

**COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED
SAFEGUARDS DATA SHEET (PID/ISDS)**

Additional Financing

Report No.: PIDISDSA241
23

Date Prepared/Updated: 07-Nov-2019

I. BASIC INFORMATION

A. Basic Project Data

Country:	Myanmar	Project ID:	P160208
		Parent Project ID :	P149960
Project Name:	Additional Financing: Essential Health Services Access Project (P160208)		
Parent Project Name:	Essential Health Services Access Project (P149960)		
Region:	EAST ASIA AND PACIFIC		
Estimated Appraisal Date:	18-Nov-2019	Estimated Board Date:	27-Feb-2020
Practice Area (Lead):	Health, Nutrition & Population	Financing Instrument:	Investment Project Financing
Borrower(s)	Republic of the Union of Myanmar		
Implementing Agency	Ministry of Health and Sports		
Financing (in USD Million)			
	Financing Source		Amount
	International Development Association (IDA)		100.00
	Global Financing Facility		10.00
	Financing Gap		0.00
	Total Project Cost		110.00
Environmental Category	B-Partial Assessment		
Decision	The review did authorize the team to appraise and negotiate		
Other Decision (as needed)			
Is this a Repeater project?	No		
Is this a Transferred project? (Will not be disclosed)	No		

B. Introduction and Context

Country Context

Since the Essential Health Services Access Project (EHSAP) was originally approved in 2014, there have been historic elections in 2015, resulting in the formation of a new democratically elected Government coming into power in April 2016. The Government, led by National League for Democracy (NLD), has since reaffirmed its commitment to the Sustainable Development Goals through the formulation and implementation of the Myanmar Sustainable Development Plan (MSDP). The Plan also sets forth the country goals of inclusion and peace, as well as universal health coverage (UHC). In complete alignment with this vision, the Government has endorsed the National Health Plan (NHP) in March 2017 as a critical first phase on the path towards the UHC goal.

Over the past several years, evidence related to Myanmar's socio-economic conditions, including health, has expanded. Findings of the Census 2014, including township-level information, were disseminated in 2016; the first Demographic and Health Survey was conducted in 2015/2016; Micronutrient and Food Security Survey in 2018. Two rounds of the Myanmar Poverty and Living Condition Survey of good international standards have also taken place, the first in 2015, which was representative at the agro-zone level, and the second in 2017, representative at the Region/State-level. In addition, the Multi-Dimensional Disadvantage Index (MDI), created using census data, has provided a deeper understanding of welfare at the township level. The MDI provides insights into geographical disparities, marked by conflict and isolation.

Reforms in the telecommunications sector have unleashed significant opportunities. Mobile phone ownership increased from 4.8 percent in 2010 to 81.5 percent in 2017, with the majority being internet-connected smart phones. The impact goes beyond mobile phone usage. People are becoming more active on social media platforms, and mobile financial services are providing new opportunities to effectively reach broader segments of the population.

Despite sound economic and political progress, conflict and fragility continue to affect a significant portion of the country. Around one-third of townships across the country are conflict-affected. Since 2011, some progress has occurred in agreeing ceasefires with ethnic armed organizations (EAOs); recently, however, the nationwide peace process has stalled. Conflict continues or has intensified in some areas of the country, such as in Shan. In Shan State, there has been an upsurge in violence between different EAOs and between the military and the EAOs. The escalation in conflict also has resulted in greater numbers of internally displaced persons (IDPs). Over the past decades, Rakhine State has seen multiple rounds of conflict, most recently in August 2017 when deadly violence led to the forced displacement of more than 730,000 Muslims who self-identify as Rohingya into Bangladesh. Such violence has exacerbated communal tensions and deepened social fractures. In recent months, new violence involving the Arakan Army, a Buddhist ethnic Rakhine insurgent group, has led to more deaths and displacement.

Sectoral and Institutional Context

The Ministry of Health and Sports (MOHS) completed the formulation of the NHP through an inclusive and transparent process. It is the first of three 5-year phases to achieving UHC by 2030. The NHP 2017-2021 sets a promising and strategic direction by seeking to ensure universal access to a basic package of essential primary health care (PHC) services. Furthermore, the foundations and principles of EHSAP are reinforced and further concretized and institutionalized in the NHP.

Health spending in Myanmar has increased steadily in the last five years, in support of the Government's commitment to UHC. Nonetheless, because of historically low levels of spending on health, in 2015 Myanmar's total health expenditure per capita continued to be one of the lowest in the world: 70,100 Kyat, or US\$54 per annum (Health Financing Systems Assessment, 2018). This level of spending is

very low compared with other countries in the region and countries at a similar level of income. The Government's share of total health spending is estimated to be about 23 percent. The health budget has increased to around 1 percent of GDP, from an average of 0.2 percent prior to 2012. However, because of rigid financial rules and weak planning processes, there remain significant challenges in executing fully the funds allocated to MOHS. Low budget execution poses an obstacle to further increases in MOHS budget allocations. To address these challenges, the Ministry of Planning and Finance (MoPF) and MOHS have convened to jointly review the budget analysis, with technical assistance from the World Bank, and have arrived at a shared understanding of the important role public financial management (PFM) plays in health service delivery. They have agreed to undertake a PFM bottleneck analysis that will identify recommendations for actions.

In addition, the challenge of Out-of-pocket Expenditure (OOPE) by households remains the dominant source of financing for health. OOPE comprises an estimated 70 percent of total health spending. It is estimated that 1.7 million persons are pushed into poverty annually due to their OOPE on health care (MPLCS, 2015).

C. Proposed Development Objective(s)

Original Project Development Objective(s) - Parent

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).

Current Project Development Objective(s) - Parent

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), and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Proposed Project Development Objective(s) - Additional Financing

Increase coverage of essential health services of acceptable quality, with a focus on maternal, newborn, and child health (MNCH).

Key Results

As service readiness of primary health care facilities at the township and below improves, and health systems are strengthened, women, newborns, and children in Myanmar will have expanded access to basic essential package of health services. Some of the key results include increased skilled birth attendance, institutional deliveries, and postnatal care.

D. Project Description

The proposed additional financing (AF) credit and grant would help to cover the costs associated with scaling up of health systems strengthening activities initiated under the Original Credit (OC) of EHSAP and with investing in supply-side readiness, namely to fill primary health care infrastructure gaps in selected townships in Ayeyarwady Region and Shan State. The support will contribute to the achievement of National Health Plan goal of extending access to a basic Essential Package of Health Services to the entire population.

Component Name:

Strengthening Service Delivery at the Primary Health Care Level

Comments (optional)

Component 1 will be re-structured to focus on fully functional health service delivery infrastructure (FFHSDI) in selected townships in Ayeyarwady Region and Shan State. The investment under this component will ensure that the project-supported health facilities will have functioning delivery rooms and newborn care facilities along with appropriate infection prevention and control measures to enhance the reduction of maternal and newborn mortality. Investments would include refurbishment of township and station hospitals and re-construction and renovation of health centers below the township, such as rural health centers (RHCs), sub-RHCs, and Maternal and Child Health Centers.

Component Name:

Systems building, Innovation, and Project Management

Comments (optional)

The proposed component will continue to scale up systems strengthening activities initiated under OC, strengthen project management and introduce or scale up innovation that takes advantage of the rapid and widespread penetration of ICT.

Component 2.1, Systems Strengthening, will strengthen human resources at the community level and quality of MNCH care; promote infection prevention and control; institutionalize mechanisms at the region/state level for better collaboration and coordination among multi-stakeholders—government, private, NGOs, and ethnic health providers; and strengthen public finance management and supply chain management. Component 2.2 will finance activities related to innovation, public-private sector collaboration, M&E and project management.

Component Name:

Contingent Emergency Response

Comments (optional)

This is a project-specific Contingent Emergency Response Component that will allow MOHS to rapidly reallocate IDA credit proceeds to respond to health problems and issues arising out of eligible crises or emergencies. The Component would finance specific set of activities to be implemented only by MOHS to address health emergencies, such as epidemics, or health-related consequences of a natural disaster, such as flooding, landslide, or earthquake.

E. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

Component 1 will focus on fully functional health service delivery infrastructure in selected townships in Ayeyarwady Region and Shan State. Selection of 19 townships was carried out using the Multidimensional Disadvantage Index, which measures poverty, health and other social conditions, and the Health Input Score index, which measures deficiency in infrastructure and sanctioned positions. After ranking townships based on poverty, social and health needs, an additional screening was done to see whether the townships ranked from the top had any active conflict (i.e., armed violence at the time of preliminary township selection) in their areas. Those with active conflicts were excluded from the selection due to inaccessibility to the areas and security concerns for the staff and contractors responsible for implementation and supervision. The project will finance construction, renovation and refurbishing of health care facilities (HCF) including sub-Rural Health Centers, Rural Health Centers, Maternal and Child Health Centers, Station Hospitals and Township Hospitals. Health centers are small in size with no in-patient beds. A station hospital has up to 16 beds and a Township hospital has more, ranging from 25-100 beds. There will be about 19 township hospitals (roughly one in each township) and about 40 station hospitals (between one and three in each township) supported under the Component 1. For these hospitals, the project will only finance upgrades to a portion of the facility that will directly benefit maternal and child health—for example, rooms for delivery, newborn, and emergency care, operation theaters, and water and sanitation facilities. For health centers, it is estimated that the project will finance around 350 facilities with renovations or re-building within existing boundaries. A facility assessment

will provide better information on the number of health centers in need of rehabilitation and reconstruction and what part of township and station hospitals will benefit from renovation. The first phase of the facility assessment (data collection from townships) is ongoing. Once the second phase of the facility (field-based) assessment has been completed, this information will be shared and discussed for the development of Township Investment Plans. These plans will be formulated using an intensive participatory consultation process, including key stakeholders such as Region/State and township government authorities, NGOs, and Ethnic Health Providers (EHPs), in decision-making about the allocation of resources for investment. Conflict sensitivity will also be integrated into the planned development process in Shan State. EHPs are involved in the health service delivery in areas where a majority of ethnic nationalities reside, both in areas under government control and areas under non-government control. While the project will not send funds or provide material support to ethnic health providers, the project will engage with ethnic providers through consultation, dialogue and support for joint decision-making, as well as knowledge sharing and learning through joint training.

Specifically, under the Component 1, the project will not finance infrastructure in non-government-controlled areas. However, EHPs will be consulted to seek their inputs during the process of field assessment, planning and review of the implementation progress on the fully functional health service delivery infrastructure.

Component 2 finances priority health systems strengthening interventions at the union and region/state levels. It will aim to improve quality of RMNCH care, human resources available at the community level, and infection control standards at the PHC facilities. Moreover, it will strengthen institutional mechanisms at all regions/states for multi-stakeholder planning, dialogue, and reviews to promote inclusion and peace, and to enhance health system efficiency nationwide through better information management in public finance management and supply chain systems. Component 2.2 on Innovation and Project Management includes piloting and scaling up ICT-based innovations, such as telehealth, ICT based training and beneficiary feedback.

Component 2 does not involve any civil works and is limited to procurement of goods, services and incremental operating costs. Activities would be mainly related to procurement of services (individuals and/or firms) that will provide technical assistance for information systems design, pilot and roll out, development of training curriculum and delivery of training for local volunteers, and facilitation of multi-stakeholder participatory platform/meetings. The support will also cover printing, trainings/workshops, and supervision and oversight of the activities. Social risks associated with such activities are minor but may involve local exclusion from participation in the benefits of these systems interventions. Risk of exclusion is partially mitigated by design. Component 2.1 finances the development of guidelines for subnational level multi-stakeholder coordination platform as well as state/region and township level trainings on community engagement and participatory township investment planning. It also finances recruitment and training of the local volunteers from the same ethno-linguistic and cultural backgrounds as community-based health workers in order to enhance community participation and expand coverage through community outreach. NGOs, CSOs, and Ethnic Health Providers would benefit from these systems strengthening activities, particularly with regards to community engagement and multi-stakeholder platform that foster joint reviews, joint decision making and joint learning. Joint decision-making refers to dialogue and information sharing on service coverage gaps and quality issues in respective geographical areas and then on discussing and agreeing on how these gaps and issues will be addressed. Application of the CEPF to inform these engagement activities to ensure participation of ethnic minorities and vulnerable groups will further mitigate these risks.

As it will be important to ensure that basic services are available and accessible in an equitable manner to the entire population including remote populations and ethnic minorities, the project will support collection of disaggregated data on geographic location, ethno-linguistic or religious composition and

gender on beneficiary communities and on efforts to recruit, train and retain frontline health staff and volunteers from the same communities would assist with monitoring and verification. Systems interventions that pilot innovation, such as telehealth and other ICT solutions, also require stakeholder engagement and awareness raising attention to ensure benefits for the poor and marginalized are maximized. While they are expected to improve equitable application across different social groups, they should be designed and piloted with an accessibility focus in a culturally and linguistically appropriate manner for ethnic groups. OP 4.10 is triggered and specific social safeguard measures will be applied under the project as described in the CEPF.

F. Environmental and Social Safeguards Specialists on the Team

Sang Minh Le, Environmental Specialist

Warren Paul Mayes, Social Specialist

II. IMPLEMENTATION

The project will continue to be implemented by MOHS, namely the Department of Public Health and Department of Medical Services.

III. SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	OP 4.01 is triggered as the project may increase health care waste and create minor environmental impacts associated with small scale renovation, refurbishment and reconstruction activities in selected health care facilities.
Performance Standards for Private Sector Activities OP/BP 4.03	No	The healthcare facilities supported by the project are fully owned and operated by the public sector.
Natural Habitats OP/BP 4.04	No	Although the parent project covers the entire country, the additional financing focuses on primary health care infrastructure development in Ayeyarwady and Shan. The project interventions linked to health care facilities are not located in or nearby protected areas or in areas with natural habitats. The Component 1 will finance only the construction of new, or expansion of existing building, within the existing boundary of health facilities.
Forests OP/BP 4.36	No	The project does not include any activities that could affect forest, forest health and forest-dependent communities.
Pest Management OP 4.09	No	The project will not finance pesticides, such as for control of vector-borne diseases such as malaria and dengue.
Physical Cultural Resources OP/BP 4.11	No	As there will be no new constructions or expansions of health facilities beyond the

		<p>boundary of the existing health facilities, it is highly unlikely that the project will affect any physical cultural resources. There are no township hospitals or lower level hospitals or health care centers which are on a national or international heritage list. As such, the project will not adversely affect sites with archeological, paleontological, historical, religious, or unique natural values.</p>
<p>Indigenous Peoples OP/BP 4.10</p>	<p>Yes</p>	<p>The provision of health services supported by the project is not expected to have adverse impacts on ethnic minorities. However, issues related to equity in access and culturally appropriate delivery of services in areas with ethnic minorities, as well as other vulnerable population groups such as internally displaced persons, remain a challenge. A social assessment (SA) was undertaken during project preparation of the parent project, along with consultations with various stakeholders, including organizations representing and working with ethnic minorities.</p> <p>A Community Engagement Planning Framework (CEPF) was prepared based on the SA and consultation process. The Framework includes the elements of an Indigenous Peoples Planning Framework as required under OP 4.10, but also addresses broader social issues and potential impacts for all communities. It contains procedures for a practical and site-specific participatory planning process involving free, prior and consultations, social analysis and preparation of site-specific plans incorporating findings from the consultation and assessment process.</p> <p>The CEPF has been updated with new guidelines on community engagement to address challenges documented in previous consultations, and guidance on enhancing and maintaining an accessible grievance redress mechanism.</p> <p>Efforts will be required to ensure that the GRM is deployed below township level to ensure easily accessible entry points and that data on ethno-linguistics and gender of complainants is disaggregated and reported. The CEPF adapts existing procedures, applied to the Township</p>

	<p>Investment Plans, to meet OP 4.10 requirements for providing culturally appropriate engagement and benefits to ethnic minorities. The Township Investment Plan is to be designed to address the concerns of other ethnic nationalities and other vulnerable and under-served population groups based on the community engagement process described in the CEPF. The CEPF envisages that broad community support to Township Investment Plans will be achieved through the participatory planning process and the involvement of township and village health committees.</p> <p>Township Investment Plans will be reviewed for the quality of community engagement activities reflecting inclusiveness of vulnerable groups by a verification agency. Special attention will be paid in supervision to root causes of any deficiency in documentation or engagement with a view to remedy this in the next township planning exercise. A simple guideline for community engagement within the township health planning process, including a checklist on how to organize and record community consultation meetings, has been developed and townships will be trained on how to use these guidelines. There are ongoing challenges to implementation of CEPF. Challenges include reaching out to ethnic nationalities or minorities where ethnic health providers do not exist due to language, physical accessibility and representation. The project is working with other donors and NGOs who are more active in reaching out to ethnic nationalities to partner with them on outreach to communities. Well established ethnic health providers have been involved not only in the relevant townships and states/regions, but also at the National level, in particular the formulation of the National Health Plan (NHP). Ethnic health providers are recognized as important providers of health services and the plan identifies greater dialogue and coordination moving towards Universal Health Coverage. Despite the progress, there continues to be a need to ensure better assessment of specific access constraints faced by marginalized populations and minorities</p>
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		<p>and establishment of broad community support.</p> <p>Under Component 1 of the AF, broad community support for Township Investment Plans as per requirements under OP4.10 is to be demonstrated through ensuring that townships with minority populations are included in the priority list, participatory involvement and documented agreement of ethnic organizations and CSOs in the planning, and disaggregated data is collected to monitor inclusion. Plans should be informed by the project CEPF to ensure that they have involved participation and consideration of the needs of ethnic communities and other vulnerable groups. During implementation, third party monitoring, where relevant in non-government-controlled areas and self-administered areas, and beneficiary reviews will be used to ensure that all activities are subject to the enhanced consultation process of the CEPF and undertaken in a manner inclusive and accessible to targeted communities.</p>
Involuntary Resettlement OP/BP 4.12	No	The additional financing project will not finance construction of new, or expansion of existing, building beyond the boundary of existing health facilities and will therefore not involve any land acquisition. To date, none of the activities implemented or planned require land acquisition or resettlement. The project will only finance activities that have short-term minor impacts associated with the minor renovation and refurbishment of the HCFs financed under Component 1. The renovation and refurbishment activities would be done in within existing boundary of health facilities. Therefore, the policy will not be triggered for the purposes of the additional finance.
Safety of Dams OP/BP 4.37	No	The Project will not finance any activities related to the construction of dams nor affect operations of existing dams or affiliated reservoirs.
Projects on International Waterways OP/BP 7.50	No	The project will not affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	No activities are planned in any disputed areas.

IV. 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:

Environmental Safeguard Issues

Project triggers the Environmental Assessment OP/BP 4.01 safeguard policy. The project will finance construction, renovation and refurbishing of HCFs including sub-Rural Health Centers, Rural Health Centers, Maternal and Child Health Centers, Station Hospitals and Township Hospitals. Health centers are small sized facilities with no in-patient beds. A station hospital has up to 16 beds and a Township hospital has more beds, ranging from 25-100 beds. There will be about 19 township hospitals (roughly one in each township) and about 40 station hospitals (between 1 and 3 in each township). For these hospitals, the project will only be financing upgrades to a portion of the facility that will directly benefit maternal and child health—for example, rooms for delivery, newborn, and emergency care, operation theatre, water and sanitation facilities. For health centers, the project is estimated to finance about 350 facilities with renovations or re-building within the same boundary. The construction and renovation activities, which are deemed to be small scale, may generate limited adverse environmental impacts, such as dust, noise, vibration, waste, solid waste and safety issues. Without proper design, basic environmental hygiene facilities (hand washing facilities, toilets and waste disposal facility) may be neglected. Also, there could be isolated health risks associated with exposure to asbestos containing materials in the case of old facilities that are using asbestos roofs. Additionally, in the case of building renovation activities including changes of internal layout (e.g., walls), there is a potential risk on the structure and safety of the existing buildings. It is anticipated that the potential impacts of construction/renovation will be minor, site specific and manageable by mitigation measures.

The project will improve healthcare service delivery at the local level, therefore, increase generation of healthcare waste and relevant wastewater. Per World Health Organization assessment, only 10-25% of solid healthcare waste at primary healthcare settings is regarded as “hazardous waste,” including sharps, infectious wastes, anatomical waste (placenta), and small amount of pharmaceutical waste. Given the amount of healthcare waste and wastewater from HCFs is expected to be limited, potential impacts on the environment are deemed to be minor, site specific, and for which mitigation measures can be readily designed.

Social Safeguard Issues

The project will support geographical areas with ethnic minorities. Overall, communities will benefit from enhanced supply side readiness of health facilities and will be encouraged to engage in a participatory planning process to improve health services at townships and village levels. However, in the absence of culturally and linguistically appropriate mechanisms of participation there is a risk of exclusion for ethnic group beneficiaries. The CEPF adapts existing procedures, informing the Township Investment Plans, to meet OP 4.10 requirements for providing culturally appropriate engagement and benefits to ethnic minorities. The Township Investment Plan is adapted to addresses the concerns of ethnic minorities and other vulnerable and under-served population groups based on the community engagement process described in the CEPF.

There are many access and inclusion challenges, including poor primary health care

infrastructure, conflict, security and safety issues, community tensions and violence, and low retention of health work force due to security concerns and hardship living conditions. There are risks associated with unequal participation in decision-making for township health plans and exclusion of ethnic minorities and other vulnerable groups in prioritization of investments. There are also conflict sensitivity risks associated with failure to engage ethnic organizations and CSOs in project areas, including coordinating engagement for internally displaced persons, and challenges with maintaining an accessible grievance redress system to address complaints of marginalized groups. The project will not trigger Involuntary Resettlement OP/BP 4.12 safeguard policy because the construction, renovation and refurbishment will be within the boundary of existing health facilities and will not involve any land acquisition.

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

There are no indirect or long term impacts due to anticipated future activities in participating townships.

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

Not applicable

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.

Environmental safeguards:

MOHS has developed experience with implementing World Bank-financed project requirements regarding Safeguard Policies. Under the EHSAP Original Credit, MOHS has been implementing an Environmental Management Plan (EMP) including (i) application of specific Environmental Code of Practices (ECOPs) to address potential adverse environmental impacts linked to planned renovation and refurbishment works, and (ii) deployment of Healthcare waste management (HCWM) plan to address solid and liquid wastes that will be generated by the HCFs. Furthermore, with the support of the Original Credit MOHS developed HCWM guidelines/SOPs and finalized training modules. The current rating of environmental safeguard compliance is moderately satisfactory.

As part of the additional financing preparation, the EMP has been revisited by MOHS. Scope of EMP revision include: (a) updating ECOPs to reflect the good practices for managing environmental risks of health infrastructure expansion; (b) updating HCWM SOPs to be in line with newly developed HCWM guidelines; and (d) adding a section on environmental management capacity building and monitoring. The MOHS will provide the necessary training for Township Medical Officers and other relevant stakeholders including among other aspects capacity building for HCWM and project safeguards management in line with the applicable safeguard documents targeting strengthening of related procedures and regulations; and providing initial supplies to allow proper implementation of procedures in the HCFs.

Furthermore, the additional financing has a specific disbursement link indicator related the implementation of a Infection Prevention and Control (IPC) and Health Care Waste Management (HCWM) system in the HCFs. The objective is that by 2024, 180 townships will have trained staff, and all township hospitals, and 70% station hospitals and 50% primary health facilities in the 180 townships are in compliance with HCWM and infection control measures according to SOP.

MOHS will contract United Nations Office for Project Services (UNOPS), an agency with successful

track record, to oversee and manage the delivery of rural health infrastructure. This component would involve an output-based contract between MOHS and UNOPS, with direct payment to be made from WB to UNOPS. UNOPS has experience in managing and implementing the large development funds in Myanmar, including the Livelihoods and Food Security Trust Fund (LIFT), Access to Health Fund (ACCESS) and the Joint Peace Fund (JPF). Furthermore, UNOPS is the Principal Recipient for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) in Myanmar and manages the Regional Artemisinin-Resistance Initiative Towards Elimination of Malaria (RAI2E). It has also experience in implementing health and rural road infrastructure projects with financing from Asia Development Bank (ADB). UNOPS has extensive experience developing rural health infrastructure in diverse settings across the country, working with a variety of stakeholders, including ethnic health providers, and has a solid track record of producing results appreciated by the government, providers, and communities. UNOPS had to-date built over 140 rural health facilities across the country, of which 46 are in conflict-affected areas including in Shan. The inclusion of an experienced agency (UNOPS) and their agreement to implement project safeguards policy requirements will add capacity and assist with mitigation of risks associated with Component 1-supported fully functional health service delivery infrastructure. The safeguard responsibilities of UNOPS will include, but not limit, the following: (i) risk screening or impact assessment for each HCF, (ii) site-specific EMP for each HCF to mitigate potential impacts, (iii) site-specific EHS performance monitoring and supervision, (iv) training and communication, (v) auditing and monitoring, etc. Detailed safeguard responsibilities of UNOPS be described in the TOR of the contract they will sign with the Government. The Bank will continue providing capacity building and operational support to the implementation of the Project, including safeguards, and UNOPS will be required to follow World Bank safeguards policy in their contractual arrangements entered for the fully functional health service delivery infrastructure.

Social Safeguards:

The CEPF, prepared for the project, includes a participatory consultation and community engagement process to address such concerns at the State/Region, Township and Village level. The CEPF envisages that the Township Investment Plans will be prepared through this community engagement process and with the involvement of key stakeholders, which will ensure broad support. Furthermore, UNOPS will adhere to CEPF as it oversees implementation for Component 1. Its responsibilities include participation in the Township Investment Planning Process, taking into consideration the findings of Village/village tract-level community assessments, conducting site-specific consultations, monitoring and supervision, and reporting on grievances. Detailed social safeguards responsibilities and resourcing requirements will be described in the Terms of Reference (ToR) of the contract UNOPS will sign with the Government.

Throughout the implementation of the parent project, the MOHS has developed guidelines for community engagement in Township Health Plans and has trained township health departments in integrating community engagement into the township planning process. These guidelines have been incorporated into the revised CEPF under the Additional Financing to ensure that the planning process is meaningfully accessible to ethnic groups in a culturally appropriate manner and in the appropriate language.

The Township Investment Planning Process under Additional Financing will comprise engagement steps undertaken in accordance with the revised CEPF. These include multi-stakeholder meetings between ethnic health providers, NGOs, CSOs, Members of Parliaments and relevant government committees and departments to select and prioritize investments. Plans would be reviewed as ground-level situations change, for example if conflict were to break out or EAOs/ethnic health providers do not agree to the development of government infrastructure in non-government areas.

Implementation experience on establishing a grievance handling and community feedback mechanism has been uneven in townships and not systematized across the project. Existing guidelines for improving communities' role in providing feedback and oversight are being reviewed for improvement and will be implemented under the additional financing, with attendant emphasis on timely and effective government responsiveness. Communication and outreach materials in major ethnic languages would be developed to ensure that the grievance mechanism inclusive and accessible for all communities.

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

Key stakeholders include: (i) MOHS and project implementing agencies; (ii) Region/State and Township authorities, including health administrators and local government; (iii) public health care providers (hospitals, health care centers); (iv) private sector, City Development Committees (Pollution Control and Cleansing Department), NGOs, CSOs, and ethnic health providers; (v) UN agencies, including UNOPS, donors—bilaterals and multilaterals; and (vi) private providers, ethnic health providers providing health services in some ethnic nationality/minority areas which are 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.

In order to address the safeguard policy OP 4.01 requirements, MOHS updated the EMP that includes: (i) specific ECoPs to address impacts linked to planned minor refurbishment, renovation and works; and (ii) HCWM Plan and Standard Operating procedures adapted to the project that will ensure proper HCWM. During the revision of the EMP, meaningful consultations were conducted. Consultative workshops with stakeholders were held in April 2017 to discuss HCWM guidelines development.

The updated EMP, including the ECoPs and the HCWM Plan and CEPF, were disclosed in country on May 29, 2019. Public consultations were undertaken in Taunggyi (Shan State) on 22 October 2019 and in Patheingyi (Ayeyarwady Region) on 23 October 2019 to review the revised safeguards documents as well as non-technical summary of additional comments from Regional Safeguards. On updated CEPF, participants commented on the need for more awareness raising and orientation on the GRM – its various tools and channels for reporting – among the beneficiary communities and project implementers, and the practicability of community engagement activities or approaches at the ground level for sustainability beyond the project period. Comments on updated EMP included the infrastructure supported under the project to be disability-friendly and have an appropriate healthcare waste management arrangement/facility.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	01-May-2019
Date of submission to InfoShop	24-Aug-2014
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	

"In country" Disclosure	
World	29-May-2019
<i>Comments:</i> The EMP has been updated and re-disclosed.	
Myanmar	29-May-2019
<i>Comments:</i> The EMP has been updated and re-disclosed.	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	01-May-2019
Date of submission to InfoShop	24-Aug-2014
"In country" Disclosure	
World	29-May-2019
<i>Comments:</i> Community Engagement Planning Framework has been updated and re-disclosed.	
Myanmar	29-May-2019
<i>Comments:</i> Community Engagement Planning Framework has been updated and re-disclosed.	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why::	

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment						
Does the project require a stand-alone EA (including EMP) report?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
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	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>

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	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
The World Bank Policy on Disclosure of Information						
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
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	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
All Safeguard Policies						
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
Have costs related to safeguard policy measures been included in the project cost?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>

V. Contact point

World Bank

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VII. Approval

Task Team Leader(s):	Name:Hnin Hnin Pyne,Nang Mo Kham	
<i>Approved By:</i>		
Safeguards Advisor:	Name:	Date:
Practice Manager:	Name:	Date:
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