

**PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.: PIDA8551

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Project Name	Essential Health Services Access Project (P149960)
Region	EAST ASIA AND PACIFIC
Country	Myanmar
Sector(s)	Health (85%), Other social services (15%)
Theme(s)	Health system performance (85%), Other social protection and risk management (15%)
Lending Instrument	Investment Project Financing
Project ID	P149960
Borrower(s)	Republic of the Union of Myanmar
Implementing Agency	Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	20-Aug-2014
Estimated Date of Appraisal Completion	29-Aug-2014
Estimated Date of Board Approval	30-Sep-2014
Decision	

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I. Project Context

Country Context

Myanmar, with a population of around 60 million, has the lowest Gross Domestic Product (GDP) per capita and one of the highest poverty rates in Southeast Asia. The poverty headcount rate is officially estimated at 37.5 percent (World Bank, 2014).

Long military rule, conflict in the border areas, centrally planned and executed policies, and international isolation explain its low level of development. A reduced role of the private sector, under-developed markets, weak foreign investment, and underinvestment took a toll on public institutions and social services.

Upon assuming office in 2011, the new Government announced a series of far-reaching reforms that aim for a triple transition: from a military system to democratic governance; from a centrally-directed, closed economy to a market-oriented one; and from 60 years of conflict to peace in the border areas.

GDP grew at an average rate of 5.1 percent per year between 2005-06 and 2009-10, and at 6.5 percent since the transition began. Myanmar successfully completed an International Monetary Fund (IMF) Staff Monitored Program and international relations, including re-engagement with the World Bank Group (WBG), have become largely normalized.

Despite progress across the three transitions, the situation remains fragile. The next elections may demonstrate the strength of the new democratic system. The peace process is tenuous and religious tensions persist, with outbreaks of violence.

Sectoral and institutional Context

Conflict, highly centralized decision making structures, a closed economy, isolation, and imposition of sanctions have impacted on the shape of the health system that Myanmar has today. With the lowest life expectancy among ASEAN countries, Myanmar compares unfavorably with regard to health status indicators. It is unlikely to achieve the targets for Millennium Development Goals (MDGs) 4 and 5, i.e., those related to maternal, newborn, and child health (MNCH), despite improvements between 1990 and 2010 when maternal mortality ratio fell from 520 to 200 per 100,000 live births, and under-five mortality rate from 100 to 52 per 1,000 live births. Infant mortality rate still stands at 40 per 1,000. About 2,000 pregnant women and 50,000 children die every year from preventable causes. Of specific relevance to MNCH are the low levels especially among the lowest quintile, of births delivered by skilled birth attendant (52 percent), post-natal care (59 percent), and exclusive breastfeeding of under-6 months olds (24 percent). Furthermore, childhood malnutrition is persistent: in 2010, 1 in 7 infants was born with low birth weight, 35 percent of children under the age of five were stunted, 23 percent underweight, and 8 percent wasted.

Challenges. Progress towards the MNCH MDGs is constrained by difficult terrain, conflict in border areas, and health systems challenges, namely health financing, human resources, state of physical infrastructure, and information, including quality of data. In remote/hard-to-reach areas, there are difficulties in deploying and retaining workers. In the border conflict-affected areas, prevention and curative care are being delivered by community-based organizations and ethnic authorities and more convergence is needed between the various delivery mechanisms. In areas such as Rakhine, NGOs, which have been providing humanitarian and emergency assistance to the internally displaced Muslim groups, have become more constrained due to political and social tensions. On the demand side, women and girls are restrained from seeking care and information about reproductive health due to gender norms and traditional beliefs and practices about child birth and child feeding and rearing. Women tend to be less literate than men across Regions and States (e.g. 38 percent vs. 45 percent in Eastern Shan and 62 percent vs. 70 percent in Rakhine). As a result, coverage of health services varies dramatically across the country.

Furthermore, Myanmar's health system suffered from fragmentation due to international sanctions, which prevented external aid from flowing through the Government. This led a strong presence of international and local NGOs on the front-line delivering services and private-for-profit health care sector thriving in peri-urban areas albeit largely unregulated. While they had helped to fill service delivery gaps, parallel financing and service delivery pose a challenge for the Government to effectively carry out its oversight and stewardship functions.

Emerging Opportunities in Myanmar. Myanmar's triple transition has catalyzed many positive changes in the health sector. Strong political commitment exists to improve health outcomes and accelerate progress towards Universal Health Coverage (UHC), through expanded coverage of quality services, enhanced financial protection, and increased satisfaction among the population. At the Second Myanmar Development Cooperation Forum in January 2014, the WBG expressed

interest in providing IDA support for Myanmar's move towards UHC, which led to the preparation of the proposed operation. In February 2014, Myanmar's President called for "people-centered" reforms in the health sector. GOM's paper on Strategic Directions towards UHC was presented at a special session of the 2014 WBG Spring Meetings. Global health leaders, including from World Health Organization, bilateral donors and foundations, endorsed the efforts for UHC and strongly committed to aligning their assistance with the GOM strategy.

As a priority, GOM introduced key health policies that aim to improve service delivery, expand utilization and reduce out-of-pocket spending, including provision of free essential drugs at township hospitals and below, and free services for pregnant women and children under five.

Furthermore, public spending on health has increased from US\$1 per capita in 2009/2010 to US\$ 2012/2013 and to US\$11 in 2013-14. Development partners (DPs) have scaled up their financial support since 2010; a total amount of about US\$950 million has been committed for the next 3 to 5 years. Of those funds, about \$750 million are managed by the United Nations Office for Project Services for the Global Fund to Fight AIDS, Tuberculosis and Malaria and for the 3MDG Fund (a pooled fund financed by seven bilateral donors, including Australia, the United Kingdom, and the United States of America. These funds do not flow through the government system, but there is donor interest in exploring that option. The remainder includes support from the Japan International Cooperation Agency (JICA) and the Global Alliance for Vaccines and Immunization.

While increasing, total health spending at 2.4 percent of GDP is considered low by both regional and global standards. Out-of-pocket spending accounts for as much as 60 percent of total health expenditure of the country, and as a share of household spending, it is greatest for the poorest, with adverse implications for financial protection.

In 2014-15, only US\$20 million of the US\$650 million MOH budget went to the operational costs (i.e. non-salary recurrent expenditure) of the frontline facilities at township level and below, which are responsible for primary and secondary care. This translates to a monthly average of US\$2,000 per township hospital, US\$175 per station hospital, and US\$225 per Rural Health Center (RHC). Travel allowances and the general goods and services budget for RHCs were only US\$5 and US\$7 per month respectively. Basic health staff (e.g. health assistants, lady health visitors, and midwives) largely rely on community donations and their own funds to cover operational costs to provide services in the community, such as immunization and environmental sanitation, to identify pregnant women and young children and encourage timely care-seeking behaviors, and to undertake behavioral change activities related to nutrition, disease control and prevention.

II. Proposed Development Objectives

The Project Development Objective (PDO) is to increase coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health (MNCH).

III. Project Description

Component Name

Component 1: Strengthening Service Delivery at the Primary Health Care Level

Comments (optional)

This component focuses on channeling funds through MOH to the States/Regions and Townships for operational expenses/recurrent budget. IDA will disburse funds to MOH upon its achievement

of disbursement linked indicator targets, which are monitored annually and subject to independent verification.

Component Name

Component 2: System Strengthening, Capacity-building and Program Support

Comments (optional)

Systems strengthening will consist of the development of strategies, plans, Standard Operating Procedures, checklists and guidelines, many of which are required preparatory steps in order to achieve the results of component 1. Key outputs of this support will be the definition and costing of an essential package of health services, and the development of a comprehensive health financing strategy for UHC. It will also finance capacity building—training, courses, South-South learning, workshops and seminars—and M&E, including studies and surveys. IDA will disburse funds based on expenditures incurred under Component 2.

Component Name

Component 3: Emergency Contingency Response

Comments (optional)

A provisional zero amount component is included under this project that will allow for rapid reallocation of loan proceeds during an emergency, disaster or catastrophic event under streamlined procurement and disbursement procedures. In addition to reallocation of funds from other project components, the contingent component may also serve as a conduit for additional funds to be channeled to the project in the event of an emergency

IV. Financing (in USD Million)

Total Project Cost:	100.00	Total Bank Financing:	100.00
Financing Gap:	0.00		
For Loans/Credits/Others			Amount
BORROWER/RECIPIENT			0.00
International Development Association (IDA)			100.00
Total			100.00

V. Implementation

MOH will be the managing and implementing agency. The Department of Health (DOH), which oversees about 80 percent of the Ministry's budget, will be responsible for implementation of Component 1 and some parts of Component 2, with the Department of Health Planning (DHP) responsible for implementation of activities related to advancing the health financing and information systems under Component 2. Other departments, such as Medical Sciences and Medical Research, will be involved in and engaged for implementation as needed.

Project focal point will be situated with the Director General, DOH, supported by a team of counterparts, the Project Steering Committee (PSC), consisting of key officials from relevant departments (Health Planning, Medical Research, Medical Sciences) responsible for coordinating and ensuring smooth implementation.

Oversight, implementation guidance and support will be through existing mechanisms of GOM. The National Health Committee, the highest health policy making body, will be updated regularly, in

particular where coordination with other ministries such as Finance, Labor (Social Security Board), Planning, and Civil Service Board is essential. Within MOH the Executive Committee (EC), consisting of the Minister, two Deputy Ministers, the Director Generals and other senior officials, will have the oversight responsibility of the proposed project. The EC will be informed about the project implementation by Director General, DOH, supported by the PSC.

Oversight at union level will be complemented by Health Committees at state/region, township, village tract, and village level. Health Committees comprise key government officials and staff as well as members of the communities. They will review timeliness of fund flow, assist in increasing transparency regarding planned and actual expenditures, and help monitor targets of service availability and quality. In addition, they will ensure planning and implementation are integrated (in terms of service delivery and financing, i.e. government, private, non-government, external assistance) and inclusive of vulnerable groups and ethnic groups.

State/Region level. The project will support the states/regions in supervising the townships, communicating to communities about the increased funds to the frontlines, coordinating government and external aided programs, and collaborating with non-governmental actors, including ethnic organizations.

Township level, led by the TMO and their teams, are responsible for planning, budgeting, implementation, and reporting on all primary care services within the township, and for the management of all basic health staff and facilities. As the lowest administrative unit with drawing rights, TMOs will be responsible for overseeing the increased funds for operational costs and ensuring that funds are provided to basic health staff at the facilities below in a transparent and accountable manner.

Village level. States/Region health directorates and TMOs will inform communities about GOM's increased support to primary care units through various channels—print, local radio, health committees, village meetings, community volunteers, women's groups, NGOs, such as Maternal and Child Welfare Association and others. Key documents and messages will be translated into local languages. Community members will be informed of opportunities to participate in the township planning process and voice concerns and perspectives of the state and progress of primary health services to the Village Health Committees.

Coordination with DPs and NGOs. GOM is now a signatory of the International Health Partnership and there is a need to activate this partnership by finalizing a code of conduct and a country-level memorandum of understanding among the DPs and between the DPs and MOH. Common sector monitoring framework, joint annual reviews, and joint financing agreements will take time to develop, as DP coordination is still at an early stage. However, GOM has taken strong initiatives in this area, by the establishment of sector working groups, including the Myanmar Health Sector Coordinating Committee (M-HSCC), chaired by the Minister. Technical and Strategy Groups on various key areas, including one on Health System Strengthening, under the M-HSCC, will allow detailed technical and operational discussion to move towards harmonization of external assistance. The project preparation has been carried out in close consultation with DPs, both through M-HSCC and in other forums outside of that committee.

During consultations regarding the project design, NGOs and private sector indicated that the WBG should focus on supporting the government's policies and processes to become more coherent and

consistent and improve its communication. This would, in turn, facilitate NGOs and private sector in delivering services. The project will support health service provision at township level in an integrated manner, i.e., the comprehensive township health plans will also reflect the activities by GAVI, 3MDG Fund, and NGOs. MOH is working with DPs on a uniform format and process for such plans, ensuring broad-based participation and inclusive consultation.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	x	
Natural Habitats OP/BP 4.04		x
Forests OP/BP 4.36		x
Pest Management OP 4.09		x
Physical Cultural Resources OP/BP 4.11		x
Indigenous Peoples OP/BP 4.10	x	
Involuntary Resettlement OP/BP 4.12		x
Safety of Dams OP/BP 4.37		x
Projects on International Waterways OP/BP 7.50		x
Projects in Disputed Areas OP/BP 7.60		x

Comments (optional)

VII. Contact point

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