



Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 21-Nov-2016 | Report No: PIDISDSC19901



BASIC INFORMATION

A. Basic Project Data

Country Chile	Project ID P161018	Parent Project ID (if any)	Project Name Chile - Health Sector Support Project (P161018)
Region LATIN AMERICA AND CARIBBEAN	Estimated Appraisal Date Mar 13, 2017	Estimated Board Date Jul 06, 2017	Practice Area (Lead) Health, Nutrition & Population
Lending Instrument Investment Project Financing	Borrower(s) Ministerio de Hacienda	Implementing Agency Ministerio de Salud	

Proposed Development Objective(s)

The Project objective would be to improve (i) the efficiency and (ii) quality of health care service delivery for the population served by the FONASA, and (iii) to strengthen the institutional capacity of the Ministry of Health to manage the health sector.

Financing (in USD Million)

Financing Source	Amount
International Bank for Reconstruction and Development	80.00
Total Project Cost	80.00

Environmental Assessment Category B-Partial Assessment	Concept Review Decision Track II-The review did authorize the preparation to continue
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Other Decision (as needed)



B. Introduction and Context

Country Context

1. Chile has made a lot of progress in terms of improving its citizens' quality of life during the last decade. The average household net-adjusted per-capita income is US\$11,039 per year (compared to an OECD average of 23,047).
2. Chile has seen a substantial reduction in moderate poverty and an increase in shared prosperity over the last decade, however inequality remains high. By 2013, only 6.8% of the population lived with US\$4 a day or less, a third of the rate observed a decade ago. Chile also made progress with respect to shared prosperity over the same period. The mean income of the bottom 40% increased by 5.1% over the same period, which was more than the overall income growth of 3.5%.
3. The above results were achieved in a context of solid macroeconomic policies that mitigated Chile's vulnerability towards external shocks. Chile was able to reach high economic growth after the 2009 international economic crisis driven by domestic demand and capital investment.
4. Nonetheless, economic growth has started to decelerate owing to the less favorable external context and uncertainty surrounding the timing of Government's reform agenda. GDP growth decreased from 5.5% in 2012 to 1.9% in 2014.
5. All these factors lead to a situation of fiscal constraints, which increases the need to reduce any remaining inefficiencies with an objective to both improve the quality of public spending and minimize the impact of budget constraints on the most vulnerable part of the population served by the social sectors.

Sectoral and Institutional Context

6. Chile relies on social health insurance (SHI) to provide nearly Universal Health Coverage (UHC) to its 17 million inhabitants. Chile's health system is mixed, with public and private entities participating in both health insurance and the provision of health services. The National Public Insurance Health Fund (*Fondo Nacional de Salud – FONASA*) covers 78% of the population, including the indigent and low- and middle-income citizens. It provides health services mostly through public providers – Ministry of Health (MOH)'s hospital network and municipal primary care facilities. The several for-profit private insurers, the so-called Health Insurance Institutions (*Instituciones de Salud Previsional -ISAPREs*), cover about 17% of the better-off population and provide services almost exclusively through the private sector. Approximately 1.1 million Chileans (around 4% of the population) are insured through other welfare systems, such as the Armed Forces and the Police. A small indeterminate number of citizens does not have any insurance, but can receive health care services from public providers in case of need.
7. Although there have been substantial improvements in health outcomes in recent decades, Chile's outcomes still lag behind the average OECD outcomes in several dimensions. Chile is in the advanced stages of demographic transition and is becoming an aging society - with fertility rates below replacement level and low mortality rates. Life expectancy at birth in Chile grew to 79.4 years, one year less than the OECD average of 80 years. Life expectancy for women is 82.2 years, compared with 76.1 for men. Concerning the Chilean epidemiological profile, as defined by population mortality statistics, Chile is in a post transition stage, with mortality predominantly linked to Non Communicable Diseases (NCDs).
8. Chile has low health care utilization levels as indicated by a low rate of consultations per capita; low screening and survival rates for certain cancers such as breast, cervical and colorectal (which is the third affecting women); and long waiting times for selected types of surgery. The proportion of adults who smoke daily is 29.8%, higher than the OECD average of 21.1%. The obesity rate among adults is 25.1%, higher than the OECD average of 17.8%.
9. Notwithstanding, Chile's public health expenditure has increased significantly over the past decade, driven in part As the second largest budget item, health accounted for 18.3% of total public spending in 2015, compared to 13.6%



- in 2005. Real public spending on health increased by 10.5 percent per year during the period 2000-2015, making it the third fastest growing budget item. Relative to GDP, this represents an increase from 2.5 to 4.2% over the decade. By 2015, total health spending had reached CLP6.6 trillion or US\$10.1 billion.
10. Yet, public as well as total expenditure on health in Chile are lower than in the OECD. On average, OECD governments spend about 7% of GDP on health versus 4% in Chile. Private health spending in Chile is larger than in most OECD countries and regional peers: half of Chile's total health expenditure comes from private sources, with almost one-third of total health spending being out-of-pocket (OOP) expenditures. Average OOP health expenditure increased in recent years and accounts for 6.3% of total household spending in Chile (51,000 Chilean Pesos).
 11. Rising public spending on health care has been mainly driven by the introduction of guarantees for a defined health benefit package in 2005¹ and increasing drug expenditures and hospital payments for contracting of physicians engaged in dual practice. Across the 29 regional health networks, there is a relatively high level of efficiency in Chile's publicly funded health system, but unequal results. Efficiency scores at the regional level are positively associated with investments in primary health care and negatively associated with both longer than expected length of stays in hospitals and a higher proportion of spending on private services through the free choice option² (*Modalidad de Libre Elección*), used by FONASA beneficiaries as a consequence of limited access to public health services (within a reasonable time).
 12. While the country is facing a context of budgetary constraints, the Ministry of Health (MOH) faces the challenge of achieving further potential efficiency gains and improving overall quality of public expenditure in the health sector. Areas where efficiency gains could be relatively quick achieved are: (1) drugs and medical supply; (2) productivity and efficiency in hospital care; (3) primary health care (PHC) and (4) MOH information systems and governance mechanisms.

Relationship to CPF

13. The proposed Project would be a key element in achieving the results articulated in the FY2011–16 Country Partnership Strategy (CPS) for Chile (Report No: 57989-CL), discussed by the Executive Directors on January 11, 2011. The CPS focuses on: (i) Public Sector Modernization; (ii) Job creation and equity improvement, and (iii) Promoting Sustainable Investment. Within the first broader theme, the proposed Project would contribute to the CPS result area of "Boosting the efficiency of resources in the public sector, especially in the health sector". The Project would do so by improving the quality of public spending in the health sector, which is a condition for sustainability. To this aim, the Project would set the groundwork for the public provision of quality services for highly prevalent pathologies (NCD), linked to the progressive growth of the elder population segment and improve the efficiency and productivity in the pharmaceutical and hospital sector, with a special focus on reducing low quality public spending and low value care.
14. In addition, the Project would contribute to the WB goals of reducing extreme poverty and boosting shared prosperity by focusing on the public health sector, which provides health services to the poorest and most vulnerable population groups insured by FONASA. This would allow improving access to quality health services,

¹ In 2005 a health reform known as "Universal Access with Explicit Guarantees" (AUGE) defined a basic package for SHI consisting of treatment for 56 priority health problems, which were expanded to 69 in 2010. The AUGE benefits package also sets upper limits on: (i) waiting time and (ii) out-of-pocket payment for treatment. Coverage for the services left out of the AUGE benefits package is not guaranteed by FONASA, although the public insurer devotes more than one-half of its budget to finance non-AUGE services.

² Free choice modality that allows insureds of FONASA to receive services from private providers by paying a higher coinsurance rate or fully paying for the services received



reducing out of pocket (OOP) expenditure and improving the health status of this population group which in turn would contribute to reducing working days lost due to sickness. By helping to provide better health care services for chronic conditions (NCD) to the population insured under the FONASA, the project would contribute to the HNP goal to end preventable deaths and reduce disability of the 40 % poorest population

C. Proposed Development Objective(s)

The Project objective would be to improve (i) the efficiency and (ii) quality of health care service delivery for the population served by the FONASA, and (iii) to strengthen the institutional capacity of the Ministry of Health to manage the health sector.

Key Results (From PCN)

PDO (i)

- Reduction in avoidable hospital admissions
- Reduction of days of hospitalization
- Reduction of unnecessary readmissions within 30 days from a prior hospital discharge of high users multi-morbid patients with chronic conditions enrolled in case management strategy

PDO (ii)

- Increase in breast, cervical and colorectal cancer screening rates, ensuring access to curative services
- Establishment of XX units for complex fragile patients at hospitals

PDO (iii)

- Increase of centralized drug procurement by hospitals and municipalities through national procurement agency (*Centro Nacional de Abastecimiento – CENABAST*)
- Development of a dynamic registry of NCD patients with high-risk and high utilization of health care services
- Increase in the number of regions that conduct patient risk stratification for NCDs

D. Concept Description

15. The proposed operation would focus produce efficiency gains in the short term. The operation would be developed and executed in the context of the country's budgetary constraints. Hence, the operation would not provide additional resources for the current budget allocation of the MOH. However, the Project would protect the MOH budgetary allocation, based on a clear framework focusing on the following three objectives: (i) to improve governance mechanisms in the MOH and the relationship with others public actors, including the Ministry of Finance; (ii) to redirect MOH investments to areas where efficiency gains can be reached in a relatively short period of time, boosting health sector transformation across different policy cycles and (iii) to ensure a high level of accountability and transparency, needed for health sector transformation.

16. The Project would be financed through an Investment Project Financing (IPF) to support the Government of Chile over a five year period. The IBRD financing would be US\$100 million. The Project would optimize execution of programs and activities already being executed by the MOH, reallocating strategically its own current budget resources. Loan funds would not be additional to the annual health budget, but would support the MOH to better allocate its own resources.

17. Since Project activities need to be carried out by MOH and Regional Health Services personnel, and supported by logistic services, the Project would finance the reimbursement of related eligible expenditure programs (EEPs). The EEPs preliminarily identified would be the: (i) "Program for efficiency and quality Improvement in Regional Health



- Services”, and (ii) Program to strengthen MOH’s institutional capacity, based on their respective payrolls and logistic expenditure (such as utilities (i.e., water and electricity), communications, transport, and per diems).
18. Loan proceeds would be disbursed to the Ministry of Finance (MEF)’s central account conditional on: (i) the execution of the EEP and (ii) the accomplishment of Disbursement Linked Indicators (DLI) targets.
 19. **Component 1. Improving efficiency of health service delivery at different levels of care.** Major savings can be derived from improvements in the clinical efficiency and effectiveness of health care services, as well as improvements in the management of hospital care services. The same holds for the management of PHC networks. The processes governing the coordination across the different levels of care are equally critical in order to improve health sector efficiency. This dimension is particularly important in the Chilean public health system given the governance problems stemming from different ownership of the PHC and hospital levels. The component would have two subcomponents, corresponding to both levels of care.
 20. **Subcomponent 1.A. Improving efficiency at the hospital level.** It would focus on two main areas: (i) to improve care in hospitals for fragile patients with multi-morbidities, who are the highest users of hospital services and (ii) to improve the management of inpatient care, including the expansion of strategies to reduce the average length of stay in acute care and to reduce waiting lists for selected procedures. This component would include activities to apply a health risk stratification of patients with NCDs to identify high users and to develop Hospital Case Management Units trained to better manage the care of chronic fragile patients identified through a case management strategy for fragile patients suffering chronic conditions. This approach is supported by evidence and increasingly is recognized as a better quality and efficient model of care. The subcomponent would also expand the use of information technology and communication (ITC) and innovative technology to better coordinate and monitor care of chronic patients, promote the development of guidelines to prevent over-treatment in hospitals, implement a Diagnosis Related Groups (DRG) -based payment system for 62 acute care hospitals, reduce low value and inappropriate care, increase the use of day surgeries, reduce avoidable hospitalizations and readmission rates, improve the management of waiting lists, reintroduce clinical governance mechanisms to audit high cost medicine prescriptions and ensure the strict financial monitoring of public hospitals.
 21. **Subcomponent 1.B. Improving efficiency at the primary health care level.** This subcomponent would focus on improving the performance of PHC, with a focus on the care for patients with multiple NCDs. The activities supported would include the development of a patient health risk stratification for NCDs; the introduction of innovations in proactive population health management; the expansion of the use of new processes and instruments for the coordination between levels of care and the strengthening of networks between levels (third level outreach, referrals and counter referrals). Also, the Project would promote the use of telemedicine for virtual specialist consultations; expand the use of ICT to monitor and follow up on ambulatory care of chronic patients and support training activities for medical staff; and help build capacity to use performance information to benchmark performance. Many of these activities would be paid from an innovation fund financed within an allocation from the current budget.
 22. This subcomponent would develop synergies with the Primary Health Care Performance Initiative (PHCPI), currently implemented by the MOH with the support of the WB and PHCPI partners.³ PHCPI proposes a sharp focus on the measurement of the performance of primary care frontline service delivery and on working with countries to put

³ PHCPI partners are: World Bank, World Health Organization, the Bill and Melinda Gates Foundation with technical support from Ariadne Labs and R4D. The PHCPI brings together country policymakers, health system managers, practitioners, advocates, development partners, researchers and communities to catalyze and accelerate PHC improvement in low- and middle-income countries through better measurement, knowledge-sharing, improvement, and advocacy in order to achieve UHC more quickly, efficiently, and equitably.



new knowledge and innovation in practice to strengthen frontline service delivery. Performance measurement and improvement activities focus on areas of performance often neglected (such as the organization and management of primary health care services, or population health outreach approaches to improve the health of target populations) both on the supply and on the demand side. The PHCPI initiative would work with the MOH and national experts to improve the international comparability of Chile's performance indicators. This focus on international comparisons, benchmarking and performance improvement would contribute to improving the governance of the PHC network, which is key to create greater value in a sustainable way for the public health sector.

23. **Component 2. Strengthening the MOH Institutional capability.** This component would aim to improve MOH performance, through improving the stewardship upon autonomous and decentralized areas (CENABAST and Hospitals), especially in pharmaceutical policies; developing actions to increase the governance of public health providers and developing critical areas of back office functions, especially related to IT, to provide better governance on the changes of the health care model for chronic diseases. The component would have two subcomponents.
24. **Subcomponent 2.A. Optimizing the procurement and logistics of drugs and medical supplies in the public sector.** Significant efficiency gains and savings can be obtained through better structured and more centralized procurement of drugs for public sector health services. The component would support the implementation of more advanced procurement mechanisms such as multi-year framework agreements and other methods that could increase the effectiveness of centralized procurement carried out by CENABAST and further drive down drug prices. A key goal would be to reduce the volume of direct procurement of drugs and medical supplies by hospitals and municipalities, eventually leading to price reductions. In addition, the component would support activities to improve logistical processes, like the introduction of a standardized nomenclature of medicines; the development and implementation of a real-time stock management information system for hospitals and PHC; regular audits of logistics processes in the provision of medicines to health care providers and the reinforcement of quality controls for medical supplies.
25. **Subcomponent 2.B. Improving the sectoral governance of the MOH.** Perception of governance in the health sector is related to the separate and isolated way in which the health sector operates and makes decisions. Promoting openness towards and cooperation with other sectors can improve the quality of decisions and consequently the sectoral governance. Another critical factor is the availability and use of relevant information to make sectoral decisions. The subcomponent would develop these critical aspects through intersectoral coordination, and promoting activities aimed at: (a) designing joint social and health care strategies for the Ministry of Social Development and municipalities; (b) improving the capacity of the MOH to conduct hospital maintenance in cooperation with engineering units from the Navy; (c) developing joint studies on the productive efficiency of health services with the Budget Directorate of the Ministry of Finance (*Dirección de Presupuesto – DIPRES*); (d) developing and implementing budgetary control techniques with DIPRES and (e) promoting collaborative work with the Promotion Corporation (*Corporación de Fomento – CORFO*) to support the strategic development of information systems. This includes the development and integration of information systems to improve the efficiency of drug procurement, the implementation of an electronic prescription system, the development and implementation of IT systems to manage the stock of drugs for hospitals & municipalities in real-time, and the improvement of health care efficiency and quality through develop a health risk stratification of patients with NCDs and the development of a dynamic registry of NCD patients with high-risk and high utilization. The subcomponent also would promote improvements in the governance of PHC through: the redesign of strengthening programs from MOH to PHC (PRAPS); improving the performance management cycle between MOH



Health Services, regional health authorities and municipalities to provide timely funding to PHC and to develop performance objectives for PCH focused on: (i) health outcomes and (ii) the patient experience to enforce contracts between the MOH and municipalities.

26. **Component 3. Project Coordination and Monitoring Unit.** There would be a Project Support, Coordination and Monitoring Unit (PSCMU) responsible for the overall Project coordination and monitoring of activities under the direct command of the MOH. The responsibilities of the PSCMU would include fiduciary aspects related to the Project implementation.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The Project would be implemented nationwide, mostly in urban areas. Notwithstanding, some activities, especially those related to the reorganization of the service delivery model for chronic fragile patients would be implemented gradually in some of the 29 health service regions, giving priority to the areas with the greatest population density. Chile's population is characterized by ethnic and cultural diversity. In 2011, indigenous people (IP) represented 9.1 percent of the total population of the country (1.565.915 people), belonging to 9 different groups. The most numerous one is the Mapuche people (representing 87.3 percent of the indigenous population) followed by the Aymara, Atacameño, Lickanantay, Colla, Rapanui, Quechua, Yámana and Alacalufe. These groups are most affected by poverty. In 2013, 31.2 percent of the IP were poor compared to the 19.3 percent of the general population (based on a multidimensional approach). Coverage of health services for IP is mainly provided by FONASA, the public health insurer (87.3 percent).

The proposed project would trigger the World Bank's Policy on Indigenous Peoples (OP 4.10) given the importance of key interventions that are being proposed such as training with intercultural adequacy for health staff, regulations to improve the cost-effectiveness of Primary Health Care and Chronic Diseases adapted to IPs needs, and a participatory approach to improve governance, transparency and management of the public health network facilities in regions with high IPs concentration. The Bank team does not anticipate adverse impacts on the IP population, as the proposed Project is intended to support ongoing activities and programs. However, there is an opportunity to support and strengthen ongoing processes with positive impacts.

(1) National Socio Economic Characterization Survey – (Encuesta de Caracterización Socioeconómica Nacional – CASEN) 2013

B. Borrower's Institutional Capacity for Safeguard Policies

Chile has a remarkable, though fragmented, history of community driven healthcare provision in indigenous areas. Chile has, in fact, pioneered in the Latin-American region in the design of intercultural strategies in the health sector, led mainly by highly empowered/local indigenous collectives. This project represents an opportunity to scale the lessons learnt from this experiences at national level.

The Ministry of Health (MOH) has two institutional areas that are in charge of IP health issues: the Department of IP Health and Intercultural issues under the Division of Healthy Public Policy and Promotion of the Public Health Secretariat, responsible for regulatory issues, studies and epidemiological research, and (ii) the Office of IP of the Department of Primary Health Care (PHC) Coordination Program, under the PHC Division of the Undersecretary of Health Service Networks, responsible for health service provision in the field.

Currently, the MOH is carrying out a broad national consultation process with the IP on the "Regulation establishing the



right of people belonging to indigenous population groups to receive health care in a culturally appropriate manner". This consultation process is above Bank standards, and in line with the Convention No.169 of the International Labor Organization. The proposed program will serve as a base for the IPPF, so the Project will be supporting the results and findings of this consultation process.

This loan will support technical assistance activities (e.g. assessments, institutional and regulatory frameworks formulation, governance of the health sector, planning, capacity building, efficiency in hospital and primary care centers, etc.) for the institutional strengthening of the MOH and increased efficiency and effectiveness of hospital and primary care centers. This loan does not include the financing of civil works or infrastructure. The MOH, the Project executing agency, is not familiar with the World Bank environmental and social safeguards. During Project preparation the Bank team will try to learn about the MOH team’s understanding of the WB environmental and social safeguard policies and its capacity (e.g. human resources, etc.) on EH&S risk management systems including indigenous people issues.

C. Environmental and Social Safeguards Specialists on the Team

Raul Tolmos, Rory Narvaez, German Nicolas Freire

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	According to OP/BP 4.01 this Project is classified as Category B even if no civil works are anticipated. Some of the health sector reforms might have direct and indirect social and environmental positive and negative impacts. In the case of adverse environmental, safety and health impacts, these can be minimized if proper mitigation and prevention measures are put in place. Some of the activities proposed will have positive environmental impacts on the environment such as the improvement in the capacity of the MOH to conduct hospital maintenance and the reduction in generation of wastes. However, in addition to environmental issues, it is also necessary to look at the health and safety risks associated with hospital maintenance and management. Maintenance of hospitals not only includes maintenance of utilities but also maintenance of medical equipment. There can be safety risks such as electrical shocks and the ones related to exposure to radiation and use of laser. Also, manipulation and final disposal of hazardous materials and waste management (e.g. inputs used in radiology, etc.) may involve EH&S risks and impacts. Fire safety is also necessary in hospitals and care centers. Given that the hospitals and care centers to be supported by the Project are not known yet, the Client will have to prepare an Environmental and Social Management Framework (ESMF) describing the



		EH&S risks screening procedures, criteria for categorization of EH&S risks and mitigation measures that hospitals and care centers needs to implement prior to their operation (applicable according to the national regulations); including public consultation requirements and the institutional arrangements for EH&S risk management. Given the technical assistance nature of project activities under components 1 and 2, the Interim Guidelines on the Application of Safeguard Policies to Technical Assistance (TA) Activities in Bank-Financed Projects and Trust Funds Administered by the Bank will be taken into account by the Client. Therefore, terms of reference for the aforementioned activities will have to include, if needed, screening and mitigation of potential adverse environmental and social impacts and risks.
Natural Habitats OP/BP 4.04	No	OP/BP 4.04 will not be triggered, because the Project does not affect critical natural habitats.
Forests OP/BP 4.36	No	OP/BP 4.36 will not be triggered because the Project does not support conversion of forest habitats.
Pest Management OP 4.09	No	OP/BP 4.09 will not be triggered since the level of septic conditions in hospitals and primary health centers prevent the application of pest management practices within health utilities.
Physical Cultural Resources OP/BP 4.11	No	OP/BP 4.11 will not be triggered because the Project will not support infrastructure and civil works in places with known and unknown presence of physical cultural resources and because hospitals and primary health centers that will benefit from this Project are not considered physical cultural resources according to definition of cultural physical resources under this policy.
Indigenous Peoples OP/BP 4.10	Yes	The proposed project would trigger the World Bank’s Policy on Indigenous Peoples (OP 4.10) given that the activities supported would directly benefit indigenous people. Currently, the MOH is carrying out a broad national consultation process with the IP on the “Regulation establishing the right of people belonging to indigenous population groups to receive health care in a culturally appropriate manner”. This consultation process is above Bank standards, and in line with the Convention No.169 of the International Labor Organization. The proposed program will serve as a base for the IPPF, so the Project will be supporting the results and findings of this consultation process.
Involuntary Resettlement OP/BP 4.12	No	OP/BP 4.12 will not be triggered, because the Project



		will not involve involuntary resettlement.
Safety of Dams OP/BP 4.37	No	OP/BP 4.37 will not be triggered, because the Project will not support the construction or rehabilitation of dams, nor will it support other investments which rely on performance of existing dams.
Projects on International Waterways OP/BP 7.50	No	OP/BP 7.50 will not be triggered because the Project will not finance activities that affect water quality and/or water resources availability in international waterways.
Projects in Disputed Areas OP/BP 7.60	No	OP/BP 7.60 will not be triggered, because the Project will not finance activities in disputed areas as defined in the policy.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Mar 07, 2017

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

No timing environmental and social safeguard-related studies are required during the Project implementation stage. During preparation an Environmental and Social Management Framework (ESMF) and an Indigenous Peoples Plan Framework (IPPF) will be prepared by the Client and it is expected that they will be completed before January 2017 (before appraisal).

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APPROVAL

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