Proposed

World Bank-Financed Project

Myanmar Essential Health Services Access

Social Assessment

Ministry of Health

Republic of the Union of Myanmar

June, 2014

1. Introduction

The proposed World Bank-financed Essential Health Services Access Project (EHSAP) aims to support the Government of the Republic of the Union of Myanmar in increasing access to essential health services. The project will provide support to strengthen the Ministry of Health (MoH) in its efforts to meet its universal health coverage goals and provide funding to township levels and below for operational costs, medical consumables and minor maintenance. The project also aims to empower local communities to take a more active role in the health sector and demand services, provide feedback and community oversight.

To inform the project design a social assessment (SA) has been undertaken. The aim has been to capture the key social issues in the health sector in order to identify project features and measures that can enhance the project outcomes and ensure equitable benefits for vulnerable social groups such as the poor, women, ethnic minorities and migrants. The SA has also been undertaken to assess potential social impacts of proposed project activities as per World Bank's operational policy on environmental assessment (OP 4.01) and to assess particular issues and risks concerning ethnic minorities following the requirements of the World Bank's operational policy on indigenous peoples (OP 4.10). Consultations with key stakeholders, including government staff, civil society representatives and local communities have been undertaken in parallel with, and as part of, the SA. The findings of the SA and the consultations to date are discussed in this report, which also provides recommendations for project design and a separate instrument to enhance community engagement and address particular issues concerning ethnic minorities.

2. Proposed Project Objectives and Design

The first phase of WBG group support focuses on bringing immediate relief from a critical constraint faced at the PHC level, namely lack of flexible, timely and sufficient resources to meet the operational costs of providing better and more health services. Furthermore, it supports the enabling environment for the resources to be used effectively—enhancing capacity of staff, increased supervision and timely implementation support at all levels, improving planning, and mobilizing communities to voice their views and engage providers of health care services at the various levels.

The proposed operation would use investment project financing with disbursement linked indicators (DLI), whereby funds are disbursed based on attainment of targets. The progress in achievement of DLI targets will be reviewed annually and will be subject to independent verification. The arrangements for the review, its financing and timing will be agreed with government during project appraisal, so that IDA disbursements can be made at a proper time in the government's budget cycle.

Component 1: Strengthening Primary Health Care Delivery and Utilization:

Resources to the PHC levels: The central approach of this component would be to channel funds through the Ministry of Health to the States/Regions, Districts and to Townships and below for operational expenses such as transportation, outreach, health promotion interventions, local labor, medical consumables, and minor maintenance and repair of buildings, vehicles, and equipment. Grants

would be provided to Township Medical Officers (TMOs), for onward disbursement to Station Hospitals (SHs), Rural Health Centers (RHC), Sub-Centers (SC) and MCH Clinics, based on Standard Operating Procedures (SOPs), for eligible expenditures (to be discussed and agreed between Government and WBG).

The increased funds for operational costs would complement inputs already being provided, by MOH and development partners, at the primary health care units. These inputs include ensuring adequate supply of essential drugs, supply chain management, well-maintained equipment, and skilled workforce.

Inputs provided to the State / Regional and District Health Departments would help strengthen supervision, coordination and oversight functions of these departments, and help build their emerging/ evolving new role in the health system in Myanmar, such as addressing health workforce gaps.

Community empowerment: Through existing mechanisms, such as health committees at village and township levels, network of grassroots volunteers and women's groups, communities would be informed of efforts to improve service delivery, empowered to demand services, and mobilized to participate in planning processes. Their role in providing feedback and oversight would be enhanced.

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

Component 2 would focus on strengthening of systems and institutions that are needed for effective service delivery at the primary health care level. It would also help prepare for the Phase II support. The support to this component would be provided in two separate sub-components as follows, the first of which would adopt the DLI approach similar to the Component 1, while the second sub-component would disburse based on expenditures incurred:

System Strengthening: Specifically, this sub-component would assist in the development of strategies, plans, guidelines, operational manual (e.g., health financing strategy, definition of essential package of health services, health care waste management guidelines), and related analytical / policy work. These activities are critical to the long-term system-building for the health sector in Myanmar, especially in the context of the country's aspiration for UHC. Though, in the interest of selectivity, three specific areas have been prioritized through the DLIs for this sub-component, other related system-strengthening initiatives, such as human resource development, supply chain management and the modernization of health information system are equally important and are being supported by several other development partners, with whom the WBG would build partnerships to provide coordinated support to the Government and people of Myanmar.

Capacity-building and program support: This sub-component would finance monitoring and evaluation, including independent verification mechanism, as well as management support, coordination both within MOH, with non-health ministries and with external development partners and internal non-state actors, technical support through consultancy services, research, training, workshops, and South-South exchanges. These activities would be financed based on a capacity-building plan, including a simplified procurement plan in line with IDA Guidelines for procurement.

In addition, the project will support the testing of RBF approaches to address bottlenecks in the system including efficiency gains by supporting conceptualization, piloting and learning from Results Based Financing (RBF) approaches. The proposed project will: (i) test the effectiveness of results based management tools through programmatic financing linked to inter-governmental transfers made to townships and below; (ii) addressing demand side barriers for maternal care through the use of vouchers. These pilot innovations will be carefully evaluated using rigorous methodologies and implemented at a sustainable level of expenditure. Financing for this development, testing and learning from RBF pilots will be sought from the Health Results Innovations Trust Fund (HRITF). Lessons learned from these pilots will provide the basis for scaling up successful interventions through subsequent IDA and other donor supported projects.

3. Social Assessment Objectives and Methodologies

This preliminary social assessment was undertaken to assess potential risks and social impacts of proposed project activities as per World Bank's operational policy on environmental assessment (OP 4.01), to identify vulnerable and under-served population groups, to identify social and cultural issues relevant for the proposed project, and to inform the design of the project and a Community Engagement Planning Framework to enhance project outcomes and ensure equitable benefits for vulnerable social groups such as the poor, women, ethnic minorities and migrants. The SA has also been undertaken to identify and assess particular issues and risks concerning ethnic minorities following the requirements of the World Bank's operational policy on indigenous peoples (OP 4.10) that aims to ensure that the project provides culturally appropriate benefits and do not have adverse social impacts on ethnic minorities.

The overall objective of the World Bank's safeguard policies is to help ensure the environmental and social soundness of investment projects, including enhancing project outcomes for local communities, including the poor, ethnic minorities, women and other vulnerable communities. Two of the Bank's policies apply to the project: (i) operational policy OP 4.01 on environmental assessment, which aims to assess the project's potential social and environmental risks and impacts in order to enhance positive impacts and to prevent, minimize, mitigate or compensate for adverse social and environmental impacts; and (ii) operational policy OP 4.10 on indigenous peoples (ethnic minorities) which aims to design and implement projects in such a way that ethnic minorities (a) do not suffer adverse effects during the development process and (b) receive culturally compatible social and economic benefits.

For the proposed project, specific areas not identified prior to project appraisal. However, the project is national and will include areas with ethnic minorities that are covered under OP 4.10. Myanmar is officially made up of 135 recognized ethnic groups, grouped into 8 "ethnic races" including the majority Bamar. Administratively, Myanmar is divided into seven Regions and seven States plus the Naypyidaw Union Territory, which is the capital, and a number of small Self-Administered Zones and Divisions. It is estimated that ethnic minorities account for about one third or more of the total population and live mainly in border areas in the 7 States (Kayah, Kayin, Kachin, Chin, Mon, Rakhine, and Shan); the vast majority or the majority population group, the Bamar, live in the 7 Regions.

The SA methodologies included: (i) review of existing literature; (ii) in-depth interviews and consultations with various stakeholders from government and civil society; and (iii) field visits to townships, including discussions with local community members. Consultations with key stakeholders, including government staff, civil society representatives and local communities have been undertaken in parallel with, and as part of, the SA. Consultations included government staff at the MoH, health personnel at township and rural health facilities. Consultations were undertaken with ethnic minority organizations as well as with professional associations, local and international non-governmental organizations. Finally, field visits were undertaken in two townships and five villages, including with ethnic minorities.

Since specific project areas have not been identified yet and project preparation has been fast-tracked, the social assessment is preliminary in nature. More detailed social assessments and consultations will need to be undertaken during project implementation; this will be described in the project's Community Engagement Planning Framework (CEPF). The CEPF will aim to enhance community engagement and provide equitable benefits to vulnerable and under-served population groups, and will also address requirements of OP 4.10 for social assessment and free, prior and informed consultations leading to broad community support from ethnic minorities present in areas where the project will operate.

4. Legal and Institutional Framework

Legal framework concerning ethnic minorities:

According to Chapter 1, clause 22 of the 2008 Constitution of Myanmar, the Union Government of Myanmar is committed to assisting in developing and improving the education, health, language, literature, arts, and culture of Myanmar's "national races." It is stated, that the "Union shall assist:

(a) To develop language, literature, fine arts and culture of the National races;
(b) To promote solidarity, mutual amity and respect and mutual assistance among the National races;
(c) To promote socio-economic development including education, health, economy, transport and communication, [and] so forth, of less-developed National races."

The constitution provides equal rights to the various ethnic groups included in the *national races* and a number of laws and regulations aim to preserve their cultures and traditions. This includes the establishment of the University for the Development of the National Races of the Union which was promulgated in 1991 to, among other things, preserve and understand the culture, customs and traditions of the national races of the Union, and strengthen the Union spirit in the national races of the Union while residing in a friendly atmosphere and pursuing education at the University.[1]

Under the current government, free media is developing and ethnic parties and associations are politically active. Ethnic minority organizations may also play a stronger role going forward through the

[1] http://www.burmalibrary.org/docs15/1991-SLORC_Law1991-09-University_for_the_Development_of_the_National_Races_Law-en.pdf

current Government's decentralization efforts which would afford States and Regions to play a more prominent role in decision-making and implementation of various policies and programs.

Legal framework for the health sector:

The National Health Policy of 1993 provides the overall legal framework for the health sector. Among other things it aims to raise the level of health of the country and promote physical and mental well-being of the people with the objective of achieving "health for all" using a primary health care approach, and to expand the health services not only to rural areas but also to border areas to meet the health needs across the country.

Supporting the progress towards universal health coverage, the Government has recently introduced a few policies that would improve service delivery, expand utilization and reduce out-of-pocket spending in health. Policies include provision of free essential drugs at primary health care facilities and township hospitals. In addition, health care services would be free at the point of delivery for children under 5, pregnant mothers, and patients needing emergency surgery (only first day of hospital admission). Ensuring effective implementation of these policies to improve MNCH outcomes is a top priority for the country moving forward.

Institutional Framework for the health sector:

The Ministry of Health remains the major provider of health care. It has a pluralistic mix of public and private system both in the financing and provision. Health care is organized and provided by public and private providers. In implementing the social objective laid down by the State, and the National Health Policy, the Ministry of Health is taking the responsibility of providing promotive, preventive, curative and rehabilitative services to raise the health status of the population. Of the seven departments under MOH, Department of Health and Department of Health Planning are the most important ones in the context of the proposed project. Department of Health plays a major role in providing comprehensive health care throughout the country including remote and hard to reach border areas. There are 14 State and Regional Health Departments, 73 District Health Departments and a township hospital in every township. Under the township hospital there are station hospitals and rural health centers (RHC) staffed by health assistants, midwives and public health supervisors. Under the (RHCs) there are sub - centers staffed by midwives and (volunteer) auxiliary midwives, supported by networks of community health workers/volunteers. At each level, oversight is provided through a system of health committees represented by local government, health staff and the community. At the national level the National Health Committee is a high level policy-making body that provides guidance to the MOH.

Some ministries are also providing health care for their employees and their families. They include Ministries of Defense (Majority of healthcare staff and facilities followed by MoH), Railways, Mines, Industry, Energy, Home and Transport. Ministry of Labour has set up three general hospitals, two in Yangon and the other in Mandalay to render services to those entitled under the social security scheme.

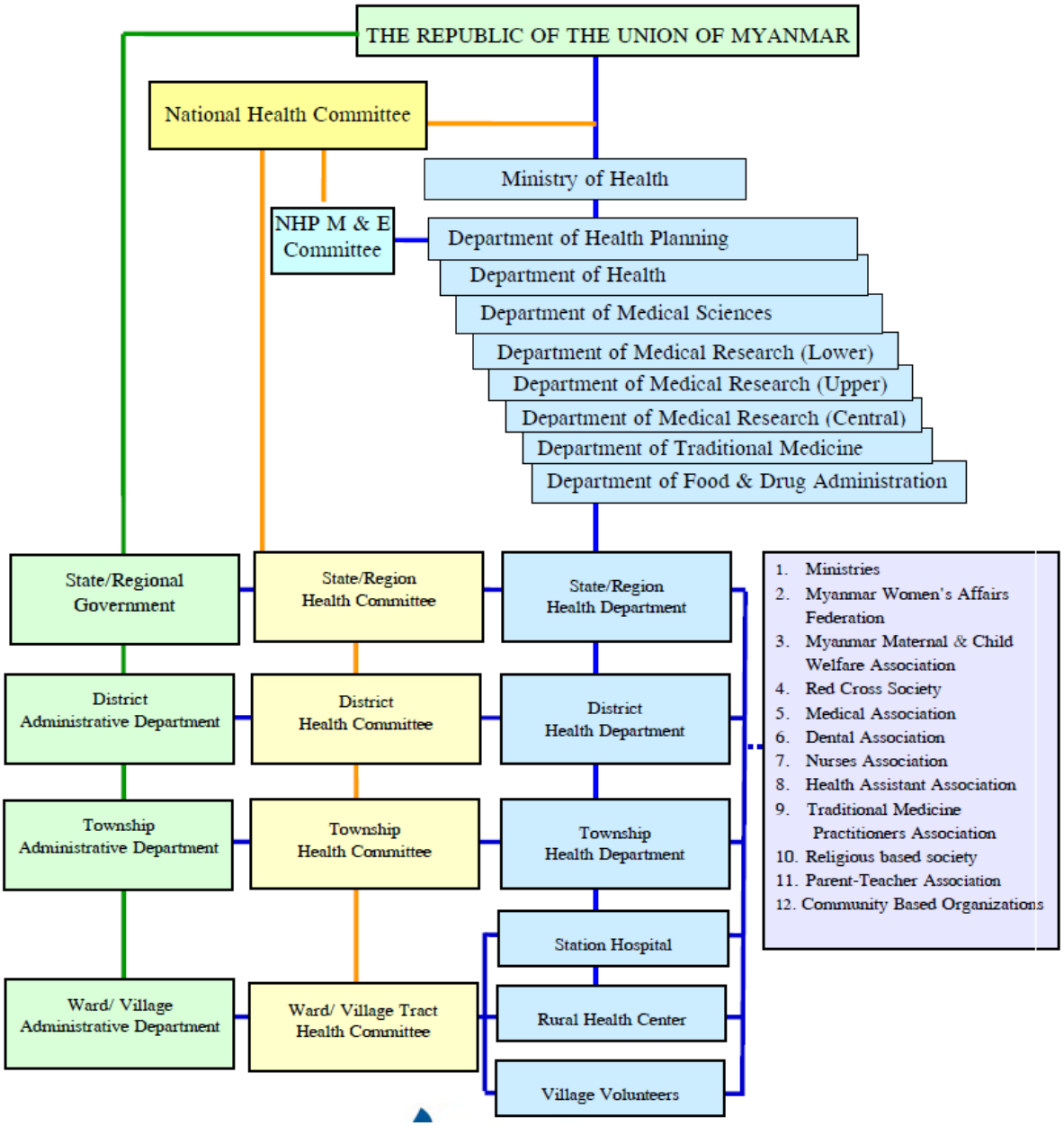
Ministry of Industry is running a Myanmar Pharmaceutical Factory and producing medicines and therapeutic agents to meet the domestic needs.

The private, for profit, sector is mainly providing ambulatory care though some providing institutional care has developed in Yangon, Mandalay and some large cities in recent years. They are regulated in conformity with the provisions of the law relating to Private Health Care Services. The Medical Association and its branches also provide a link between them and their counterparts in public sector so that private practitioners can also participate in public health care activities.

The private, for non-profit, run by Community Based Organizations (CBOs) and Faith based Organizations are also providing ambulatory care though some providing institutional care and social health protection has developed in large cities and some townships. There is a strong presence of international and local NGOs on the front-lines delivering services supported by development partners. Moreover, ethnic minority organizations provide health services in many conflict and post-conflict areas in the *States*. Recognizing the growing importance of the needs to involve all relevant sectors at all administrative levels and to mobilize the community more effectively in health activities, health committees had been established in various administrative levels down to the wards and village tracts.

Ministry of Health is taking initiatives to strengthen its stewardship functions. MOH is also making efforts to strengthen regulation of the fast growing private sector.

Organization of Health Service Delivery



5. Key Project Stakeholders

Key stakeholders include: MoH, State/Region, District and Township medical staff and administrators; other health care providers, such as NGOs, faith-based organizations, private providers, and ethnic minority organizations providing health services in some ethnic minority areas not covered by the Government; professional organizations; NGOs and civil society organizations with an interest in the health care sector; and local communities at township and village levels, including vulnerable and under-served population groups such as ethnic minorities. These stakeholders were consulted with during project preparation.

States and Regions, and Districts: With the ongoing reform and decentralization process in Myanmar the States and Regions and Districts are likely to play an increasing role in the delivery and oversight of health services. However, their current role is limited, particularly as funds are transferred directly from the central level to townships. The States/Regions and Districts could play an important role in the project's support to townships, including developing mechanism for cooperation with existing health care services provided by private entities such as ethnic minority organizations and NGOs. A stronger coordination between the central and state/region level is likely to improve health services.

Ethnic Minority Organizations: Ethnic minority organizations that provide social services such as health care are key stakeholders for project implementation in the seven States. Most of these have arisen after cease-fire agreements between the military government and ethnic armed opposition groups. The armed groups and their affiliated organizations administer the territories under their control, and have departments responsible for areas such as education, health, finance and agriculture. In many instances, they work with local and international NGOs to set up health services in their areas. Organizations include the Kachin Independence Organization in Kachin State, the New Mon State Party in Mon State; most States have one or more of such organizations. During the SA and consultation process some raised concerns about the sustainability of their own health services (which they feel provide good services and have the trust of community members) in the context of the project's support to the Government's UHC program. For instance, ethnic minority community members and organizations in Mon State stated that they would like to see that the services provided by their organization are enabled to continue with the official recognition and support from the Government.

Private sector and NGOs: The WHO/MoH Health System Assessment notes that more than 60% of medical doctors trained in Myanmar is employed in the private sector, but some estimate the proportion to be even bigger. In spite of the added costs, the private sector attracts many patients, even in many rural areas. In addition, many national and international organizations provide health services, often focusing on certain locations or 'thematic areas' such as HIV/AIDS and malaria prevention.

In this context of a significant involvement of various non-government entities in the health sector, a strengthened institutional and legal framework is important. The prevalence of private health providers both present challenges and opportunities.

6. Socio-economic Context

6.1. Population Overview

According to official estimates, the population of Myanmar reached almost 60 million in 2010. The Bamar is the largest ethnic group, comprising around two-thirds of the population, and various ethnic minorities accounting for about one third. The majority Bamar population mainly lives in the central and delta regions (divided into seven Regions) while the ethnic minorities live mainly in the seven *States* (Kayah, Kayin, Kachin, Chin, Mon, Rakhine, and Shan) along the borders. The official population estimates of the main ethnic minority groups are roughly: Shan (9%), Kayin/Karen (7%), Rakhine (4.5%), Chin (2%), Mon (2%), Kachin (1.4%), Kayah (1%). The eight "ethnic races," including the majority Bamar are subdivided into 135 officially recognized ethnic groups and belong to five linguistic families (Tibeto-Burman, Mon-Khmer, Tai-Kadai, Hmong-Mien, and Malayo-Polynesian); there are no population figures for ethnic minority sub-groups.[2]

There is freedom of religion in Myanmar. Some estimates list the proportion of Buddhists at 90%, while others at 80%.[3] Other major religions as estimated by Pew Research Center are: 7.8% Christians, 5.8% folk religions, 4% Muslims, and 1.8% Hindus.

Table 1. Population by state and region, 2007-2008

State/Region	Population in ('000)			Density (Per sq km)	Percentage of total population
	Total	Males	Females		
Total Union	**57,504**	**28,586**	**28,918**	**85**	**100**
Kachin State	1,511	747	764	16	2.62
Kayah State	336	170	166	28	0.58
Kayin State	1,740	861	879	58	3.02
Chin State	533	260	273	14	0.92
Mon State	2,997	1,506	1,492	244	5.21
Rakhine State	3,183	1,586	1,592	87	5.53
Shan State	5,464	2,738	2,726	35	9.50
Total States	**15,764**	**7,868**	**7,892**		**27.41**
Sagaing Region	6,274	3,084	3,190	67	10.91
Tanintharyi Region	1,632	814	818	37	2.83
Bago Region	5,793	2,912	2,881	146	10.07
Magway Region	5,392	2,653	2,739	120	9.37
Mandalay Region	8,062	3,984	4,078	172	14.01
Yangon Region	6,724	3,338	3,386	661	11.69
Ayeyarwady Region	7,863	3,934	3,929	224	13.67
Total Regions	**41,740**	**20,719**	**21,021**		**72.58**

[2] The government with support from the United Nations Population Fund (UNFPA) undertook a census in April 2014 using the official list of 135 ethnic groups; numbers are still to be released.

[3] Pew Research Center's Religion & Public Life Project: Burma. Pew Research Center. 2010.

Source: Statistical Yearbook, 2008, CSO. Nay Pyi Taw, Myanmar, 2009.

6.2. Socio-economic Overview

Good socio-economic data for Myanmar is limited, although a number of activities are currently ongoing, including a new census completed in April 2014 (data still being prepared). Living Standards Measurement Study, and a Demographic and Health Survey are planned for 2015.

Myanmar has the lowest GDP per capita and one of the highest poverty rates in South East Asia. In 2009/2010, the poverty headcount rate is officially recognized as 26% (IHLCA 2009/2010). The situation is improving since the current administration came to office in March 2011 with policy reforms towards a democratic society, market-oriented and open economy, and efforts to reach peace agreements in the border areas. The economy grew 5.1 percent between 2005/06 and 2009/10 and has grown at an average of 6.5 percent since the transition.

The poverty headcount index at the national level was 32 percent in 2004; 22 percent in urban areas and 36 percent in rural areas. There are disparities among the regions. Chin State is the poorest with 73 percent poor followed by Shan State with about 50 percent. Both fertility and mortality rates are high. The average household size is estimated to be about 5 persons with minor differences between urban and rural households. One fifth of the households are female-headed households and this proportion is higher in urban areas than in rural areas.[4]

6.3. Health Overview:

Myanmar is behind its closest neighbors in regards to health status indicators. It has the lowest life expectancy among ASEAN countries and is facing challenges to achieve the targets for Millennium Development Goals (MDGs) 4 and 5 related to maternal, newborn, and child health (MNCH). The maternal mortality ratio (200/100,000), infant mortality rate (40/1,000), and under-five mortality rate (52/1,000) remain high (2012 data from WHO, last updated on May 2014). Of specific relevance to MNCH are the low rates of skilled birth attendance and institutional deliveries, antenatal care visits early enough in pregnancy, post-natal care, and the appropriate treatment of common childhood illnesses. Furthermore, childhood malnutrition is persistent: 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.

While Myanmar has made substantial improvements since 1990, with maternal mortality falling by more than 50 percent and under-five mortality falling by 50 percent from 1990 to 2010, significant inequities persist. For example, 55 percent of women in the top quintile group have access to contraceptives, whereas only 38 percent of the bottom quintile does. Financial barriers lead to forgoing care, including emergency care. The 2009/10 MICS found that nearly 1 in 3 of the poorest did not seek medical care the last time they were sick. The most frequent sources of curative care for the poor were home visits (31

[4] UNPFA 2010.

percent) of unknown quality, followed by private clinics (26 percent) and rural health centers (13 percent). The wealthiest, on the other hand, received care from the private sector in nearly 80 percent of the cases.

Until recently, Myanmar used to have a very low level of government expenditures on health. In 2011-2012 the health sector accounted for only 1.3 percent of total government expenditure (about US$ 2 per person per year) but by 2013-14 it has increased to almost 4%. Out-of-pocket (OOP) spending accounted for almost 80 percent of total health spending in 2010 and, as share of total household spending, it is greatest for the poorest. With increased government spending on health in the last few years and many initiatives to reduce out of pocket spending by the MOH, OOP spending has been going down (according to Public Expenditure Review, report to be released). Myanmar households spent an average of 2.4 percent of overall consumption expenditure on health care; however, for poorest households, this climbs to 6 percent, higher than any other ASEAN country.

7. Key Findings

The social assessment involved review of relevant literature, interviews with government staff, interviews with staff and representatives from ethnic minority organizations, professional associations and local and international non-governmental organizations, and field visits to five villages in two townships: Ye Township in Mon State and Paletwa Township in Chin State, both predominantly with a population of ethnic minorities. Field visits included interviews with health staff in government run health facilities, staff at private health facilities, including those run by NGOs and ethnic minority organizations, and community members. Social aspects of primary health care systems and health service delivery were reviewed.

For this *preliminary* social assessment, the focus was to: (i) identify key issues in the health sector relevant to the project, particularly pertaining to vulnerable and under-served population groups such as ethnic minorities; and (ii) obtain views on the situation of the current health services and views on the proposed project from different stakeholders.

7.1. Vulnerable and Under-served Population Groups

Women and children:

The main target group of the project – women and young children – is also the group at most risk in regards to the health sector because of the risks associated with birth and early childhood. About one third of births in Myanmar are not attended by a skilled birth attendant (2009 MICS). A number of factors have been identified: limited availability of health facilities and trained birth attendants in remote areas, affordability, and cultural factors. Women in Myanmar have relative equality in terms of major decisions, however in property ownership and financial aspects, the roles that girls and women assume throughout their lives are still based on culturally accepted notions of womanhood and manhood.

Ethnic minorities:

It is estimated that one third of the population belong to one of Myanmar's many ethnic minorities. Most of them live in the seven States along the border areas. Economic development, infrastructure and social services in ethnic minorities' areas need more improvement and these areas have lower achievements in health and education statistics. All of the main ethnic minority groups' areas had been in conflict since 1962. Most of the armed groups have currently signed ceasefire agreements with the Government. However fighting between the military and ethnic armed groups remains in a few areas of Kachin and Shan States.

In relation to previous ceasefire agreements, ethnic minority groups were granted authority over political and economic affairs in their areas, covering large areas of the States. Social services were developed by ethnic authorities, often with support from NGOs, and are still operating in many areas. However, the health services in ethnic authorities' areas are under-developed with inadequate health infrastructure and human resources.

In remote ethnic minority areas covered by government provided health services, the services are sometimes inadequate due to geographic and economic constraints. In addition, language and cultural barriers are key factors preventing people from accessing public health care facilities, combined with poor understanding of the benefits of health care.

The Nationwide Cause Specific Maternal Mortality Survey 2004-2005 estimated Maternal Mortality Ratio (MMR) to over 500 per 100,000 live births in most of Shan State, and as low as 136 in Sagaing Division; national level was 316, 140 in urban and 363 in rural. According to other routine health information, in 2007 the highest maternal mortality ratios were observed in Kayah, Rakhine, and Shan States.[5]

Internally displaced population groups:

Due to military and civil conflicts there are internally displaced populations in some areas of the country for example in Kachin, Rakhine, Shan states. They are among the poorest and most vulnerable population groups and have limited access to quality health services, and combined with language and cultural barriers for many of them, they are highly vulnerable in terms of health services. They may not be identified in local population statistics and therefore local health plans may not be able to deliver in time the quality services that accommodate the particular circumstances and needs of internally displaced groups.

Migrants and post-disaster groups:

Migrants and post-disaster groups have also been identified as highly vulnerable groups. This includes post-disaster communities in the Delta region, and seasonal migrant workers in Mon and Karen States who come from central Myanmar to work in rubber plantations; migrants in Mon State may account for up to 20% of the population. In addition, there are returnees from Thailand who fled previous conflicts

[5] UNPFA, 2010.

in the border areas but who in many cases have not been able to return to their original villages.[6] Often these populations are not in a position to purchase health care, and they may not have established health or social networks for assistance when needed. They are also likely not to be identified in local poverty assessments and health plans.

7.2. Key Health Sector Issues and Constraints

The following analysis is based on the field visits, literature review, interviews and consultations undertaken for the social assessment. Key issues and constraints in the health sector are discussed, mainly as they concern vulnerable and under-served population groups.

Some general findings from the field visits to Ye Township in Mon State and Paletwa Township in Chin State include: There are several different ethnic groups and languages in both townships. In Paletwa common causes of maternal death are Ante-partum Hemorrhage (APH), Post-partum Hemorrhage (PPH), retained placenta and uterine rupture. There is no uniform standard for renovation or construction of infrastructure and there are at least some infrastructure needs in basic health facilities (e.g. some sub-rural health centers do not have water supply for general use and no electricity). In Mon State some rural health centers were built by the community and there were no such support for sub-rural health centers which in many cases are in bad condition. It was noted that there is a need for building houses for midwives at sub-rural health centers. Although services, such as midwives assistance at births, should be free people often have to pay informal fees.

Overlapping Health Service Delivery:

There are many different health service providers in Myanmar, including in the two townships visited for the social assessment. These include private providers such as NGOs, ethnic minority organizations, community based organization, charity clinics and informal practitioners. In the cease fire zones of Mon State, there are clinics or health services run by the Mon Health Service Department, under the New Mon State Party authority. Government health staff are often not welcomed to visit such areas, but the government provide them with supplies for vaccines and immunizations. In Ye Township in Mon State, according to the Mon Health Service Department, healthcare services delivery is partly done by government services and partly by the Mon Health Service Department. Most of the villages near the main township can be reached by government health facilities, while hard-to-reach areas are covered by the Mon services.

Coordination and cooperation between government and private run services needs strengthening. There are already some efforts to coordinate under the new government. In Ye Township it was reported that there are many civil society and NGOs running health services (e.g. in primary health care, TB, malaria, and reproductive health) and some cooperation with the government run health centers, for instance in terms of provision of training and recruiting of new community health workers. The nature of accreditation or certification by local government authorities of private health services vary by region. In Kayah State, the health units of the ethnic minority group has agreed to join the Public Health

[6] WHO and Ministry of Health. *Health Financing Review Myanmar*. February 23, 2012.

Supervisor type II course which is a foundation course to be able to delegate health services to private providers in hard to reach areas.

In Mawlamyine City in Mon State, the Mon Women Network reported that several community based organizations (CBOs) run health services with funding from international donors and NGOs. They have great knowledge of specific local health and development issues and needs, and are able to respond quickly to patients and local events. However, they are unable to provide services on a long-term and systematic basis due to short-term and uncertain funding arrangements. They requested that the CBOs are informed and engaged by state and central level health authorities, that the current administrative procedures on the government side be simplified for better coordination and implementation of activities. Moreover, ethnic minority organizations want recognition of their health system from the government to enable them to continue delivering health services in areas they currently serve.

Existing planning and implementation systems:

Township, village tract and village health committees are in place in many places, although not in many remote areas. In Paletwa Township, for instance, there are village health committees only in around 70 villages out of 384 villages. Moreover, when they do exist, they are often inactive and with poor participation of women and vulnerable groups. The township health committee was established in Paletwa, led by the township administrator and includes personnel from various sectors at township level (e.g. social welfare, Myanmar Red Cross, Myanmar Maternal and Child Welfare Association). In Ye Township it was reported that the village committees were not very active and their structure inadequate. It was felt, however, that the committees could be strengthened to play a stronger role in engaging community members and improving health services. During discussion with the New Mon State Party, they stressed the importance of ensuring transparency, accountability and inclusion of ethnic minority groups in health committees and project supported interventions.

The social assessment and field visits also found that there is room to improve the township planning system. Particularly its analytical aspects could be improved to provide a better understanding of the local health situation, of various providers and constraints, and provide a basis for targeted services that meet the particular circumstances of the population, including vulnerable groups such as ethnic minorities.

It is important to note that constraints to a participatory approach may not just originate from a centralized political system. Traditional culture and local hierarchical systems may also discourage people from expressing their views and actively participate in local decision-making and planning processes. Efforts to enhance community engagement may need capacity building and information activities to change the planning process.

Key Constraints to Accessing Health Services for Vulnerable Groups:

A number of constraints or barriers have been identified that prevent people from accessing public health services and prevent a more equitable participation of ethnic minorities and vulnerable groups. Key constraints identified are:

Affordability: Patients are required to pay for some medicines (not included in the essential medicines list) and some investigative services. "Out of pocket expenditure" for health service access is estimated to account for up to 80% in 2010 in Myanmar. However with significant increase in government health spending and free essential medicines initiatives, the out of pocket spending is reducing (Public Expenditure Review -report not yet released). Communities contribute to build and maintain basic health infrastructure and contribute to operational costs at the primary care level. Many poorest household cannot afford to access health services. Others may do so, but is highly exposed to risk of catastrophic health spending that will put them in poverty. Some measures to address this situation are being implemented, such as village health funds, trust funds for the poor, maternal voucher scheme, free essential drugs, and drug revolving funds, but these need to be expanded and communicated well among the community for better coverage and utilization.

Geography: Myanmar is a vast country with rugged or mountainous terrain in the border areas and in the flood-prone areas of the Delta region. Physical infrastructure, such as roads, is lacking or not accessible in the raining season and remote areas are poorly covered by health facilities and staff. Health staff may be unwilling to be posted, or unable to do regular visits, in remote and hard-to-reach villages.

Transportation is a key barrier in Paletwa Township. Geographically, a majority of hard-to-reach villages are located around the border of the township. Some-hard to-reach villages are at least three days away from the township center; the mode of travel is mainly by boat or walking. Currently, health services (e.g. emergency referral services and expanded program of immunization) in these hard-to-reach areas are covered by health facilities from nearby townships.

Language and culture: Language and cultural barriers, including cultural beliefs and practices, may prevent ethnic minorities from visiting public health providers. Ethnic minorities often have a more holistic view of health and diseases, seeing health as directly related to their emotional health and social relations, and they may feel that traditional health practitioners are better equipped to guide them on health matters. Many people may also be more comfortable with village based care, particularly for maternal health, that allows them to be near their family and social network rather than going to the nearest health clinic or hospital. Finally, the language and cultural barriers may result in limited trust between patient and health care practitioner.

In both townships there are traditional beliefs and practices that may challenge antenatal care and nutritional services, for instance abstinence of certain foods (e.g. omitting eating salt) during pregnancy. The gender biases and male dominance might delay women's use of maternal, neonatal and child health. Traditional health practitioners still play an important role in many communities and are often the first point of contact in case of health issues.

In Mon State it was reported that the health staff often have difficulty in communicating with local people since most of the ethnic minorities in remote rural areas only speak Mon. Most of the communities in the areas controlled by the New Mon State Party (NMSP) cannot read Burmese. As a result many people are reluctant to seek health services from government run facilities.

Under the current government there is already recognition of the problem and some ethnic minorities have been recruited in Mon State. Such continued efforts should be encouraged and supported. NMSP also suggested to prepare health information and education material in local languages and in ways that are better understood by rural community members that are illiterate or do not speak and read Burmese.

Conflict and post-conflict areas: All of the seven States have experienced armed conflicts between various military governments and ethnic armed groups. However, under the current Government several ceasefire agreements have been made and coordinated negotiations are undergoing. There are, however, still a few areas under armed conflict. The Government services do not have full access to active conflict areas and health services are provided by ethnic minority organizations and NGOs. Given the past history of mistrust that is likely to linger for many years, expanding the Government's services will be difficult and may not be welcome in some areas. Recurrent civil conflicts in Rakhine State also affect the health services for people living in these areas.

Health system and staffing: Capacity constraints of the health system at all levels challenge the ability of the public sector in Myanmar to deliver basic health services to all its population. Inequitable geographical distribution of staff, particularly deployment and retention in remote and hard-to-reach areas, constrain the provision and quality of services. As noted earlier, there have been some attempts at improving the staffing practices. This has included prioritizing or actively selecting students from ethnic minorities (for PHS II, midwives, health assistant and medical doctors). In Karen State, MoH plans to provide accreditation courses to medical and health staff trained from other health providers (e.g. Thai MoPH or international NGO's trainings programs in border areas) to work as basic health staff in their particular villages under the territory of Karen Ethnic Group Administration. It is still under the process. Similar efforts are ongoing in Kayah state with certification for PHSII for medics from Kayah Non-State Actor (Kayah Civil Health and Development Network).

Information system: The data and information system is weak and currently have limited input into improved planning at all levels. The system is constrained by limited availability of reliable township, village tract and village level population data, and available data does not differentiate patients at the hospital and health centers by ethnicity and socio-economic circumstances. The recent census would be able to improve the data collection and system in the future, but better efforts in the township health planning process and State and MoH level monitoring could provide more nuanced data sets to improve planning at the township level and below. Currently, there is also no regular data collection of availability, accessibility and acceptability of health services provided by various health care providers.[7]

7.3. Potential social benefits, impacts and risks

The project is likely to provide benefits to all population groups through an increase in health care financing and improved health systems through institutional strengthening and capacity building. This may particularly be the case for the poor and other persons currently choosing not to use the public health system for economic reasons. By improving the quality of health services, enhancing

[7] See also the 2012 Health System Assessment by WHO and Ministry of Health.

participatory approaches and increasing accountability, it is expected that more people will access health services.

While UHC typically involves the continuum of health care through all three tiers, the priority for Myanmar is to strengthen primary health care, which is the first point of access to the public system, and is often the only point of access for the most under-served populations who live in the remote rural areas of Myanmar. Primary health care interventions have globally shown to be among the most cost-effective and pro-poor interventions in the health sector.

The provision of health services supported by the project is not expected to have adverse impacts on ethnic minorities or other vulnerable groups as such. There is a strong demand in States as well as in the seven Regions of Myanmar in improving health care. NGOs and ethnic minority organizations do not deliver health services that are any different from government delivered services, although the institutional and operational aspects differ. However, the project presents issues related to equity in access to services and quality of services in areas with ethnic minorities as well as other vulnerable population groups. It may pose some risks in areas where ethnic minority health organizations are operating, either solely (often along with NGOs) or in addition to government services, as the proposed project activities may affect their own services or be perceived to affect them.

Alternative health systems, particular those managed by ethnic minority organizations, may have concern about sustainability of their health services in the changing context. Health providers, such as NGOs and ethnic minority organizations, are operating in addition to the national government's health system. The government, particularly at field level (township, village), recognizes the NGOs contribution to reach some hard to reach populations. NGOs and other health care providers have health staff that are trained and experienced, but cannot work in the public health system yet due to accreditation issues; in addition significant numbers of health staff of ethnic minority organization and NGOs may not meet MoH Burmese language requirements. In some States, however, there have been some attempts to coordinate the efforts after ceasefire agreements have been made between the government and ethnic armed groups.

7.4. Summary of the Results of Consultations

The World Bank's policy on indigenous peoples (OP 4.10) requires that broad community support from ethnic minorities are obtained through a free, prior and informed consultation process in cases where Bank-financing supports activities in areas with ethnic minorities. However, since specific townships have not been identified yet, it is premature to obtain such broad community support. The project's instrument to address OP 4.10—a Community Engagement Planning Framework (CEPF)—will need to provide a consultation and social assessment process for participating townships. Similarly, the required site-specific plans to address particular issues pertaining to ethnic minorities will be prepared during implementation. Both should be integrated into existing planning processes to enhance outcomes and sustainability.

The consultations have identified a strong interest and demand in improving health services. There is naturally an interest in expanding health services to all communities in Myanmar as part of the

government's goals for universal health coverage. However, some risks and issues concerning the proposed Bank-financed project have been raised during the consultations such as acceptance of government services among some ethnic minority organizations and communities, discrimination, language and cultural barriers. Some ethnic minority organizations have also expressed concerns that the project's support to strengthen government services and the government's universal health coverage goals may affect sustainability of their own health services. Some have suggested that the project should support improved cooperation between the government and their organizations, and some have suggested project support to their own services.[8]

These issues will need to be addressed during project implementation as project areas are being identified. Consultations should be held with a broad range of stakeholders at national, state, township and village level to seek input into, and broad community support to, the proposed project's support to strengthening the health system and services in Myanmar. Such measures for consultations and engagement with stakeholders and communities should be included in CEPF.

8. Recommendations

This social assessment has been undertaken for a fast track project where specific project areas have not yet been identified. It should therefore be considered as a preliminary assessment, with broad consultations that are not site-specific. Project implementation would need to include a more detailed and more site-specific social assessment and consultation process in the Community Engagement Planning Framework to enhance project outcomes and community participation as well as address requirements of the Bank's policy on indigenous peoples in areas with ethnic minorities.

The project's positive impacts will depend upon the degree to which it is successful in increasing the inclusion of vulnerable groups such as ethnic minorities. This would require a more participatory approach in the health care system and ways to address barriers of economic and geographical character as well as language and cultural barriers. Improved coordination with private health care providers, including ethnic minority organizations and possible traditional health practitioners, is likely to improve health services and outcomes, and provide incentives for ethnic minorities to avail themselves of the public health system. Other measures are recommended to enhance the project benefits to poor communities and vulnerable groups.

Coordination and cooperation: Enhanced coordination and cooperation between the government health system and private health care providers are recommended to enhance the health services and health outcomes for local communities. Improved coordination and cooperation between MoH and the health administrations of Regions and States is also recommended. This is particularly the case in States where ethnic minority organizations are providing health services in addition to the government and sometimes exclusively. In States it is recommended that Ethnic Minority Organizations are included in efforts to enhance coordination and cooperation.

[8] Similar concerns are raised by ethnic minority organization in a paper prepared by ethnic minority organization; HCCG, 2014: *A Federal, Devolved Health System for Burma/Myanmar: A Policy Paper (draft)*. Health Convergence Core Group (HCCG).

Improving Participatory Planning: As described in this social assessment, a significant number of constraints exist concerning the availability, utilization and quality of health services. This is particular the case in areas with vulnerable population groups such as ethnic minorities. To better identify and address such constraints, an improved participatory planning process involving consultations with community members and other stakeholders, assessments of social issues, existing issues, constraints and needs, and mapping of the various health care services available to local communities should be developed and undertaken at participating townships. Such activities will help build capacity in social analytical and participatory planning methods of MoH and township level health staff. It should also strengthen the responsiveness of health services to the needs of local communities, increase consumer participation (or their representatives), and to move towards greater social accountability at the local level. The township and village health committees should play a key role in the participatory planning process, and for that to happen there is a need to strengthen their capacity.

Improving data collection and monitoring and evaluation: Data collection on, and monitoring and evaluation of, the health situation at township and village levels needs further strengthening, and it is recommended to provide support to improve the system. It is recommended to better incorporate social and poverty variables into data collection and monitoring and evaluation systems. Core indicators should be disaggregated by sex, socio-economic status, and ethnicity. This would enhance the health sector's ability to better target and monitor health services for different social groups, including the poor, women, displaced population groups and ethnic minorities, at the township level and below.

The monitoring system may be enhanced by including consumer and civil society participation in monitoring project and sector performance. Such mechanisms are likely to improve community engagement in the health sector and enhance accountability and transparency of health care providers—government as well as private. Monitoring tools could include community scorecards, social audits, citizen report cards and citizen satisfaction surveys. In addition, various qualitative studies could be undertaken to assess social issues critical to enhancing the health services and outcomes; for instance, participatory research to assess barriers to access, health seeking behavior, and factors that drive demand for public health services of the poor and vulnerable groups.

Other Recommendations: Other measures that might be considered to enhance the project's outcome, particularly for ethnic minorities and other vulnerable groups, include:

- Training for health managers and providers to raise their understanding of, and sensitivity to, the circumstances of various population groups they serve, such as women, ethnic minorities, and other communities with different health views and practices.
- Revising human resource and hiring policies and practices to enable more active hiring and training of health practitioners from ethnic minorities. This may include waiving or lowering current language requirements for government health staff.
- Development of oral and written education and information material in minority languages regarding the government's universal health coverage program and general health education issues.

- Involving traditional health practitioners to improve their capacity and their knowledge of critical situation where referral to professional health providers is essential. Traditional health practitioners are likely to continue to be the first point of contact for many ethnic minorities and other rural households.

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