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# Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 25-Apr-2017 | Report No: PIDISDSA21871



**BASIC INFORMATION**

**A. Basic Project Data**

Country Chile	Project ID P161018	Project Name Chile - Health Sector Support Project	Parent Project ID (if any)
Region LATIN AMERICA AND CARIBBEAN	Estimated Appraisal Date 20-Mar-2017	Estimated Board Date 08-Jun-2017	Practice Area (Lead) Health, Nutrition & Population
Lending Instrument Investment Project Financing	Borrower(s) Ministerio de Hacienda	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

The project objectives would be to: (i) improve the efficiency of the public health care sector; and (ii) to improve the quality of Non Communicable Disease-related health care services.

Components

Improving the efficiency of health service delivery networks with a focus on better integration of health care services  
Optimizing the procurement and logistics of drugs and medical supplies in the public sector  
Technical Assistance, Coordination and Monitoring

**Financing (in USD Million)**

Financing Source	Amount
International Bank for Reconstruction and Development	80.00
<b>Total Project Cost</b>	<b>80.00</b>

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

**Note to Task Teams:** End of system generated content, document is editable from here.

Other Decision (as needed)



## B. Introduction and Context

### Country Context

1. Since the 1990s, Chile has exhibited high levels of economic growth and has been able to reduce poverty substantially. In 2010, it became a full member of the Organization for Economic Co-operation and Development (OECD). Chile is an upper middle-income country (MIC), with the highest Gross Domestic Product (GDP) per capita in Latin America. The average household net-adjusted per-capita income is US\$11.039 per year (compared to an OECD average of US\$23.047 per year). Chile has seen a substantial reduction in moderate poverty and an increase in shared prosperity over the last decade. In 2013, only 6.8% of the population lived with US\$4 or less per day, a third of the rate observed a decade ago. Inequalities - as measured by the Gini index - have also decreased: From 0.55 in 2000 to 0.50 in 2011, which is still above LAC's already high Gini average rate of 0.48 and OECDs' rate of 0.32 in 2012).
2. Chile was able to reach high economic growth after the international crisis of 2009. During this period, economic growth was mainly driven by domestic demand and capital investment. Nonetheless, economic growth started slowing down in 2014, owing to the less favorable external context (i.e. decreasing prices for copper, the end of a mining investment project cycle) and uncertainty surrounding the timing of the reform agenda of the Government of Chile (GOC). GDP growth decreased from 5.5% in 2012 to 1.9% in 2014. These reforms are part of a broad agenda of the GOC to improve the quality of public services and reduce inequalities. The agenda includes: a tax reform, approved in 2014, in part to finance an education reform; a labor reform already enacted; changes in the pension system; and an announced constitutional reform.
3. Chile has now reached the advanced stages of demographic transition and is quickly becoming an ageing society. Chile has the highest life expectancy and the second highest median age in Latin America by 2015<sup>1</sup>. The share of the population over age 65 has increased from 6 percent in 1990 to 11 percent in 2015. The decline in the proportion of the working-age population has implications for public finances. International experience from comparable OECD countries shows the increased demand for health services as the population ages. Such a pattern could threaten the fiscal sustainability of the health sector unless changes are made to improve the efficiency and effectiveness of services delivered to patients with non-communicable diseases (NCDs), who now constitute the bulk of the burden of disease.
4. Public spending in the health sector as a percentage of GDP increased by 2.4 percent per year (from 3.3 to 4.6 percent) during the period 2000-2015 mainly due to the introduction and expansion of a guaranteed health benefit package<sup>2</sup>. Health was the third fastest growing budget category during that period and now accounts for 18.3 percent of total public spending in 2015. Yet, public (as well as total) health expenditure in Chile are lower than the OECD average. OECD governments spend about 7% of their GDP on health, compared to 4.6% in Chile. In view of increasing health expenditure and an overall

<sup>1</sup> UN World Population Prospects 2012 Revision.

<sup>2</sup> The "Universal Access with Explicit Guarantees" (AUGE) benefit package guarantees the coverage of 80 diseases by FONASA and sets upper limits on: (i) waiting times and (ii) out-of-pocket payments for treatment. Coverage for other services is not guaranteed, but FONASA devotes more than 50% of its budget to finance non-AUGE services.



population ageing, the objective for the health sector is to both improve the efficiency of public spending while minimizing the impact of budget constraints on the most vulnerable part of the population.

Sectoral and Institutional Context

- Chile relies on social health insurance (SHI) to provide nearly Universal Health Coverage (UHC) to its 17.4 million inhabitants. The Ministry of Health (MOH) defines the policies and exercises stewardship of the health sector. The National Public Health Insurance Fund (*Fondo Nacional de Salud – FONASA*) covers 78% of the population, including the poorest segment of the population. It mostly provides health services through public health care providers: the public hospital network and municipal primary care facilities. The group of for-profit private insurers, so-called Health Insurance Institutions (*Instituciones de Salud Previsional – ISAPRES*), cover about 17% of the population, mainly the middle and high income population, and provide services almost exclusively through private providers. Approximately 4% of the population are insured through other welfare systems (e.g. police or armed forces) and a small number of Chileans does not have any health insurance, but can receive emergency care from public providers. The public provision of health services is highly decentralized.
- Chile has enjoyed substantial improvements in main health outcomes over the last decades (see Table 1). However, the burden of disease in Chile has evolved from being dominated by maternal, child health and communicable diseases to being dominated by chronic conditions and NCDs. Diseases of the circulatory system and malignant tumors (cancer) alone accounted for 54% of female deaths and 51% of male deaths in 2012.

**Table 1: Health Outcome Indicators<sup>3</sup>**

Indicator	Result	Indicator	Result
Infant Mortality Rate x 1,000	7.41	% of births attended by a skilled health professional	99.83
Under 5 Mortality Rate x 1,000	8.64	HIV Mortality Rate x 100,000	2.62
Maternal Mortality Rate x 100,000	22.14	TB Mortality Rate x 100,000	0.8

- Chile’s outcomes still lag behind the average OECD ones. Life expectancy (79.1 years at birth) is lower than the OECD average of 80.0 years at birth. The challenge of addressing the burden of disease related to NCDs is prioritized by the GOC in its 2011-20 National Health Strategy (Government program), where three of nine strategic objectives are related to NCDs. This priority is also recognized in the Government Program 2014-2018. Since 2011, Chile has implemented long-term public health policies aimed at reducing the burden of disease from NCDs, by promoting active lifestyles and the consumption of healthier foods (e.g. through better food labeling and regulations enforcing reduced salt and trans fat contents in processed foods. The Ministry of Health is also implementing targeted interventions at the primary health care level and to provide secondary prevention and appropriate treatment to NCD patients for a better management of their conditions.

<sup>3</sup> Basic Health Indicators, IBS, DEIS, MINSAL, Chile 2014 and Basic Health Indicators, IBS, DEIS, MINSAL, Chile 2014



8. The rise in public spending on health care during the last five years has been mainly driven by an increase in drug expenditures and payments to physicians engaged in dual practice. Drug expenditures have been growing substantially for the last ten years due to decentralized purchases of drug and medical supplies by public hospitals and municipalities. Based on a panel of drugs studied by the national pharmaceutical procurement agency (*Central Nacional de Abastecimiento – CENABAST*)<sup>4</sup>, drugs purchased directly by providers were substantially more expensive than comparable ones procured by CENABAST (50% more for hospitals and 33% more for PHC facilities). A recent Public Expenditure Review (PER) commissioned by the GOC to the World Bank<sup>5</sup> found a relatively high level of efficiency in Chile’s publicly funded health system - with substantial variations across the 29 health Care Districts - and identified (1) drugs and medical supply; (2) productivity and efficiency in hospital care; and (3) primary health care (PHC) as focus areas for short- to mid-term efficiency gains. A WB study of the incentive mechanisms in the health system<sup>6</sup> had identified fragmented information systems and related governance issues as sources of remaining inefficiencies.
  
9. In order to achieve efficiency gains in the short to mid-term and improve the fiscal sustainability of the health sector, the Project would target the development and implementation of new models of care better integrating care levels, and aim at achieving efficiency gains in the pharmaceutical and hospital sectors. The Project would focus on a subset of related priorities included in the 2011-20 National Health Strategy and the Government Program 2014-2018, which will serve as the policy and operational framework for the Project. The proposed Project would also play a key role in achieving the results articulated in the FY2011–16 Country Partnership Strategy (CPS) for Chile (Report No: 57989-CL). The proposed Project would directly contribute to the CPS result area of “boosting the efficiency of resources in the public sector, especially in the health sector” by improving the quality of public health spending.

### C. Proposed Development Objective(s)

**Note to Task Teams:** The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet.

#### Development Objective(s) (From PAD)

The project objectives would be to: (i) improve the efficiency of the public health care sector; and (ii) to improve the quality of Non Communicable Disease-related health care services.

#### Key Results

PDO (i)

<sup>4</sup> CENABAST is a MOH decentralized entity.

<sup>5</sup> Report No: 106334-CL

<sup>6</sup> WB. Optimización del Sistema de salud de Chile. Análisis de los Sistemas de Incentivos y Opciones de Política, Junio 2011.



- Percentage of public hospitals reporting inpatient services based on DRGs
- Accumulated savings through the central procurement of medicines and medical supplies as a percentage of the amount of all centrally procured items

PDO (ii)

- Percentage of population diagnosed with hypercholesterolemia under follow up and treatment
- Cervical cancer screening rate

## D. Project Description

The Project would have three components:

10. **Component 1. Improving the efficiency of health service delivery networks with a focus on better integration of health care services.** (US\$61.9 million total cost; US\$61.9 million of IBRD financing). This component would support implementation of activities for the achievement of Strategic Objectives number 2, 4 and 5 linked to NCDs, number 7, Strengthening the health sector, and number 8, referring to Access and Quality of Health Care of the National Health Strategy, specifically. The component would have two subcomponents. The first one would focus on improving the integration between levels of health care services working on NCDs; while the second one would focus on managerial measures that need to be implemented at the hospital level to close current performance gaps and improve the efficiency of hospital care delivery.
11. **Subcomponent 1.A. Improving the integration of public health care services for patients with non-communicable diseases and chronic conditions.** US\$43.3 million total cost; US\$43.3 million of IBRD financing) This subcomponent would include activities to: (a) develop and implement the strategy for a health risk stratification of patients with NCDs to identify high users at both hospital and PHC facilities levels; (b) develop Case Management Units (CMU) and train health care staff to better manage the care of chronic fragile patients identified through risk stratification analytics; (c) at the PHC level, the subcomponent would support activities to: (c.i.) use patient health risk stratification analytics to ensure the continuity of care and treatment adherence, preventing the disease progression of NCDs patients and reducing or postponing future use of health care services; (c.ii.) introduce IT innovations and education measures for proactive population health management to improve NCD patient self-management at the early stages of their condition; and (c.iii.) foster screening activities for early cancer detection, with a special focus on highly prevalent cancers among women (cervix, breast, and colon)<sup>7</sup>; (d) expand the use of new processes and instruments to improve the integration of services for NCDs by better coordinating care across different levels, including (d.i.) third level outreach activities; (d.ii.) the strengthening of referral and counter-referrals mechanisms; (d.iii.) the use of telemedicine for virtual specialist consultations; (d.iv.) the use of ICT to monitor and follow up outpatient care for chronic patients; (d.v.) training activities for medical staff in primary and secondary care; and (d.vi.) building capacity to use information for clinical improvement by benchmarking.

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<sup>7</sup> This last intervention will ensure better compliance with access to treatment for priority cancers accompanied with wait times guarantees. Treatment to cancer is assured through GES (Explicit Guaranteed of Health)



12. **Subcomponent 1.B. Improving managerial capacity at the hospital level.** . (US\$18.6 million total cost; US\$18.6 million of IBRD financing). This subcomponent would support the introduction of managerial tools aimed at solving current problems in the management of inpatient care at the level of hospital networks.
13. **Component 2. Optimizing the procurement and logistics of drugs and medical supplies in the public sector** (US\$12.9 million total cost; US\$12.9 million of IBRD financing). This component would support Strategic Objective 7, strengthening the Health Sector, (specifically its financing) of the National Health Strategy. It would support efficiency gains through the implementation of activities aimed at fostering a better structured and more centralized procurement of drugs for public sector health services. Activities would include: (a) supporting the national pharmaceutical procurement agency (*Central Nacional de Abastecimiento* – CENABAST) in the implementation of advanced procurement mechanisms, including the development and implementation of multi-year framework agreements and other methods that could increase the effectiveness of centralized procurement; (b) the introduction of a standardized nomenclature of medicines; (c) the development and implementation of a real-time stock management information system for hospitals and PHC facilities; (d) the implementation of regular audits of logistical processes in the provision of medicines to health care providers; and (e) the reinforcement of quality controls for medical supplies.
14. Components 1 and 2 would finance payments under Eligible Expenditure Programs (EEPs) of the MOH triggered by the achievement of agreed specific results (“Disbursement-Linked Indicators” or DLIs), which will reimburse a portion of the EEPs.
15. **Component 3. Technical Assistance, Coordination and Monitoring** (US\$ 5 million total cost; US\$5 million of IBRD financing). This component would provide Technical Assistance (TA) activities to generate missing information needed to risk-stratify patients insured by FONASA, develop management tools and provide training to health managers and staff that are key to support the implementation of Components 1 and 2. It would finance consultant and non-consultant services, operating costs and training. This component would also support the Project Support, Coordination and Monitoring Unit (PSCMU) responsible for the overall Project coordination and monitoring activities under the direct command of the MOH.

## E. Implementation

16. The implementing agency for the proposed Project would be the MOH. Project activities would be implemented by the MOH Undersecretaries of Health Care Networks and Public Health through its technical divisions, in particular the Health Care Network Division (División de Gestión de Redes Asistenciales – DIGERA), the Primary Health Care Division (División de Atención Primaria DIVAP), the Division of Health Planning (DIPLAS) and Division of Prevention and Control, DIPRECE at the MOH. FONASA and CENABAST who are autonomous institutions will work closely in the Project implementation. The DIGERA, the DIVAP, DIPLAS, TICS, DIPRECE, CENABAST and FONASA would serve as the Technical Units of the Project and would use their own administrative structure and staff. There would be a Project Support, Coordination & Monitoring Unit (PSCMU) responsible for overall Project technical assistance, coordination and monitoring, including coordination of fiduciary aspects under the direct command of the Minister of Health.



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**F. 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 nine 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% of the IP were poor compared to the 19.3% of the general population (based on a multidimensional approach). Indigenous people also have a higher incidence both of non-communicable and communicable diseases.

**G. Environmental and Social Safeguards Specialists on the Team**

Raul Tolmos,Rory Narvaez,German Nicolas Freire

**SAFEGUARD 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. Increase in efficiency of hospital and health centers management may, or may not, favor effective management of environmental, safety and health risks. For instance, there are environmental, health and safety risks associated with hospital maintenance.





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. The MOH has prepared an Environmental Management Plan (EMP) 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 Component 3, 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 triggers the World Bank's Policy on Indigenous Peoples (OP 4.10) because



Chile has a large indigenous population, scattered across several regions, which would be a potential beneficiary of the Project interventions and fulfill the OP 4.10 criteria. Chilean indigenous peoples have a higher-than-average incidence of NCDs (including indigenous people living in urban areas), and there is a risk that the current gaps in access may increase as a result of Project implementation, should the Project not include specific actions targeted at them. The MOH prepared an Indigenous People Plan (IPP) which was disclosed prior to appraisal. Chile has a large indigenous population (nearly 10% of the total), grouped in 9 different peoples, namely Mapuche (87.3 percent), Aymara, Atacameño, Lickanantay, Colla, Rapanui, Quechua, Yámana, and Alacalufe. These groups are the most affected by poverty in the country, and have the highest incidence of communicable and non-communicable diseases (both in urban and rural environments). Between 2016 and 2017, the MoH conducted nationwide consultations to draft a special program for health care provision aimed at addressing this problem. This lengthy consultation process involved over 9 thousand indigenous persons and over 1,300 representative organizations. This program has served as a base for preparing the IPP, so the Project will be supporting the results and recommendations of this consultation process, through interventions aimed at improving the socio-cultural relevance and promoting cost-effective actions at the local level to improve the management and adherence to the treatment of NCDs. The IPP was widely discussed with selected indigenous leaders related to the health sector and with health care specialist in January 2017.

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.

## KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

### A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

No potential large scale, significant and/or irreversible impacts associated to project activities.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

The Project will improve the access to better integrated health care services related to NCDs for all the population, but given preexisting gaps, if there are not specific actions targeted to IP the current gaps in access and quality of services may increase as a result of Project implementation.

No potential indirect and/or long term environmental impacts due to future project activities are foreseen.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

Proposed key interventions aimed at remediating the gaps in access between indigenous and non-indigenous peoples include studies to fill-in knowledge gaps; training for health staff on intercultural adequacy; proposals to improve the cost-effectiveness of Primary Health Care and Chronic Diseases adapted to the needs of indigenous people; and proposals to improve the governance, transparency and management of the public health network facilities in regions with high indigenous concentration.

No civil works or infrastructure development is involved in this project. Analysis of project alternatives is not applicable to this project.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

Chile has a quite complete set of environmental, health and safety regulations applicable to health centers that are described in an Environmental Management Plan document prepared by the Ministry of Health.

The weak focus of public health programs in Chile on the social, economic, environmental and cultural determinants and the lack of knowledge about the disease with cultural differentiation, point to some problems in the adherence to pharmacological treatments and the hardly preventive approach in healthy lifestyles of the indigenous population. The Department of Health and Indigenous Peoples and Interculturality of the MOH considers the Project as an opportunity to progressively implement an adequate approach to NCDs with a special focus on HTA and DM II, through the



strategic reorientation of the Cardiovascular Health Program (Programa de Salud Cardiovascular - PSCV) based on updated evidence.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The IPP responds to needs identified by indigenous peoples through a nationwide consultation process carried out by the MOH between 2016 and 2017, which is the umbrella program within which the IPP will work. The IPP, however, has been further discussed in three technical meetings with the participation of health teams and indigenous representatives (including PSCV beneficiaries) in health care services with presence of indigenous populations: Arica, Araucanía Sur, and Metropolitano Occidente.

**B. Disclosure Requirements**

**Environmental Assessment/Audit/Management Plan/Other**

Date of receipt by the Bank  10-Mar-2017	Date of submission to InfoShop  15-Mar-2017	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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**"In country" Disclosure**

Chile  
15-Mar-2017

Comments

<http://web.minsal.cl/wp-content/uploads/2017/03/Plan-de-Gesti%C3%B3n-Ambiental-Proyecto-Salud-Chile-9-de-marzo-2017.pdf>

**Indigenous Peoples Development Plan/Framework**

Date of receipt by the Bank  07-Mar-2017	Date of submission to InfoShop  15-Mar-2017
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**"In country" Disclosure**

Chile  
15-Mar-2017

Comments

[http://web.minsal.cl/wp-content/uploads/2017/04/PPI-\\_Chile\\_HESSP-7-de-abril-2017-MINSAL-OK.pdf](http://web.minsal.cl/wp-content/uploads/2017/04/PPI-_Chile_HESSP-7-de-abril-2017-MINSAL-OK.pdf)



**C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)**

**OP/BP/GP 4.01 - Environment Assessment**

Does the project require a stand-alone EA (including EMP) report?

No

**OP/BP 4.10 - Indigenous Peoples**

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?

Yes

If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?

Yes

If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?

Yes

**The World Bank Policy on Disclosure of Information**

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

**All Safeguard Policies**

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes



**CONTACT POINT**

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**APPROVAL**

Task Team Leader(s):	Luis Orlando Perez
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**Approved By**

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Practice Manager/Manager:	Daniel Dulitzky	25-Apr-2017
Country Director:	Boris Enrique Utria	26-Apr-2017



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