of his or her right of access to such health services.2**. States Parties shall endeavour to ensure the full implementation of this right and, in particular, shall take appropriate measures:(a) To reduce infant and juvenile mortality;(b) Ensure the provision of necessary medical and health care to all children, with emphasis on the development of primary health care;(c) 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 food and clean drinking water, taking into account the hazards and risks of environmental contamination;(d) Ensure adequate prenatal and postnatal health care for mothers;(e) Ensure 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 on child health and nutrition, the benefits of breastfeeding, hygiene and environmental sanitation and accident prevention;(f) Develop preventive health care, parental guidance and family planning education and services.3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices harmful to the health of children.4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in this article. In this regard, special account will be taken of the needs of developing countries.
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in Health**
International Treaty	International Convention on the Protection of the Rights of All	1993	2005	Article 28 **Migrant workers and members of their families shall have the right to receive all urgently required medical**

	Migrant Workers and Members of Their Families			**care to preserve their lives or prevent irreparable damage to their health**, on the basis of equality of treatment with nationals of the State concerned. Such emergency medical treatment may not be refused on the ground of any irregularity in respect of residence or employment. Article 431. Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to:(e) Access to social and health services, provided that the conditions for participation in the respective schemes are met; Article 451. Members of the families of migrant workers shall enjoy, in the State of employment, equality of treatment with nationals of that State in relation to:(c) Access to social and health services, provided that the conditions for participation in the respective schemes are met;
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	
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in Health**
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: HealthStates 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 level of free or affordable health care and programs as others, including in the areas of sexual and reproductive health and population-based public health programs;(b) Provide the 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 new disabilities, including among children and older persons; (c) Provide these health services as close as possible to their own communities, including in rural areas;(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and 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 liquids on the basis of disability.
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in Health**
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, **which is 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 their development, in a spirit of self-sufficiency and self-determination. It is an integral part of both the country's health system, 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 is the first element of a continuous process 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 the country's 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 ensure, inter alia, equal opportunities for all in their access to basic resources, education, health services, food, housing, employment and fair distribution of income.** Effective measures must be taken to ensure that women play an active role in the development process. Appropriate economic and social reforms must be carried out with a view to eradicating all social injustices.
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in Health**

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/AIDSThe 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 persons 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, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat epidemic-related stigma and social exclusion;59. By 2005, taking into account the context and nature of the epidemic and the global disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and the full enjoyment of all human rights by women; promote the shared responsibility of men and women to ensure safe sex; and empowering women to be in control and to 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;
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in Health**

Other universal standards	Astana Declaration on Primary Health Care	2018	s/i	I. We firmly 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. **Convened on 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 4The child shall enjoy social security benefits. Have the right to grow and develop healthily; To this end, he and his mother shall be provided with special care and protection, including adequate prenatal and post-natal 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 Labour Convention	1999	s/i	Article 3For the purposes of this Convention, the term "worst forms of child labor" includes:(d) work which, by its nature or the circumstances in which it is performed, 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 3Women have the right to enjoy and protect, on an equal footing, all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. These rights include, but are not limited to:((f) The right to the highest attainable standard of physical and mental health; [...]
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in 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	Article 7 (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 they inhabit. Special development projects for the areas concerned shall be designed 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) Medical and social assistance, occupational safety and health, all social security and any other work-related benefits, and housing; [...] Article 251. Governments should ensure that adequate health services are made available to the peoples concerned, or provide them with resources to enable them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.2. Health services should, as far as possible, be community-based. These services should be planned and administered in cooperation with the peoples concerned and take into account their economic, geographical, social and cultural conditions, as well as their preventive care, curative practices and traditional medicines.3. The health care system will give preference to the training and employment of health workers in the local community, and will focus on primary health care, while maintaining strong links with other levels of health services.4. The provision of these health services will be coordinated with other social, economic and cultural measures in the country.
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Mentions in Health**
Rules for specific groups	United Nations Declaration on the Rights of Indigenous Peoples	2006	s/i	Article 211. 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 23Indigenous peoples have the right to identify and develop priorities and strategies for the realization of their right to development. In particular, indigenous peoples have the right to participate actively in the design 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 241. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous persons also have the right to access, without discrimination, all social and health services. 2. Indigenous persons have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary measures to achieve progressively the full realization of this right.
Rules for specific groups	Standard rules on the equalization of opportunities for persons with disabilities	1993	s/i	22. The term "prevention" refers to actions aimed at preventing the occurrence 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, endemic disease control measures, safety standards, accident prevention programs in different settings, including adaptation of workplaces to prevent disabilities and diseases professionals, and the prevention of disability resulting from environmental pollution or armed conflict.
Guy	**Instrument**	**Year of signature**	**Year of ratification, accession or succession**	**Health Citations**
Rules for specific groups	The United Nations Principles for Older Persons	1991	s/i	1. Older persons should have access to adequate food, water, shelter, clothing and health 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 optimal physical, mental and emotional well-being and to prevent or delay the onset of disease.

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