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Report No: PAD1020

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT
IN THE AMOUNT OF SDR 65.4 MILLION
(US$ 100 MILLION EQUIVALENT)

TO

THE REPUBLIC OF THE UNION OF MYANMAR

FOR AN

ESSENTIAL HEALTH SERVICES ACCESS PROJECT (P149960)

SEPTEMBER 23, 2014

Health Nutrition and Population Global Practice
East Asia and Pacific Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective July 31, 2014)

Currency Unit	=	Myanmar Kyat
970 Myanmar Kyat	=	US$1
US$1.53131	=	SDR 1

FISCAL YEAR
April 1 – March 31

BEmONC	Basic Emergency Obstetric and Neonatal Care
CEPF	Community Empowerment and Planning Framework
DA	Designated Account
DHP	Department of Health Planning
DHS	Demographic and Health Survey
DLI	Disbursement-Linked Indicator
DOH	Department of Health
DP	Development Partner
EC	Executive Committee
ECOPS	Environmental Code of Practices
EEP	Eligible Expenditure Program
EPHS	Essential Package of Health Services
FM	Financial Management
GDP	Gross Domestic Product
GOM	Government of Myanmar
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
HRITF	Health Results Innovation Trust Fund
HSS	Health Systems Strengthening
IDA	International Development Association
IHLCA	Integrated Household Living Conditions Assessment
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IHP+	International Health Partnership
IUFR	Interim Unaudited Financial Report
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MD Account	Ministry and Department Account
MDG	Millennium Development Goal
MEB	Myanma Economic Bank
M-HSCC	Myanmar Health Sector Coordinating Committee
MICS	Multi Indicator Cluster Survey
MNCH	Maternal, Neonatal and Child Health
MOF	Ministry of Finance
MOH	Ministry of Health
MPLCS	Myanmar Poverty and Living Conditions Survey

NGO	Non-Governmental Organization
NHA	National Health Accounts
OM	Operations Manual
OP	Operational Policies
PDO	Project Development Objective
PHC	Primary Health Care
PPP	Public Private Partnership
PSC	Project Steering Committee
RBF	Results-Based Financing
RHC	Rural Health Center
SARA	Service Availability and Readiness Assessment
S/RHD	State/Region Health Department
SC	Sub-Center
SH	Station Hospital
SOE	Statement of Expenditures
SOP	Standard Operating Procedures
TMO	Township Medical Officer
UHC	Universal Health Coverage
WB	World Bank
WBG	World Bank Group

Regional Vice President:	Axel van Trotsenburg
Country Director:	Ulrich Zachau
Sector Director:	Xiaoqing Yu (through June 30, 2014)
Global Practice Senior Director:	Timothy Evans (from July 1, 2014)
Global Practice Director:	Olusoji Adeyi (from July 1, 2014)
Sector/Practice Manager:	Toomas Palu
Task Team Leader:	Hnin Hnin Pyne

MYANMAR
ESSENTIAL HEALTH SERVICES ACCESS PROJECT

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PAD DATA SHEET

Myanmar

Essential Health Services Access Project (P149960)

PROJECT APPRAISAL DOCUMENT

EAST ASIA AND PACIFIC

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Report No.: PAD1020

Basic Information		
Project ID P149960	EA Category B - Partial Assessment	Team Leader Hnin Hnin Pyne
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [X] Financial Intermediaries [ ] Series of Projects [ ]	
Project Implementation Start Date 01-Jan-2015	Project Implementation End Date 30-Jun-2019	
Expected Effectiveness Date 01-Jan-2015	Expected Closing Date 30-Jun-2019	
Joint IFC No		

Practice Manager/Manager	Senior Global Practice Director	Country Director	Regional Vice President
Toomas Palu	Timothy Grant Evans	Ulrich Zachau	Axel van Trotsenburg

Borrower: Republic of the Union of Myanmar
Responsible Agency: Ministry of Health
Contact: Dr. Kyaw Khaing Title: Director Telephone No.: (95-67) 411-353 Email: kyawkhaing68@gmail.com

Project Financing Data(in USD Million)					
[ ]	Loan	[ ]	IDA Grant	[ ]	Guarantee
[X]	Credit	[ ]	Grant	[ ]	Other

Total Project Cost:	100.00	Total Bank Financing:	100.00
Financing Gap:	0.00		

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	100.00
Total	100.00

Expected Disbursements (in USD Million)

Fiscal Year	2015	2016	2017	2018	2019	0000	0000	0000	0000	0000
Annual	25.00	25.00	25.00	25.00	0.00	0.00	0.00	0.00	0.00	0.00
Cumulative	25.00	50.00	75.00	100.00	100.00	0.00	0.00	0.00	0.00	0.00

Proposed Development Objective(s)

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).

Components

Component Name	Cost (USD Millions)
Component 1: Strengthening Service Delivery at the Primary Health Care Level	84.00
Component 2: System Strengthening, Capacity Building, and Project Management Support	16.00
Component 3: Contingent Emergency Response	0.00

Institutional Data

Practice Area / Cross Cutting Solution Area

Health, Nutrition & Population

Cross Cutting Areas

[ ] Climate Change
[X] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	85		
Health and other social services	Other social services	15		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	85
Social protection and risk management	Other social protection and risk management	15
Total		100

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

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

Legal Covenants

Name	Recurrent	Due Date	Frequency
Institutional Arrangements	X		CONTINUOUS

Description of Covenant

The Recipient shall maintain, all times during the implementation of the Project, a Project steering committee, project implementation staff at the MOH, health committees at the state/region, township,

village tract and village level, and township medical officers, all with functions and resources satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
Project Operations Manual	X		CONTINUOUS

Description of Covenant

The Recipient shall ensure that the Project, including the provision and administration of Health Facility Grants, is carried out in accordance with the arrangements and procedures set out in the Project Operations Manual.

Name	Recurrent	Due Date	Frequency
Environmental and Social Safeguards	X		CONTINUOUS

Description of Covenant

The Recipient shall ensure that the Project is carried out in accordance with the provisions of the Environmental Management Plan and the Community Engagement Planning Framework and the safeguard provisions of the Financing Agreement.

Name	Recurrent	Due Date	Frequency
Independent Verification Agent		31-Mar-2016	

Description of Covenant

Recipient shall appoint an independent Disbursement Linked Indicator verification agent, with terms of reference and qualifications satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
Submission of Disbursement Linked Indicator Report	X		Yearly

Description of Covenant

The Recipient shall: (i) not later than May 31 of each year during the implementation of the Project, furnish reports to the Association on the status of achievement of the relevant DLI Targets; and (ii) not later than July 31 of each year, furnish to the Association the DLI verification reports of the independent DLI verification agent.

Name	Recurrent	Due Date	Frequency
Financial Management staffing at township level		31-Mar-2015	

Description of Covenant

The Recipient shall ensure that the Departments of Health and Health Planning of MOH, each Region/State Health Department, and each Township Health Department has appointed staff at appropriate level, and with terms of reference and qualifications specified in the Operations Manual, to assist the said department in the carrying out of their financial management functions in accordance with the OM.

Name	Recurrent	Due Date	Frequency
Contingent Emergency Response	X		CONTINUOUS

Description of Covenant

The Recipient shall adopt a satisfactory Contingent Emergency Response Implementation Plan for

Component 3 of the Project and, in the event of an eligible crisis or emergency, ensure that the activities under said component are carried out in accordance with such plan and all relevant safeguard requirements.

Conditions

Source Of Fund	Name	Type
IDA	Withdrawal Conditions	Disbursement

Description of Condition

The Recipient may not withdraw the proceeds of the Financing under Component 1 unless and until it has furnished evidence satisfactory to the Association that it has achieved the respective DLI(s) and reported a corresponding amount of Eligible Expenditures, and under Component 3 until and unless an eligible crisis or emergency has occurred, the contingent emergency response plan has been adopted and all safeguard and other requirements under the Financing Agreement have been complied with.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Hnin Hnin Pyne	Senior Human Development Specialist	Team Lead	GHNDR
Nang Mo Kham	Human Development Specialist	Human Development Specialist	GHNDR
Cornelis P. Kostermans	Lead Public Health Specialist	Lead Public Health Specialist	GHNDR
Caryn Bredenkamp	Senior Economist	Senior Economist	GHNDR
Lars M. Sondergaard	Program Leader	Country Sector Coordinator	EACTF
Frederick Yankey	Sr Financial Management Specialist	Sr Financial Management Specialist	GGODR
Zhentu Liu	Senior Procurement Specialist	Senior Procurement Specialist	GGODR
Sirirat Sirijaratwong	Procurement Specialist	Procurement Specialist	GGODR
Myat Kay Khine	Procurement Specialist	Procurement Specialist	GGODR
Ruxandra Maria Floroiu	Senior Environmental Engineer	Senior Environmental Engineer	GENDR
Manush Hristov	Senior Counsel	Senior Counsel	LEGES
Chau-Ching Shen	Senior Finance Officer	Senior Finance Officer	CTRLN
Khay Mar San	Program Assistant	Administrative Support	GURDR

Non Bank Staff

Name	Title	City
Sundararajana Gopalan	Senior Consultant	Bangalore
Seida Heng	Financial Management	Phnom Penh

	Consultant	
Svend Jensby	Sr. Social Safeguards Specialist	Washington, D.C.
Kyemon Soe	Financial Management Consultant	Yangon

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

I. STRATEGIC CONTEXT

A. Country Context

1. Myanmar, with a population of around 51.4 million[1], has the lowest Gross Domestic Product (GDP) per capita and one of the highest poverty rates in Southeast Asia. The poverty headcount rate is officially estimated at 37.5 percent (World Bank, 2014).

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

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

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

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

B. Sectoral and Institutional Context

6. Myanmar has the lowest life expectancy among ASEAN countries. It is unlikely to achieve Millennium Development Goals (MDGs) 4 and 5, i.e., those related to maternal, newborn, and child health (MNCH), despite improvements between 1990 and 2010 when maternal mortality ratio fell from 520 to 200 per 100,000 live births, and under-five mortality rate from 100 to 52 per 1,000 live births; infant mortality rate still stands at 40 per 1,000. Each year about 2,000 pregnant women and 50,000 children die from preventable causes. Of relevance to MNCH are the low levels, especially among the lowest quintile, of births delivered by skilled birth attendant (52 percent), post-natal care (59 percent), and exclusive breastfeeding of under-6 months olds (24 percent). Childhood malnutrition is persistent: in 2010, 1 in 7 infants was born with low birth weight, 35 percent of children under the age of 5 were stunted (low height for age), 23 percent underweight, and 8 percent wasted (low weight for height).

7. ***Challenges***. Progress towards the MNCH MDGs is constrained by difficult terrain, conflict in border areas, and health systems challenges, namely health financing, human resources, state of physical infrastructure, and information, including quality of data[2]. In

[1] On August 30, 2014, the government officially announced this provisional figure based on 2014 Census.

2 Over the past 10 years, data on health has come from either administrative sources or from four large household surveys, namely the Integrated Household Living Conditions Assessment (IHLCA 2004/2005 and 2009/10) and Multiple Indicator Cluster Surveys (MICS 2004/5 and 2009/10). The country has not had a census in 30 years, thus making any estimation involving a population denominator less reliable.

remote/hard-to-reach areas, there are difficulties in deploying and retaining workers. In the border conflict affected areas, prevention and curative care are being delivered by community-based organizations and ethnic authorities and more convergence is needed between the various delivery mechanisms.[3] Health services access has been significantly constrained for ethnic and religious minorities in some parts of the country, including Kachin and Rakhine States. Access has been impeded, in particular for Muslim populations in Rakhine State, both those internally displaced living in camps and those living in their own villages, due to disruption of NGO services and controlled mobility. On the demand side, women and girls face obstacles from seeking care and information about reproductive health due to gender norms and traditional beliefs and practices about child birth and child feeding and rearing. Women tend to be less literate than men across Regions and States (e.g. 38 percent vs. 45 percent in Eastern Shan State and 62 percent vs. 70 percent in Rakhine State). As a result, coverage varies dramatically across the country.

8. The health system suffered from fragmentation due to international sanctions, which prevented external aid from flowing through the Government of Myanmar (GOM). This led to a strong presence of international and local NGOs for delivering key services and a private-for-profit health care sector thriving in peri-urban areas albeit largely unregulated. Parallel systems present a challenge for GOM to effectively implement its stewardship functions.

9. ***Emerging Opportunities.*** Myanmar's triple transition has catalyzed many positive changes in the health sector. Strong political commitment exists to improve health outcomes and accelerate progress towards Universal Health Coverage (UHC), through expanded coverage of quality services, enhanced financial protection, and increased satisfaction among the population. At the Second Myanmar Development Cooperation Forum in January 2014, the WBG expressed interest in providing IDA support for Myanmar's move towards UHC, which led to the preparation of the proposed operation. In February 2014, Myanmar's President called for "people-centered" reforms in the health sector.[4] GOM's paper on Strategic Directions towards UHC was presented at a special session of the 2014 WBG Spring Meetings. Global health leaders, including from World Health Organization, bilateral donors and foundations, endorsed the efforts for UHC and strongly committed to aligning their assistance with the GOM strategy.

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

11. Furthermore, public spending on health has increased from US$1 per capita in 2009/2010 to US$8 in 2012/2013 and to US$11 in 2013-14. Development partners (DPs) have scaled up

3 The Ministry of Health (MOH) and ethnic authorities and non-governmental organizations (NGOs) working in the border areas have been in dialogue to ensure greater convergence of the health systems ranging from coordination to full integration. This initiative is embedded in the larger peace process dialogue.

4 More specifically, reforms to: (a) Improve the supply side readiness to scale up coverage and quality of services, in particular human resources, medicines, equipment, infrastructure, and information system; (b) enhance governance of the health sector, through improved planning and management of budget and finances, greater monitoring and supervision of service delivery, increased transparency in administration, such as deployment and promotion of health staff; (c) provide greater oversight of quality in both private and public sectors; (d) improve communication with community and patients/customers; (e) introduce performance-based incentives; (f) involve communities in service delivery and monitoring; and (g) provide a greater and clearer role of State/Region governments.

their financial support since 2010; a total amount of about US$950 million has been committed for the next 3 to 5 years. Of those funds, about $750 million are managed by the United Nations Office for Project Services for the Global Fund to Fight AIDS, Tuberculosis and Malaria and for the 3MDG Fund (a pooled fund financed by seven bilateral donors, including Australia, the United Kingdom, and the United States of America. These funds do not flow through the government system, but there is donor interest in exploring that option. The remainder includes support from the Japan International Cooperation Agency (JICA) and the Global Alliance for Vaccines and Immunization.

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

13. In 2014-15, only US$20 million of the US$650 million MOH budget went to the operational costs (i.e. non-salary recurrent expenditure) of the frontline facilities at township level and below[5], which are responsible for primary and secondary care. This translates to a monthly average of US$2,000 per township hospital, US$175 per station hospital (SH), and US$225 per Rural Health Center (RHC)[6]. Travel allowances and the general goods and services budget for RHCs were only US$5 and US$7 per month respectively. Basic health staff (e.g. health assistants, lady health visitors, and midwives) largely rely on community donations and their own funds to cover operational costs to provide services in the community, such as immunization and environmental sanitation, to identify pregnant women and young children and encourage timely care-seeking behaviors, and to undertake behavioral change activities related to nutrition, disease control and prevention.

C. Higher Level Objectives to which the Project Contributes

14. The proposed operation is aligned with the WBG Interim Strategy Note for Myanmar for the period FY13-14, which was discussed at the Board on November 1, 2012. It focuses on producing tangible impact for communities through the improvements in the delivery of essential health services, which in turn would build trust and confidence in the reform process. It would build the institutional capacity of MOH to fulfil its stewardship function. It would contribute to ending poverty and boosting shared prosperity by improving human capital and laying the groundwork for preventing impoverishing and catastrophic health expenditures.

II. PROJECT DEVELOPMENT OBJECTIVE

A. PDO

15. 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. The project would thus contribute to Myanmar's move towards UHC. It would also support a prompt and effective response to crises and emergencies.

[5] Facilities at township level and below include township hospitals, station hospitals, rural health centers (RHCs), urban health centers, maternal and child health centers, and sub-centers.

[6] Facility averages derived from combining data from 2014/15 MOH budget and 2009 list of facilities.

B. Project Beneficiaries

16. The project focuses on quality maternal, newborn and child health (MNCH) services.[7] Over the 4-year implementation period, the project is expected to benefit approximately 4 million pregnant women and their young children across all of Myanmar's 330 townships in 17 states and regions. Indirect beneficiaries are other members of the communities, basic health staff and medical doctors.

C. PDO Level Results Indicators

17. The PDO indicators are:[8]

(a) Percentage of deliveries with skilled birth attendants
(b) Percentage of deliveries followed by adequate post-natal care
(c) Percentage of children under six months who are exclusively breast-fed
(d) Number of townships where the township hospital and at least 60 percent of other health facilities meet a minimum readiness level of 14 out of 20 to provide essential MNCH services.

18. Readiness level is measured by a composite index that covers domains of health system standards, such as staffing, drugs/vaccine availability, basic equipment, record keeping, and health care waste management.

III. PROJECT DESCRIPTION

A. Proposed Project Design and Rationale

19. The proposed project will tackle a ***key binding constraint*** to expanding access to quality MNCH service delivery at the primary health care (PHC) level (township and below), namely ***lack of ready access to sufficient, predictable, timely and flexible financing at frontline service delivery units***. GOM has significantly increased its allocation to capital expenditures, salaries, and pharmaceuticals, with smaller but marked increases to non-salary recurrent budgets as well. This creates a need to improve the allocation of these additional resources across township and facilities, and a need to increase the amount going to the facilities, especially for lower levels and in remote areas. GOM now intends to use IDA financing to achieve a more efficient, equitable and predictable allocation of operational resources.

20. Removing this constraint will transform the way health services function, as well as empower and motivate frontline workers to perform better and be more responsive and accountable to communities, thus expanding coverage of MNCH services. The increased funds will be used to catalyze bottom-up, inclusive planning and budgeting, together with strengthened local management of resources.

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[7] The use of the word, coverage, in PDO is aligned with Monitoring Progress towards UHC: Framework, Measures and Targets, WHO and World Bank, 2014. Adequate quality refers to health systems standards and does not include technical/clinical dimensions of quality.

[8] PDO indicators (a)-(c) are expressed here as percentages (to be derived from sample surveys). Absolute numbers will be calculated by extrapolation to population data to be generated from the 2014 census.

21. The project would improve the flow of funds to front line providers through health facility grants in the following way: (a) increasing the ***quantity*** of funds reaching township level and below; (b) increasing the ***efficiency*** of resource allocation by shifting a greater share of resources toward primary care and secondary prevention; (c) promoting ***transparency and predictability*** of the operational budget; (d) ensuring ***equity*** in resource allocation, by sending a larger share of operational budget to hardship townships; and (e) ensuring ***timeliness*** of resource flows. Facilities will have considerable ***flexibility*** with respect to the budget codes on which funds can be spent, in order to allow them to best adjust to their unique circumstances, but ***oversight and accountability*** will be ensured by clear guidelines and training on fund use and reporting, as well as the involvement of local communities in facilities' spending decisions.

22. In so doing, the proposed project aims to establish credible and transparent mechanisms for fund flows to the front line services. A strong financial management (FM) system would enhance the DPs' confidence that resources will be used for intended purposes and lay the basis for possibly expanding DP support in the future, and for channeling them on budget, through Government systems.

23. The project would also help address the issue of impaired health service access to ethnic and religious minorities by strengthening inclusion, both system wide and in States and selected Townships from hardship and conflict affected areas: (i) Township health plans incorporating Community Engagement Planning Framework (CEPF) and community involvement in service delivery are pre-requisites for receiving health facility grants; (ii) IDA disbursement is linked to the quality of township health plans and adherence to CEPF; (iii) the project will include intensive capacity building—training and technical assistance—to selected townships to facilitate effective implementation of CEPF as part of township health plans; and (iv) States, such as Mon, Rakhine, and Kachin, will be provided with additional resources to promote inclusion and convergence of service provision by government and non-governmental actors.

24. Complementary capacity-building investments and technical assistance, namely in FM, procurement, and planning, at the central, state/region, and township levels, to be financed by the project, will help to channel the increases in government health expenditures toward their most efficient use, strengthen the institutions and processes associated with FM, and develop a financing strategy conducive to financial sustainability as a sector goal.

25. A complementary project currently under consideration will also support ***testing of*** specific ***results based financing approaches***, beyond the Disbursement-linked Indicators (DLI) Approach used for Component 1 of this project, see below. This project will be financed by a ***grant*** from the Health Results Innovations Trust Fund for conceptualization, piloting, learning and evaluation.[9]

26. IDA financing of operational expenses at the frontlines of service delivery complements, as well as enhances, the support of UN agencies, international NGOs, and bilateral donors. IDA support selectively focuses on recurrent costs, avoiding areas where Government and DPs are

[9] Types of results based financing pilots could include inter-governmental performance-based transfers to states, regions and townships, performance-based financing of health facilities or the use of cash transfers or vouchers to remove demand-side barriers to using of health services. A maternal voucher scheme, financed by the Global Alliance for Vaccines and Immunization has been piloted in one township.

already engaged, namely construction and major rehabilitation and repair of hospitals, RHC and sub-centers (SC), supply chain management, procurement of drugs, and information systems. UN agencies, which have long been involved in Myanmar, provide technical assistance and training at all levels, manage cash flow, and procure essential commodities/drugs and supplies. International NGOs, such as Save the Children and Population Services International, implement public health interventions, deliver services, and provide implementation support to local organizations and providers. Annex 2 provides an overview of support by other DP.

B. Project Components

27. **Component 1: Strengthening Service Delivery at the Primary Health Care Level (US$84 M)** focuses on channeling funds through MOH to the states/regions and townships (the latter in the form of health facility grants) for operational expenses or non-salary recurrent expenditures. MOH has prepared an Operations Manual (OM) for the project, which sets out the details of how such grants would be provided, used and accounted for, as part of the overall implementation arrangements.

28. ***Health Facility Grants to the Township and Below***. US$ 60 million (about 70 percent of the component allocation) is expected to flow to the public facilities at the township and below. Funds will be provided through Township Health Departments (THD) led by Township Medical Officers (TMOs), for use at the township hospitals and onward disbursement to SHs, RHC, and maternal and child health centers, based on Standard Operating Procedures (SOP), which are included in the OM. The grants will be provided to support (i) the expansion of supervision, communication and community engagement activities by basic health staff and medical officers; (ii) the operation, maintenance and repair of health facilities and equipment; and (iii) the provision of amenities and consumables required for effective health care.

29. Township Hospitals would receive about US $3,000, while SH/rural health centers, secondary (urban) health centers US $500 to 1,000 (to be phased in over the project life) and school health and MCH centers about US$100. When applied across the country, these amounts add up to US$35 million per year for all the PHC facilities put together. This is a 75% increase over the current allocation of US$20 million (from MOH's own resources) for operational (non-salary recurrent) expenses in these facilities in Myanmar. Thus the IDA contribution to the health facility grants would be $15 million per year or $60 million over the four years.

30. The allocation of resources across facilities was determined by a simple formula which results in a payment that is fixed for all facilities of a particular type, but adds a 100 percent premium to facilities located in hardship townships. The formula is designed with the following principles in mind: simplicity, transparency (based on data that are easily available and beyond dispute), equity (with larger allocation to facilities in hardship townships) and predictability (in terms of the facility amounts and their timing). Based on experience gained, it is possible that the formula may evolve over time. The formula will apply to government's entire recurrent operational budget for township level and below; the IDA share of this will be approximately 40 percent in the first year, but is expected to decline as GOM spending increases over time.

31. ***Allocation to the State/Regional Health Departments.*** Around US$24 million will be provided to the State/Regional Health Departments (S/RHDs) for operational expenses to carry out supervision, coordination, convening, and communication activities, hiring basic health staff or financial officers on contractual basis, and for development of a convergence strategy by state

authorities together with ethnic group organizations. The amount provided to each of the 17 S/RHDs will consist of an annual allocation of US$200,000 per state/region plus an amount that varies proportional to the number of townships in that state/region, for a total of between US$200,000 and US$400,000 per S/RHD per year.

32. ***Community empowerment.*** The project would support activities to enhance communities' awareness of Government's efforts to improve health service delivery through increased operational budgets, empowered to demand services, and mobilized to participate in planning, funded through the allocation for facilities and community actions. Communication methods to achieve this would include the effective use of all available media, sign-boards, local events, and inter-personal communication at health facilities and during outreach services. A Community Engagement Planning Framework (CEPF) has been developed for this purpose (see also Component 2 and Section VI. E. below).

33. ***DLIs***. For Component 1, IDA will disburse funds to MOH upon achievement of DLI targets, which are monitored annually and subject to independent verification. Table 1 below describes the DLIs and their contribution to the PDO. DLI 1 is the overarching measure of service readiness (PDO level); DLI 2 measures the predictable and flexible availability of resources at the local level; DLI 3 measures service availability closer to the community; DLI 4 ensures that township level planning is socially inclusive and participatory; DLI 5 and 6 measure the extent to which supervision visits are carried out by the township and S/RHDs, respectively, and DLI 7 measures human resource readiness. Detailed DLI verification protocols are in Annex 3 as well as in the OM.

34. DLIs focus on measuring improvements in service delivery readiness, not health outcomes or service coverage (which is affected by demand side factors as well and require population denominators). Health outcomes are further downstream indicators, which require inputs beyond the control and scope of the project, and therefore not included among PDO indicators. Coverage indicators require household surveys, which are expensive, and therefore not conducted every year, also health outcomes typically do not show demonstrable changes within one year, and since DLIs need to be monitored annually, coverage and outcome indicators are not appropriate to link with disbursement. Readiness reflects availability and is a reasonable proxy for access. Service delivery readiness is essential for the achievement of UHC.

35. Townships are the units of interest for disbursement, as they are the lowest administrative units responsible for primary care and also the lowest facility level with bank accounts and drawing rights, and counting the number of townships which meet the criteria would be a practical way of aggregating these measures across the nation.

36. The project is nationwide in scope and, so, additional resources are expected to flow to all townships from the first year of implementation. However, in view of the likely challenges in strengthening fiduciary systems and other capacity requirements, DLI cumulative targets have been set realistically, so that expected achievement will be scaled up progressively. The achievements will be measured in a selected 50 townships in 2015, increase to 100 in 2016, 200 in 2017 and 300 in 2018 cumulatively. Results will, thus, reach nationwide scope by the end of the project, as there are 330 townships. To ensure that results are being achieved in the most needy areas right from the beginning of the project, it has been agreed that at least 20 percent of

the townships selected for DLI measurement each year should represent hardship and conflict affected areas in States, such as Kachin, Shan, and Rakhine. [10]

37. The township health planning process is detailed in the OM. A sample of township health plans will be reviewed by the WB every year. As it is a DLI, the plans will also undergo review by the third party conducting independent verification.

Table 1. Disbursement Linked Indicators (DLIs) and their relationship to the PDO

Indicator	How does the DLI contribute to the PDO
DLI 1: Number of Townships in which the Township hospital and at least 60% of other Health Facilities have met a minimum Readiness Level of 14 out of 20 to provide essential maternal, neonatal and child health services. *Readiness level is measured by a composite index included in the OM that covers domains of health system standards, such as staffing, drugs/vaccine availability, basic equipment, record keeping, and health care waste management.*	Health systems readiness at the township and below is essential for expanding essential MNCH services, including skilled attendant, immunization, antenatal and post-natal care, promotion of exclusive breast feeding, and integrated management of childhood illnesses.
DLI 2: Number of Townships in which the Township hospital and at least 80% of the other Health Facilities have received Health Facility Grants in accordance with the Project Operations Manual	Flexible, predictable and transparent flow of operational funds allows health staff to travel to make household visits; facilities and equipment are maintained; and basic needs of the users of the facilities are met.
DLI 3: Number of Townships in which at least 80% of the required number of antenatal and postnatal visits and deliveries have been carried out by basic health staff in accordance with the Project Operations Manual.	Improving MNCH outcomes requires regular household visits to women and children unable to come to facilities. Outreach also supports health education for communities.
DLI 4: Number of Townships in which the Township Health Departments have prepared an annual integrated and inclusive Township Health Plan in accordance with the Project Operations Manual and the CEPF. *"Integrated" refers to the manner in which contributions from various actors—providers and financiers—are reflected in the plan.* *"Inclusive" refers to the participation of ethnic groups and vulnerable groups and incorporation of social analysis findings.*	Community engagement and involvement of ethnic groups and other vulnerable groups contribute to better accountability of service delivery and better access in an inclusive manner. The different planning templates currently in use for DP-funded programs would be integrated into one common system. While inclusiveness as per CEPF would be promoted in all townships from year 1, the integration and improved quality would be scaled up from 50 townships in the first year to 300 townships by year 4 of the project.
DLI 5: Number of Townships in which all rural health centers and at least 50% of rural health sub-centers have been supervised at least twice in the Fiscal Year by the Township Health Department	Operational funds will allow TMOs to enhance supervision of basic health staff, help resolve problems in a timely way, and identify needs and gaps. Beyond technical supervision, the checklist

[10] In 2013, 76 (23 percent) of the 330 townships were designated as "hardship" which means that either the entire township or at least one area within the township area are locations where civil servants are eligible for hardship allowances.

medical officers using the supervision checklist in the Project Operations Manual.	includes FM quality, data quality etc.
DLI 6: Number of Townships in which the Township Health Departments have been supervised at least twice in the Fiscal Year by State/Region Health Department officials using the supervision checklist in the Project Operations Manual.	States/Regions have become more prominent and have an important supervision role for service delivery at the township level to enhance equity and effectiveness. Beyond technical supervision, the checklist includes FM quality, data quality etc.
DLI 7: Number of Townships with at least 60% of midwives have been trained to deliver basic emergency obstetric and neonatal care and integrated management of childhood illnesses.	BEmONC is essential for quality services for pregnant women and newborns. Childhood illnesses will be handled in an integrated manner

Component 2: System Strengthening, Capacity Building, and Project Management Support (US$16M)

38. ***System strengthening*** will focus on the definition and costing of an Essential Package of Health Services (EPHS) which GOM would provide to the entire population. System strengthening also includes the development of a comprehensive health financing strategy for UHC, the preparation of health care waste management guidelines, and development of quality score card for township and below, and testing SOPs for FM and internal audit, among others. MOH at the central level intends to produce these outputs using in-house and national expertise and carrying out consultation meetings and workshops.

39. ***Capacity building*** includes training, courses, South-South learning, workshops and seminars. It will also support career development for basic health staff, who are recognized for their outstanding performance, and for MOH officials for further studies in health economics, financing, management, and other areas critical for universal health coverage. Criteria for selecting training programs, institutions and the trainees, and other relevant details about this fund are included in the OM. This component will benefit technical and administrative staff at the central, regional/state, and township levels, and basic health staff providing key services. In addition, capacity building will include national and local organizations working in ethnic group areas. A simplified procurement plan, in line with IDA Guidelines, has been developed. Annex 2 broadly defines the key areas of capacity building and OM will include a more detailed plan for Year 1.

40. ***Project management support*** includes preparatory work for the implementation of Component 1, such as strengthening of monitoring and evaluation (M&E) arrangements, including studies and surveys, and technical assistance for independent verification. These activities will be carried out in early 2015, which is one of the reasons why the DLI targets have been kept modest for that year.

Component 3: Contingent Emergency Response (US$0M)

41. A component with a provisional allocation of zero dollars is included under this project in accordance with OP 10, paragraph 12 and 13, for projects in situations of urgent need of assistance or capacity constraints. This will allow for rapid reallocation of credit proceeds in the event of the government declaring that a crisis or emergency has occurred and the WB agreeing with such determination. Requirements for withdrawals under this component include: (a) preparation and disclosure of all safeguards instruments required for activities under the

components, if any, and the government has implemented any actions which are required to be taken under said instruments; (b) establishment of adequate implementation arrangements, satisfactory to the WB, including staff and resources for the purposes of said activities; and (c) preparation and adoption of the Contingency Emergency Response Implementation Plan, acceptable to the Bank and annexed to the OM. Disbursements under this component will be made according to the process described in Annex 3.

42. In the event of an emergency, financial support could be mobilized by reallocation of funds from component 2 and/or application for additional financing. In the case of such reallocation, the component 2 activities would be reviewed and revised as necessary.

C. Project Financing

a. Lending Instrument

43. The proposed operation will use Investment Project Financing. Component 1 will disburse against an eligible expenditures program (EEP) linked to achievement of targeted results for DLIs; Component 2 will use traditional input-based financing. Component 3 will allow the reallocation of funds in the event of an emergency which would be disbursed either against a positive list of critical goods and/or against the procurement of works, and consultant services required to support the immediate response and recovery needs of GOM (see Annex 3 for details).

44. An Investment Project Financing instrument with DLIs balances the ambition to facilitate results orientation against Myanmar's limited systems capacity. The Program for Results instrument was considered, but current limited systems capacity does not yet allow for it. The project now focuses on building this capacity in a key area: the delivery of essential health services.

b. Project Financing

45. The proposed project will be financed by an IDA Credit. Under Component 1 (US$84 million), the project will provide flexible, predictable, and transparent funds for operational expenditures, by using the GOM budget lines under the "Current Budget and Expenditure." Component 2 (US$16 million) provides funding for system strengthening, capacity building and program support. The project will support eligible expenditures as described in Annex 3 and the cost and financing is provided in Table 2 below.

Table 2. Project Cost and Financing (in US Dollar Millions)

Project Components	Project Cost	IDA Financing	% Financing
1. **Strengthening Service Delivery at Primary Health Care Level (DLI based)**	84	84	100%
2 System Strengthening, Capacity-Building, and Project Management Support (in-put based)	16	16	100%
3. Contingent Emergency Response	0	0	100%
Total Financing Required	**100**	**100**	**100%**

D. Lessons Learned and Reflected in the Project Design

46. Under the Interim Strategy, the WB carried out a public expenditure review as well as various analytical and advisory work funded by the 3MDG Fund. The project incorporates the following lessons from local and international experience with development assistance for Health, from the WB's recent engagement in other sectors of Myanmar, and from the WB's experience with DLI-based operations:

(a) ***Keep it simple:*** A special effort has been made to keep the project simple by focusing on a key binding constraint to improving service coverage, namely the lack of adequate, predictable, flexible and timely resources to the PHC level operations.

(b) ***Focus on results***: The DLI approach has been chosen based on growing evidence that incentivizing results rather than financing inputs leads to enhanced service delivery and use.

(c) ***First things first:*** While UHC typically involves the continuum of health care through all three tiers, the priority for Myanmar is to achieve MNCH outcomes and strengthen PHC, often the only point of access for under-served populations in remote rural areas.

(d) ***Avoid fragmentation of DP inputs and parallel systems:*** In line with the Paris Declaration and International Health Partnership (IHP+), which Myanmar has recently joined, WB support was designed in collaboration with relevant DPs. The operation will be implemented using the GOM systems, including management and fund-flow.

(e) ***Importance of maintenance/operational costs:*** Local and global experience with development assistance shows that often buildings and equipment financed by external funds remain unused or underused due to the lack of corresponding recurrent inputs.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

47. The OM has been prepared as a comprehensive reference document for implementation, with details including DLI verification protocols, disbursement, financial management, SOP for fund-flow from TMO to health facilities, procurement procedures, safeguards documents, terms of reference for various committees, monitoring and reporting templates. Annex 9 contains the outline of the OM. Here the key elements of implementation arrangements are summarized.

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

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

50. ***Oversight, implementation guidance and support*** will be through existing mechanisms of GOM. The National Health Committee, the highest health policy making body, will be updated regularly, in particular where coordination with other ministries such as Finance, Labor (Social Security Board), Planning, and Civil Service Board is essential. Within MOH the Executive Committee (EC), consisting of the Minister, two Deputy Ministers, the Director Generals and other senior officials, will have the oversight responsibility of the proposed project. The EC will be informed about the project implementation by Director General, DOH, supported by the PSC.

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

52. ***State/Region level.*** The project will support the state/regional health departments in supervising the township health departments, communicating to communities about the increased funds to the frontlines, coordinating government and external aided programs, and collaborating with non-governmental actors, including ethnic organizations.

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

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

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

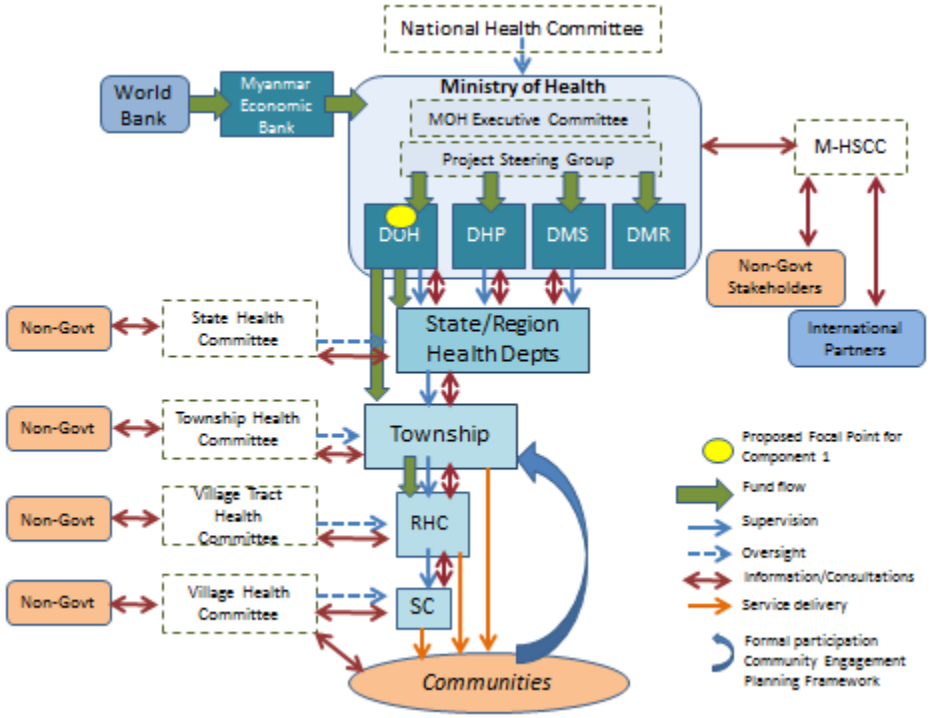
partnership with health sector DPs even before the project preparation began (e.g., a mapping exercise and joint consultations on UHC held in partnership with WHO). Many bilateral donors are waiting for the WB-financed operation to strengthen the government systems prior to channeling their funds through these.

56. The project supports health service provision at township level in an integrated manner, i.e., the comprehensive township health plans will also reflect the activities by GAVI, 3MDG Fund, and NGOs. MOH is working with DPs on a uniform format and process for such plans, ensuring broad-based participation and inclusive consultation.

57. During consultations regarding the project design, NGOs and private sector indicated that the WBG should focus on supporting the government's policies and processes to become more coherent and consistent and improve its communication. This would, in turn, facilitate NGOs and private sector in delivering services.

58. Detailed arrangements, in particular the roles and responsibilities of each level and mechanism, and terms of reference are in the OM. The first draft of the OM has been prepared by MOH and reviewed and agreed at negotiations; the OM will be a "living document" updated from time-to-time as necessary with WB approval. The OM would be a comprehensive reference document which guides the implementation of the project. In addition, SOPs are also developed for specific aspects, and annexed to the OM. For instance, FM SOP applies to township and below levels, and applies to Government funds as well as IDA funds.

Figure 1. Organizational chart of implementation arrangements



B. Results Monitoring and Evaluation

59. The project will have a strong system of M&E to: (a) ensure effective and timely implementation according to plan with course corrections if needed; (b) measure achievement of results; (c) learn lessons; and (d) provide a basis for the disbursement of IDA funds.

60. Annex 1 presents the proposed Results Framework for the project. DLIs will be a subset of the fuller list of indicators. Indicators will be regularly monitored through the various information sources, including routine health management information system (HMIS). Its data quality will be strengthened as part of a capacity building program.

61. DLIs need more intensive monitoring and ***independent verification***, to determine the amount of IDA disbursements. MOH will contract an international firm in partnership with national/local organization to carry out independent corroboration of the DLI report through sample surveys, including a review of checklists filled by township and state teams to verify results.

62. To evaluate project progress towards achieving the development objectives, population level data will be collected through household surveys. Baseline data will be obtained from the 2014 Myanmar Poverty and Living Conditions Survey (MPLCS) and the 2015 Demographic and Health Survey (DHS). Interim baseline data will be from the MICS 2009/10. As DHS 2015 data will be collected before additional project resources flow, they will form an appropriate baseline. End-line data will be gathered from the same series of surveys (DHS is expected to be repeated in 2018). However, if no such survey is available, the project will finance the follow-up data collection (see Annex 3 for a more detailed description of the M&E arrangements).

C. Sustainability

63. ***Financial Sustainability*** is considered from two perspectives: (a) sustaining overall public expenditures on health; and (b) sustaining the additional resources on operational expenditures at the PHC level beyond the project.

64. With respect to the former, there is both broad political support for the UHC agenda and considerable fiscal space. GOM's commitment to the sector has been demonstrated by the recent rapid increases to the sector budget from about US$1 per capita in 2007-08 to about US$11 per capita in 2013-14. In addition, with health spending at just 2.4 percent of GDP (among the lowest in the region) and good medium term macroeconomic prospects (7.75 percent growth in 2014/15, inflation stable at 7 percent, and a declining fiscal deficit), [11] Myanmar is likely to have more than sufficient fiscal space to sustain the increased health expenditures, including beyond the project period. Moreover, total IDA resources allocated to the project are relatively small, equivalent to only 4 percent of the GOM's 2014-2015 health budget of US$650 million.

65. With respect to the latter, GOM increased allocations for operational expenditures at township level and below (from about US$3 million in 2012-13 to around US$20 million in 2013-14 and 2014-15), and it has indicated a commitment to further increasing resource flows to this level over time. That said, the proposed scale-up of health spending at the township level and below through the project, on top of a recent increase in the MOH budget to that level, raises questions about the absorptive capacity at the local level. This is why the project is not only supporting the reform of the process of resource allocation through the introduction of an allocation formula that is needs-based, efficient and equitable, but also related planning activities, development of guidelines (SOPs), FM capacity building (training) and more decentralized management of resources in order to help facilities plan for and use these additional funds efficiently.

66. Finally, the project supports the development of a comprehensive health financing strategy for UHC. Reaching consensus on such a financing strategy is expected to considerable analytical work, political dialogue and broad-based discourse, but will be key to ensuring the long-term fiscal sustainability of sector investments as a whole (see Annex 6 for more details).

67. ***Institutional sustainability*****.** The project uses and strengthens existing GOM mechanisms for fund-flow, planning, and other implementation aspects and it supports GOM in the development of policies, strategies and action plans.

68. ***Technical sustainability*** is expected to be high as the project includes resources to build capacity, especially at the most peripheral levels, thus facilitating learning by doing, rather than directly delivering goods and services.

V. KEY RISKS AND MITIGATION MEASURES

69. The health sector challenges outlined in sections A and B are significant. Moreover, the proposed operation represents the first time that WBG engages in the sector and, in marked difference from other external financing, will rely on strengthened government systems for project implementation and management. With a fragile peace process and ongoing political transition, this justifies a high risk rating for the project. To mitigate such risks, there has been

[11] 2nd Review of the joint WB-IMF Joint Staff Monitored Program, January 2014

intensive dialogue, including meetings, workshops and seminars, between MOH, WB, parliament, the civil society, other DPs, and these consultations will continue during implementation. The WB is also working with other DPs to ensure that assistance is provided synergistically.

70. As the operation intends to increase fund flow to the primary facilities, FM is a critical risk. To reduce leakage, there will be an emphasis on building the capacity of local authorities and facilities to manage funds and enhancing public transparency by proper reporting on the use of funds and oversight by community through Health Committees at various levels of planning and budgeting processes.

71. Another risk is that poor and under-served populations, especially ethnic groups in the border areas, such as in Kayin, Shan, and Kachin States, and other vulnerable groups in the Rakhine state affected by conflict, do not benefit from the project. Also, hard-to-reach areas (due to geographic and security constraints) could be left out of the programs unless special care is taken to include them. The project design mitigates this risk by supporting inclusive planning through the CEPF and through transparency and accountability of fund flows. Extensive consultations were held with CSOs and stakeholders, including public consultations on the CEPF on July 7 and 8, 2014. The CEPF provides for a continuous consultation process throughout project implementation.

72. The CEPF will be implemented to ensure that social analysis (identifying ethnic and other vulnerable groups, their needs and existing gaps) and consultations are undertaken at the township level and that the findings are incorporated into the planning and budgeting process. Improved township health plans will include required elements of an ethnic minority plan in townships with ethnic groups. The project also includes capacity building of MOH and other relevant partners in the implementation of the CEPF and provides resources to states and townships for better convergence and collaboration between government and ethnic authorities.

73. Furthermore, to enhance access to health services by vulnerable and minority groups in the Rakhine state, the government has taken actions as follows: (i) a plan has been prepared to improve access to health services in the Rakhine state, including for vulnerable groups; (ii) the ministry is meeting with CSOs on a regular basis; and (iii) international CSOs, whose services were disrupted, are resuming their activities. The Bank will continue to work with other partners in supporting the government to provide inclusive services in the Rakhine state.

74. The table below summarizes the ratings of the operational risk assessment framework in Annex 4.

A. Risk Rating Summary

Table 3. Risk Ratings

RISKS	**RATINGS**
Project Stakeholder Risks	
• Stakeholder Risk	High
Implementing Agency (IA) Risks (including Fiduciary)	
• Capacity and Governance (including FM)	High
Project Risks	
• Design	Substantial

• Social/Environment	High
• Program and Donors/Development Partners	Substantial
• Delivery Monitoring and Sustainability	Substantial
Overall Implementation Risk	High

B. Overall Risk Rating Explanation

75. Overall risk is rated high. Although GOM commitment is strong, this is the first IDA operation in the sector, will be implemented by MOH, and significant time is needed to ensure shared understanding about internal processes and requirements. Risk is also high because of uncertainty of MOH capacity to put in place all the systems for implementation. The risks are moderated by high level and broad based ownership of health systems strengthening (HSS) for UHC and by close collaboration with DPs for implementation.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

76. ***The project's expected contribution to development***. Ending poverty and boosting shared prosperity can be realized only if households no longer risk impoverishment through payment for health services, and their education and work opportunities are not unduly constrained by illness. The project will therefore have an impact on development through human capital formation.

77. ***The efficiency rationale for investment***. Pervasiveness of market failures, externalities and spillover effects provide a rationale for public intervention. This holds particularly for this project which focuses on improving service delivery at the lower levels of care through substantial additional operational resources to frontline service providers, improving allocative efficiency, and supporting policy changes and institutional reforms that enhance the environment for providers. There is an important role for the private sector in the delivery and financing of health care and a later stream of the WB support will help put in place a health care financing system that includes a strong stewardship role for GOM and a private sector engagement.

78. ***The equity rationale for investment***. There are at least three equity challenges. First, access to services, both curative and preventive, is inequitably distributed. The use of MNCH services is concentrated among the better-off. While 87 percent of the wealthiest quintile seek care when ill, only 67 percent of the poorest do. Second, there appears to be little financial protection. At 60 percent of total expenditure, out of pocket payments are the dominant form of health financing and in the absence of widely-available prepayment mechanisms households face a risk of incurring medical expenditures that are impoverishing and catastrophic. In 2009/10, 21 percent of households incurred catastrophic health expenditure (IHLCA 2009/10). Third, benefit incidence analysis, based on the IHLCA 2009/10 data and the 2009/10 National Health Accounts for health expenditure, shows that GOM health spending is currently slightly pro-rich, driven by the expenditure share of general and specialist hospitals, where the subsidy concentration indices are 0.165 and 0.219 respectively. Spending at SHs and lower levels of care (i.e., RHC, maternal health centers and public health clinics) is slightly pro-poor with subsidy concentration indices of -0.008 and -0.012.

79. The design of the project is strongly pro-poor: (a) it focuses interventions and financing on the lowest levels of service delivery (i.e. facilities at township level and below) which are disproportionately used by the poor, which should make overall GOM health spending more pro-poor; (b) it focuses on the health services (and health outcomes) that are most inequitably distributed (such as reproductive health), (c) the introduction of a resource allocation formula that allocates more money to facilities in "hardship" townships (i.e. the hardship premium), and (d) ensuring that the allocation of project funds to S/RHDs results in a distribution that advantages the S/RHDs of the (ethnic) states, relative to their size. In addition, the fact that at least 20 percent of the DLI achievement in any given year should be in the "hardship" states (i.e., approximately proportional to their population share) would ensure that the poor are not left behind in project implementation. Finally, the project will explicitly monitor the effect on the poor in the results framework, by disaggregating the PDO indicators by poor and non-poor.

80. ***The financing gap – at macro and micro level.*** The project's economic and financial analysis shows that there is a significant financing gap at both the macro and the micro levels. While GOM health spending has grown by about 480 percent over the last 5 years, overall levels of health spending remain very low at only 2.4 percent of GDP, and GOM health spending is equivalent to only US$11 per capita. These figures suggest a history of chronic underinvestment in the health sector and that current levels of financing are likely insufficient to provide needed health services. At the micro-level, there is also a scarcity of resources, especially in the operational budget of facilities at the township level and below on which this project focuses. Despite some recent budget increases, only US$20 million of the US$650 million MOH budget is spent on operations at this level. A township hospital receives only US$2,000 per month in its operational budget and an RHC receives only US$225 (see more extensive analyses in Annex 6).

B. Technical

81. Constraints to UHC are present on both supply and demand side, i.e., both in terms of health system readiness for private and public sectors to make services available and accessible and in terms of the clients' willingness and ability to utilize those services. Clients are constrained by financial, social, geographical barriers, as well as inadequate information and knowledge. WB support will begin to address these barriers, but a comprehensive health financing strategy is yet to be developed and consensus arrived on it. This first stream of support focuses on a critical constraint at PHC level (i.e., lack of flexible, timely and sufficient resources to meet the operational costs of PHC services) and the absence of interventions that are universally recognized as being among the most cost-effective and are expected to have a significant impact on maternal and child health. The empowerment of communities will lead to their proactive involvement in local planning and implementation of health actions.

C. Financial Management

82. The project will apply procedures and fiduciary requirements acceptable to IDA, through the OM and SOP. An assessment of the FM arrangements has been conducted based on the guidelines issued by the FM Sector Board, as stipulated in OP/BP 10.00. The overall FM risk is assessed as High. The main risks that need to be addressed include (a) weak capacity of the township to manage the larger scale of operational budget; (b) inadequate documentation of policies and procedures; (c) limited participation of service delivery units in budget preparation

process; (d) lack of mechanism for allocation of budget to the service delivery levels; and (e) lack of clarity and inadequate guidance in the applicable government rule on travel allowances.

83. Mitigation measures to address these identified risks include: (a) development of FM policies and procedures especially for township level and below; (b) appointment of staff of appropriate level to assist the health departments (Central, State/Region, and Township) in carrying out of financial management functions and to cope with the increased work volume; (c) provision of training to accounts staff at all level on the developed FM policies and procedures; (d) increased oversight and monitoring of township FM activities by State/Region FM teams and communities; and (e) strengthening the internal audit function of MOH. In addition the program design is structured to allow phasing the resource transfers, by starting small in year one before scaling up year on year to cover all states and township in the four year life of the project. With respect to the identified risks and mitigation measures agreed, the FM arrangements for this project meet the FM requirements of the WB. As per WBG's Access to Information Policy, audited statements will be made public.

84. Project funds will be part of the overall budget for MOH and flow through existing mechanisms. IDA disbursement will follow three approaches: DLI-based approach for Component 1 (US$84 million), traditional input-based lending for Component 2 (US$16 million) for systems building, capacity-building and project management support, and financing of pre-defined emergency response expenditures in the event of an eligible crisis or emergency under Component 3 (see Annex 3 for greater detail on disbursements, fund-flow and FM).

85. Under the DLI approach, the amount advanced on credit effectiveness will be 100 percent of the value of the DLIs targets to be achieved in the first year. Disbursement in subsequent years will be upon the Borrower fulfilling two requirements: (a) GOM expenditures on an agreed eligible expenditure program (EEP) exceed the amount advanced by IDA in the prior year documented in an Interim Unaudited Financial Report (IUFR); and (b) achievement of agreed targets of DLIs, documented in an annual DLI report, verified independently. If the EEP is lower than the previous IDA advance, the subsequent disbursement of IDA will be adjusted accordingly—a situation which is not expected to occur.

86. The EEP would consist of the GOM budget for the health sector except what is included in a negative list (see Annex 3). By excluding the negative list from the EEP the project seeks to finance travel allowances, utility bills (electricity, phone, internet, etc.), local labor/contractual services for the operation of health facility, minor maintenance/repairs/refurbishment of health facilities, vehicles and equipment, and essential consumables that are locally available such as vehicle fuel, office supplies, soap, cleaning supplies, gauze, gloves, syringes, etc. This list is just illustrative of what constitutes operational expenditures. Other types of expenditures not foreseen here may also be financed, as long as they are not in the negative list.

87. In an effort to synchronize the disbursement of IDA funds with the GOM budget cycle, the following calendar of actions has been developed. DLI measurement and reporting will be done annually, as they relate to the GOM fiscal year (April 1 to March 31), with verification carried out by June 30 and disbursement of next fiscal year's advance completed by mid-August. The following table shows the key dates/steps, with details in Annex 3).

Table 4. Disbursement-Related Steps

Date	IDA disbursement-related steps
FIRST YEAR	
September, 2014	MOH includes project-related costs in budget request to MOF for the subsequent fiscal year.
January 15, 2015	MOH forwards withdrawal application to IDA for Component 2 for year 1
January 31, 2015	IDA advances up to 100% of the estimated expenditures for component 2 in 2015-16 (US$ 4 million).
March 15, 2015	MOH forwards withdrawal application to IDA for Component 1 for year 1.
March 31, 2015	IDA advances up to 100% of the value of all DLI targets to be achieved in 2015-16 (US$ 21 million).
September 30, 2015	GOM forwards Audited Report for fiscal year 2014-15. MOH submits to MOF, its requests for supplemental budget for FY 2015-16. MOH includes project-related costs in budget request to MOF for the subsequent fiscal year.
November 15, 2015	MOH forwards IUFR for the semester ending September 30, 2015 to IDA demonstrating adherence to EEP.
SUBSEQUENT YEARS	
May 15	MOH forwards IUFR for the entire year ending March 31, demonstrating adherence to EEP.
May 31	MOH forwards DLI report for prior fiscal year (April - March).
July 15	Independent Verification completed by third-party agency.
July 31	Independent verification of DLI report forwarded to the WB, which then confirms to GOM the amount to be advanced – see formula Annex 3.
August 15	GOM forwards withdrawal application based on the agreed amount to be advanced, together with supporting documentation.
August 31	IDA release advance for next fiscal year.
September 30	GOM forwards to IDA, the Audit Report for previous fiscal year. MOH submits to MOF requests for supplemental budget. MOH includes project-related costs in budget request to MOF for the subsequent fiscal year.
November 15	MOH forwards IUFR for the semester ending September 30 to IDA - demonstrating adherence to EEP.

88. In case of partial achievement of DLIs in a given year, the advance for the subsequent year will be prorated accordingly. The WBG, in consultation with GOM, might cancel or reallocate funds in case of severe underachievement. Disbursements for any DLI will be capped at the amount allocated for that year for the concerned DLI target, i.e. over-achieving the DLI targets will not lead to ever increasing disbursements. On project completion, the final DLI achievement for 2018 would be verified by the third party evaluation by June 30, 2019. In case of under-achievement of targets, GOM would need to reimburse IDA an amount equivalent to the value of unachieved DLIs, unless an extension of the closing date is requested by GOM and agreed by IDA, and the targets are met during the extension.

89. Component 2 disbursements will be through advances into the respective designated accounts (DA) and accounted for by Summary Sheets with Records and Statement of Expenditures (SOE) for the specific inputs procured, as per agreed procurement plan and replenished on that basis. Direct Payments can also be made by IDA to the vendors on instructions from GOM (especially for large payments in foreign currency).

90. IUFRs will be prepared by MOH, using the existing arrangement and consolidated at the finance unit of the Minister's office on a six-monthly basis, reflecting both GOM and IDA funds.

The format and content are expected to be similar to the current MOH financial reports. MOH will forward copies of these IUFRs to the WB within 60 days after the semester end for the first year and then within 45 days for the subsequent years. Annual financial statements will be audited by the Office of Auditor General and copies of audit reports sent to the WB within 6 months after GOM financial year ends (i.e., by September 30).

91. The existing fund flow mechanism at MOH was found acceptable and will be used up to the township level for Component 1. Since there is a limited fund flow for non-salary operational cost at this stage, the budget allocation and mechanism of fund-flow from township to the service delivery level will be reviewed and any changes to fund-flow arrangements agreed with GOM and documented as part of the SOP for FM.

92. For Component 1, IDA funds will be advanced into a DA to be maintained in Myanmar Kyat at the Myanma Economic Bank (MEB) with a variable ceiling, managed by the DOH. DOH, using the existing government systems, will then channel the funds to townships and States / Regions. For Component 2, IDA will advance funds to two DAs, to be maintained in Myanmar Kyat, one managed by DOH and the other by DHP, to support their respective project activities. The overall FM arrangements including the operation of the DAs will be overseen by an FM committee (to be appointed by MOH). Annex 3 provides more detail on disbursement, FM and fund-flow.

93. No disbursements can take place under Component 3 unless the government has: (a) declared that a crisis or emergency has occurred, and the WB has agreed with such determination; (b) prepared and disclosed all safeguards instruments required for activities under Component 3 of the project, if any, and the government has implemented any actions which are required to be taken under these instruments; (c) established adequate implementation arrangements, satisfactory to the WBG, including staff and resources for the purposes of these activities; and (d) has adopted a Contingent Emergency Response Implementation Plan (CERIP) acceptable to the Bank and annexed to the OM.

94. For Component 3, disbursements would be made either against a positive list of critical goods and/or against the procurement of works, and consultant services required to support the immediate response and recovery needs of GOM. The details of eligible expenditures and disbursement arrangements will be further defined in the Contingent Emergency Response Implementation Plan (CERIP) annexed to the OM, which will be developed early during Project implementation and before any disbursements under that component can be released.

D. Procurement

95. The bulk of project funds (US$84 million going to Component 1) will be linked to results/outputs, with disbursements contingent on achieving DLI targets. At the state/region level, funds will be used for operation costs, such as staff travel, workshops, etc. and procurement will be very limited. Each township hospital will receive around US$36,000 per year for operational expenditures (travel allowances, utility bills (electricity, phone, internet, etc.), local labor/contractual services for the operation of health facility, minor maintenance/repairs/refurbishment of health facilities, vehicles and equipment, and essential consumables that are locally available such as vehicle fuel, office supplies, soap, cleaning supplies, gauze, gloves, syringes, etc.). Below township level, RHCs, SHs and Secondary Health Centers (Urban facilities) will each receive about US $9,000 per year for similar expenditures as above. It is expected that the value of any single procurement will be small. The procurement

procedures to be used are specified in the OM and were found in accordance with the principles of the World Bank Procurement Guidelines. At the same time, the procurement systems, procedures and capacity at the township level and below will be strengthened.

96. For Component 2 (US $16 million), GOM has prepared a capacity building plan, including TA, studies/analytical work, training, and South-South exchanges, and a procurement plan acceptable to IDA (revised only with the concurrence of the WB); thresholds have been prescribed for prior review. Component 2 will not entail any works; only goods and services (both consulting and non-consulting services) which would be procured based on the WB's Procurement and Consultant Services Guidelines.

97. In the event that Component 3 may finance goods, works and consultant services required for immediate response, procurement will be arranged following the related World Bank procedures and will be further detailed in the project CERIP.

98. Within the Ministry of Health, International Health Division (IHD) would be responsible for overseeing and supporting selection and recruitment of consultants and Central Medical Store Depot (CMSD) for procurement of goods. MOH will appoint a focal coordinator in IHD and a focal coordinator in CMSD to handle the procurement.

99. The risk for procurement is high because (a) a huge number of township hospitals and health centers will do small purchases; (b) there is no clear procurement procedure at this level; and (c) it will be the first WB project in the sector and all the entities of MOH do not have experience with the World Bank procurement procedures.

E. Social (including Safeguards)

100. The project is national in scope including areas with ethnic groups, covered under Operational Policy 4.10 on indigenous peoples. Myanmar has 135 officially recognized ethnic populations, grouped into 8 "major ethnic groups". Smaller ethnic groups account for about a third of the total population, and live mainly in seven states (Kachin, Kayah, Kayin, Chin, Mon, Rakhine and Shan) in border areas.

101. A social assessment of the risks and social impacts of the proposed project identified vulnerable social groups, social and cultural issues relevant for the project, and informed the project design and community engagement framework to enhance outcomes and ensure equitable benefits for vulnerable groups such as the poor, women, ethnic groups, internally displaced, and migrants. The assessment also sought to identify and assess issues and risks concerning ethnic groups following the WB operational policy 4.10 that aims to ensure that the project provides culturally appropriate benefits and not have adverse social impacts. Provisions for continued and site-specific social analysis/assessments are included in the project.

102. Adverse impacts on ethnic groups, religious minorities, or other vulnerable groups are not expected. Rather, it is expected to help address the issue of impaired health service access to ethnic and religious minorities by strengthening inclusion, both system wide and in States and selected Townships from hardship and conflict affected areas. Consultations with NGOs representing ethnic groups did not reveal opposition to the proposed project and improved health services are in demand. Some of the key health sector issues identified by the preliminary social assessment include: (a) the overlapping of health services by various service providers such as the government, ethnic health organizations, private sector; (b) limited capacity and inclusiveness of the existing planning and implementation systems; (c) major barriers in

accessing health services are affordability, remoteness, language and culture, limited health staff and weak information dissemination. In addition, the project presents issues related to equity in access to services and quality of services. The outcome of peace negotiations with ethnic groups will determine how GOM health systems could complement and coordinate with services being delivered by ethnic authorities.

103. To enhance project benefits to vulnerable and under-served population groups, a Community Engagement Planning Framework (CEPF) has been prepared and incorporates recommendations from the social analysis as follows: (a) enhancing the participatory planning process which requires each township to map stakeholders and health care services, carry out consultations and a social analysis and incorporate the findings into its health plans, which will be the basis of project support to the respective township; (b) developing key health education related materials in group languages; (c) improving the capacity of staff including those from ethnic health organizations, NGOs and international NGOs; and (d) improving data collection and monitoring and evaluation at the township and village levels with the support from civil society organizations. The CEPF includes the elements of an "Ethnic Groups Planning Framework" required under the Operational Policy 4.10 and incorporates procedures for the township-level social analysis and consultations during implementation and the preparation of Township Health Plans that incorporate the required elements of an "Ethnic Group Plan".

104. The project was prepared in discussion with stakeholders, including DPs, government, private health care providers, local and international NGOs, NGOs representing ethnic group groups, professional associations, members of Parliament, and representatives from major political parties for greater ownership of the project. Annex 7 summarizes the key points from these stakeholder meetings. Field visits to several townships were undertaken and included discussions with community members, government and private health providers, including ethnic group organizations providing health services. Earlier WB operations in the country also provided insights in needs and ground realities.

105. The preliminary social assessment and the draft CEPF were discussed with civil society organizations representing ethnic groups and with national and international NGOs July 7-8, 2014 in Yangon and in Mawlamyine, Mon State. Copies of the draft documents (in Myanmar language and in English) were provided to the invited agencies two weeks (June 23) before the consultation meetings. Overall, participants expressed support for the project, and for measures provided in this CEPF to ensure that the project would benefit the underserved, including women, disabled, migrants and ethnic groups.

106. The key recommendations from the consultations include: The program should consider measures to: (a) ensure better alignment, coordination and collaboration between government and ethnic authorities' health services; (b) integrate health plans of ethnic organizations in the township health plans; (c) include participation of private sector, communities, and civil society in the project process, activities and mechanisms, especially in the health committees; (d) disaggregate project data by ethnicity; (e) build the capacity of staff from ethnic health organizations; and (f) ensure that M&E can adequately measure results and impacts of the project.

107. The CEPF has integrated input from the consultations, especially the inclusion of the vulnerable groups including disabled, migrants, women and ethnic group organizations in the township health planning process. The CEPF also includes the participation of civil society

organizations, private sector and local communities in the project, and in the monitoring of activities and provision of feedback. In the OM, MOH has prepared operational guidelines which incorporate key principles of the CEPF. Capacity building component of the project will also be extended to both male and female staff of ethnic health organizations. Data will be collected and disaggregated by household surveys.

108. The DOH will be responsible for the implementation of CEPF and the site specific township health plans which incorporate CEPF principles. The Project will provide capacity building and training support for staff to be able to supervise and implement participatory planning and monitoring the Project. The WB will review a number of randomly selected township health plans making up at least 10 percent of the plans prepared during the regular planning process prior to financing to ensure that CEPF procedures and requirements have been adequately undertaken. Once, as a result of such prior review, townships are judged to have developed the necessary capacity to prepare the township health plans, the WB's role will shift to post review of these plans. The implementation of the township health plans will be reported to MOH and the WB annually as part of MOH's annual reporting on project implementation.

109. The final CEPF was officially adopted by the MOH and disclosed in-country on August 28, 2014 and at the InfoShop on August 24, 2014. A more detailed description of CEPF is provided in Annex 3.

F. Environment (including Safeguards)

110. The proposed project is expected to provide additional financing to the existing operational budget for services provided at township and below. The project may include financing for small-scale rehabilitation of existing health care facilities within the same foot print and support for new supplies and equipment for primary care use (e.g., syringes). Given the relatively weak capacity of the implementing agency (MOH), especially at the local level, to manage environmental safeguards provisions, the project will not consider financing of new construction or expansion of existing facilities, nor items that generate radioactive healthcare waste during operation (e.g., biomedical equipment) or use and purchase of pesticides such as those for control of vector-borne diseases (e.g., malaria, dengue). The planned activities might generate minor temporary site-specific environment impacts (e.g., dust, noise) and contribute to increased health care waste, for which guidance on management and disposal is integrated in the project design. The project has thus been proposed as category B since all activities will take place within the footprint of existing facilities and with known limited impacts on surroundings and people. MOH has prepared an Environmental Management Plan to meet the requirements of the Operational Policy 4.01.

111. The project investments may cause dust, noise or vibrations, and construction waste affiliated with the small scale renovations; it may increase generation of wastewater and waste from facilities that receive health items or equipment. Other risks may be associated with safety hazards including workers protection, especially related to dismantling of asbestos containing materials if old health facilities funded by project include roofs made of asbestos. When such waste is generated there must be safe and reliable methods for its handling to avoid any negative impact on the public and/or environment. In the absence of national guidelines for waste management, the project intends to improve the hygiene conditions and address environmental risks linked to handling and disposal of health-care wastes, through implementation of site

specific Environmental Code of Practices (ECOPs) (for renovations[12]) and health waste management plans.

112. A social assessment was undertaken during project preparation to assess potential social impacts and risks as per both Operational Policy 4.01 and 4.10, and measures to address such impacts during project implementation are addressed in the Community Engagement Planning Framework as well as site-specific plans in the form of adapted Township Health Plans.

113. As part of the EMP preparation, the following main aspects have been considered: (a) collection of information on current health legislation, technical guidelines and other policies linked to possible environmental impacts (and their management) generated by health care activities in Myanmar (e.g., medical waste management); health and safety practices of health staff and waste workers; training, education and public awareness of health personnel of waste management; (b) assessment of health care waste management planning in the country (e.g., assignment of responsibilities in waste management for health-care facilities; assessment of waste generation; existence/development/implementation of hospital waste management plan); presence of a health-care waste minimization, reuse and recycling approach; segregation, storage and transport of medical waste; treatment and disposal methods used in Myanmar for medical waste; and (c) current status of, and needs for, infrastructure and medical equipment in the sector, e.g., hospitals' connection to wastewater treatment facilities (see Annex 3 for details).

114. The environmental management plan has been prepared by MOH as the project environmental assessment safeguard document to include: (a) specific ECOPs to address potential adverse environmental impacts linked to planned minor refurbishment works (e.g., painting, window repairs, possible risks from dismantling asbestos containing materials such as roofs, etc.) and (b) a simple health-care waste management plan to address solid and liquid wastes that will be generated by the health care facilities supported by the project. Training and capacity building for implementation as well as more public awareness on hazards to communities and health officers associated with poor health-care waste management are included in the project.

115. The environmental management plan underwent review by main stakeholders, which discussed the draft during the public consultations organized by MOH in Yangon and Mawlamyine on July 7 and 8, 2014 respectively. Suggestions from the consultations were incorporated in the final document and minutes of discussions attached for reference. Disclosure of the final safeguard documents occurred in country on August 28, 2014 and on the Infoshop website on 24 August, 2014, in line with the WB public consultation and disclosure of information guidelines.

116. OP 4.01 Environmental Assessment and OP 4.10 Indigenous Peoples are triggered as described above.

G. Other Safeguards Policies Triggered

117. Not applicable. The Bank's policy on involuntary resettlement (OP 4.12) is not triggered as there will be no construction or activities requiring land acquisition.

[12] When applicable, it will include provisions to follow WB Guidelines on asbestos waste management.

ANNEX 1: RESULTS FRAMEWORK AND MONITORING
ESSENTIAL HEALTH SERVICES ACCESS PROJECT

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

Indicators	Core	Unit of Measure	Baseline 2014	Cumulative Target Values**				Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (indicator definition etc.)
				2015-16	2016-17	2017-18	2018-19				
PDO LEVEL INDICATORS											
% of deliveries with skilled birth attendant (among the lowest quintile)	X	%	71 (52) (MICS 2009/10)				82 (70)	Every3-5 years	MICS DHS	MOH	DHS 2014/15 will serve as baseline for these indicators with MICS 2009/10 as interim baseline, DHS data collection is under way with results expected early 2015. "Adequate for the second indicator is defined as by a skilled attendant (which the Myanmar MICS defines as doctor, nurse, or midwife).
% of deliveries which are followed by adequate post-natal care (among the lowest quintile)	X	%	78 (59) (MICS 2009/10)				85 (75)	Every 3-5 years	MICS DHS	MOH	
% of children under 6 months who are being exclusively breastfed	☐	%	24 (MICS 2009/10)				40	Every3-5 years	MICS DHS	MOH	

Indicators	Core	Unit of Measure	Baseline 2014	Cumulative Target Values**				Frequency	Data Source/ Methodo-logy	Responsibili-ty for Data Collection	Description (indicator definition etc.)
				2015-16	2016-17	2017-18	2018-19				
Number of Townships in which the Township hospital and at least 60% of other Health Facilities have met a minimum Readiness Level of 14 out of 20 to provide essential maternal, neonatal and child health services. (**DLI 1)**	☐	Number	0	50	100	200	300	Annual	Health Facility Surveys	MOH Third Party Verifiers	Readiness level is measured by a composite index specified in the OM that covers domains of health system standards, such as staffing, drugs/vaccine availability, basic equipment, record keeping, and health care waste management.
INTERMEDIATE RESULTS (OUTPUTS)											
Component 1: Strengthening Service Delivery at the Primary Health Care Level											
Number of Townships in which the Township hospital and at least 80% of the other Health Facilities have received Health Facility Grants in accordance with the Project Operations Manual (**DLI 2**)			SOPs for Town-ship FM being develop-ed	50	100	200	300	Annual	Budget & financial reports from MOH	MOH & Third Party Verification	
Number of Townships in which at least 80% of the required number of antenatal and postnatal visits and deliveries have been carried out by basic health staff in accordance with the Project Operations Manual (**DLI 3**)				50	100	200	300	Annual	MOH reports, independently verified	MOH Third Party Verifiers	

Indicators	Core	Unit of Measure	Baseline 2014	Cumulative Target Values**				Frequency	Data Source/ Methodo-logy	Responsibili-ty for Data Collection	Description (indicator definition etc.)
				2015-16	2016-17	2017-18	2018-19				
Number of Townships in which the Township Health Departments have prepared an annual integrated and inclusive Township Health Plan in accordance with the Project Operations Manual and the CEPF. (**DLI 4**)		Process Mile-stone	Commu nity engage-ment strategy does not exist	50	100	200	300	Annual	MOH reports, independently verified	MOH Third Party Verifiers	"Integrated" refers to the manner in which contributions from various actors—providers and financiers—are reflected in the plan. "Inclusive" refers to the participation of ethnic groups and vulnerable groups and incorporation of social analysis findings.
Number of Townships in which all rural health centers and at least 50% of rural health sub-centers have been supervised at least twice in the Fiscal Year by Township Health Department medical officers using the supervision checklist in the Project Operations Manual (**DLI 5**)		Number	0	50	100	200	300	Annual	Completed Supervision Checklists	MOH + third party verifiers (by contacting a sample of TMOs)	This checklist will include technical, FM, and data validity.
Number of Townships in which the Township Health Departments have been supervised at least twice in the Fiscal Year by State/Region Health Department officials using the supervision checklist in the Project Operations Manual. (**DLI 6**)		Number	0	50	100	200	300	Annual	Completed Supervision Checklists	MOH + third party verifiers (by contacting a sample of TMOs)	

Indicators	Core	Unit of Measure	Baseline 2014	Cumulative Target Values**				Frequency	Data Source/ Methodo-logy	Responsibili-ty for Data Collection	Description (indicator definition etc.)
				2015-16	2016-17	2017-18	2018-19				
Number Townships in which at least 60% of midwives have been trained to deliver basic emergency obstetric and neonatal care and integrated management of childhood illnesses. (**DLI 7**)		Number	0	50	100	200	300	Annual	MOH reports, independently verified	MOH Third Party Verifiers	
Number of townships where data quality assessments were carried out.		Number	0	50	100	200	300	Annual	MOH reports, SARA	MOH Third Party Verifiers	
Number of townships where at least 60% of the health facilities had no stock-out of supplies in the past year		Number	0	50	100	200	300	Annual	MOH reports, SARA	MOH Third Party Verifiers	
Component 2: System Strengthening, Capacity Building and Program Support											
Service readiness scorecard implemented		Process milestone		Develop Services Readiness Scorecard	(see DLI 1)			One time	MOH reports	MOH	
Improved funds flow (recurrent) to PHC health facilities		Process milestone		Training on SOP provided	(see DLI 2)			One time	MOH reports	MOH	
Improved supervision		Process milestone		Develop supervision standards and checklists	(see DLI 3)			One time	MOH reports	MOH	

Indicators	Core	Unit of Measure	Baseline 2014	Cumulative Target Values**				Frequency	Data Source/ Methodo-logy	Responsibili-ty for Data Collection	Description (indicator definition etc.)
				2015-16	2016-17	2017-18	2018-19				
Essential Package of Health Services (EPHS) including quality standards defined, costed, approved and publicly communicated		Process Mileston e	EPHS not defined	Package developed, costed, approved, and implementa-tion plan prepared.				One time	MOH reports	MOH	This EPHS will be broader than the MNCH package which already exists, and is meant to be preparatory for the longer-term UHC goal.
Health Financing Strategy for UHC developed, approved and communicated		Process Mileston e	Strategy does not exist	Strategy drafted through broad consultation s & communicat ed	Strategy approved			Annual	MOH reports	MOH	
Communication strengthened – to improve care-seeking behaviors and to increase transparency and accountability		Process Mileston e	No compreh ensive commun ication strategy	Strategy and implementa-tion plan developed and approved	Strategy implemented according to plan	Strategy implemented according to plan	Strategy implemented according to plan	Annual	MOH reports	MOH	
Health care waste management guidelines and policy developed`		Process Mileston e	No compre-hensive policy or guide-lines	Policy and guidelines developed and approved	Guidelines implemented according to plan	Guidelines implemented according to plan	Guidelines implemented according to plan	Annual	MOH report	MOH	

ANNEX 2: DETAILED PROJECT DESCRIPTION
ESSENTIAL HEALTH SERVICES ACCESS PROJECT

118. The Government of Myanmar's Strategic Directions towards UHC paper (2014) identified the following challenges facing the country's health system: (a) a rapid demographic, health and social transition; (b) the majority of the population (70 percent) living in the rural areas, in many places that are hard-to-reach; (c) triple burden—unfinished MDG agenda related to maternal and child health and communicable diseases, and the rise of non-communicable diseases; (d) gaps in supply side, such as PHC facilities, human resources, emergency care; (e) out of pocket health expenditures; and (f) accessibility and equity of services. The Ministry aims for "the provision of optimal quality of health care to everyone in the country that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public". Its goals are in line with the UHC: (a) improving health outcomes; (b) enhancing financial protection; and (c) ensuring consumer satisfaction. The main elements of the Strategic Directions are:

(a) Identify Essential Health Package
(b) Effective human resources planning and management
(c) Availability and affordability of Essential Medicines
(d) Enhancing Public Private Partnership
(e) Strengthening the health infrastructure
(f) Health financing – scaling up financial protection
(g) Building up evidence informed health policy making
(h) Re-orienting the community participation
(i) Governance and policy development

119. In line with the Strategic Directions paper, the proposed project, in support of Myanmar's move towards UHC, focuses on expanding coverage of essential services, starting with MNCH. In addition, it will lay the foundations to address the other dimension of UHC, the coverage of financial protection by supporting the formulation of a health financing strategy and the development of an expanded and costed essential package of health services (EPHS) for UHC.

Project Components

120. **Component 1: Strengthening Service Delivery at the Primary Health Care Level (US$84 M)** focuses on channeling funds through MOH to the states/regions and townships (the latter in the form of health facility grants) for operational expenses or non-salary recurrent expenditures.

121. ***Health Facility Grants to the Township and Below***. US$ 60 million (about 70 percent of the component allocation) is expected to flow to the public facilities at the township and below. Funds will be provided to Township Medical Officers (TMOs), for use at the township hospitals and onward disbursement to SHs, RHC, and maternal and child health centers, based on Standard Operating Procedures (SOP). The grants will be used to (a) assist basic health staff and medical officers to expand outreach, supervision, communications, and engagement with communities; (b) keep facilities, vehicles, furniture and equipment functioning and maintained; and (c) allow users of facilities to have basic needs met, such as clean water, therapeutic foods and emergency travel costs.

122. Township Hospitals would receive about US $3,000, while SH/rural health centers, secondary (urban) health centers US $500 to 1,000 (to be phased in over the project life) and school health and MCH centers about US$100. When applied across the country, these amounts add up to US$35 million per year for all the PHC facilities put together. This is a 75% increase over the current allocation of US$20 million (from MOH's own resources) for operational (non-salary recurrent) expenses in these facilities in Myanmar. Thus the IDA contribution to the health facility grants would be $15 million per year or $60 million over the four years.

123. The allocation of resources across facilities was determined by a simple formula which results in a payment that is fixed for all facilities of a particular type, but adds a 100 percent premium to facilities located in hardship townships. The formula is designed with the following principles in mind: simplicity, transparency (based on data that are easily available and beyond dispute), equity (with larger allocation to facilities in hardship townships) and predictability (in terms of the facility amounts and their timing). Based on experience gained, it is possible that the formula may evolve over time. The formula will apply to government's entire recurrent operational budget for township level and below; the IDA share of this will be approximately 40 percent in the first year, but is expected to decline as GOM spending increases over time.

124. ***Allocation to the State/Regional Health Departments.*** Around US$24 million will be provided to the State/Regional Health Departments (S/RHDs) for operational expenses to carry out supervision, and coordination, convening, and communication activities, hiring basic health staff or financial officers on contractual basis, and possibly for development of a convergence strategy by state authorities together with ethnic group organizations. The amount provided to each of the 17 S/RHDs will consist of an annual allocation of US$200,000 per state/region plus an amount that varies proportional to the number of townships in that state/region, for a total of between US$200,000 and US$400,000 per S/RHD per year.

125. ***Community empowerment.*** Communities will be informed of Government's efforts to improve services through increased operational budgets, empowered to demand services, and mobilized to participate in planning, funded through the allocation for facilities and community actions. A Community Engagement Planning Framework (CEPF) has been developed for this purpose (see also Component 2 and Section VI. E. below).

126. ***DLIs***. For Component 1, IDA will disburse funds to MOH upon achievement of DLI targets, which are monitored annually and subject to independent verification. DLI 1 is the overarching measure of service readiness (PDO level); DLI 2 measures the predictable and flexible availability of resources at the local level, with improved financial management; DLI 3 measures service availability closer to the community; DLI 4 ensures that township level planning is socially inclusive and participatory; DLI 5 and 6 measure the extent to which supervision visits are carried out by the township and S/RHDs, respectively, and DLI 7 measures human resource readiness. Detailed DLI verification protocols are in Annex 3 as well as in the OM.

127. DLIs focus on measuring improvements in service delivery readiness, not health outcomes or service coverage (which is affected by demand side factors as well and require population denominators). Health outcomes are further downstream indicators, which require inputs beyond the control and scope of the project, and therefore not included among PDO indicators. Coverage indicators require household surveys, which are expensive, and therefore not conducted every year, also health outcomes typically do not show demonstrable changes

within one year, and since DLIs need to be monitored annually, coverage and outcome indicators are not appropriate to link with disbursement. Readiness reflects availability and is a reasonable proxy for access. Service delivery readiness is essential for the achievement of UHC.

128. Townships are the units of interest for disbursement, as they are the lowest administrative units responsible for primary care and also the lowest facility level with bank accounts and drawing rights, and counting the number of townships which meet the criteria would be a practical way of aggregating these measures across the nation.

129. The project is nationwide in scope and, so, additional resources are expected to flow to all townships from the first year of implementation. However, in view of the likely challenges in strengthening fiduciary systems and other capacity requirements, DLI cumulative targets have been set realistically, so that expected achievement will be scaled up progressively. The achievements will be measured in a selected 50 townships in 2015, increase to 100 in 2016, 200 in 2017 and 300 in 2018 cumulatively. Results will, thus, reach nationwide by the end of the project, as there are 330 townships. To ensure that results are being achieved in the most needy areas right from the beginning of the project, it has been agreed that at least 20 percent of the township selected for DLI measurement each year should be from hardship areas.[13]

130. The township health planning process is detailed in the OM. A sample of township health plans will be reviewed by the WB every year. As it is a DLI, the plans will also undergo review by the third party conducting independent verification.

131. Every year MOH will forward a detailed implementation plan for this component and a corresponding procurement plan prepared as per the template contained in the OM.

Component 2: System Strengthening, Capacity Building, and Project Management Support (US$16M)

132. ***System strengthening*** will focus on the definition and costing of an Essential Package of Health Services (EPHS) which GOM would provide to the entire population. System strengthening also includes the development of a comprehensive health financing strategy for UHC, the preparation of health care waste management guidelines, and development of quality score card for township and below, and testing SOPs for FM and internal audit, among others. MOH at the central level intends to produce these outputs using in-house and national expertise and carrying out consultation meetings and workshops.

133. ***Capacity building*** includes training, courses, South-South learning, workshops and seminars. It will also support career development for basic health staff, who are recognized for their outstanding performance, and for MOH officials for further studies in health economics, financing, management, and other areas critical for universal health coverage. Criteria for selecting training programs, institutions and the trainees, and other relevant details about this fund are included in the OM. This component will benefit technical and administrative staff at the central, regional/state, and township levels, and basic health staff providing key services. In addition, capacity building will include national and local organizations working in ethnic group areas. A simplified procurement plan, in line with IDA Guidelines, has been developed. Annex

[13] In 2013, 76 (23 percent) of the 330 townships were designated as "hardship" which means that either the entire township or at least one area within the township area are locations where civil servants are eligible for hardship allowances.

2 (Detailed Project description) broadly defines the key areas of capacity building. The OM (see outline in Annex 9) will include a more detailed plan for Year 1.

134. ***Project management support*** includes preparatory work for the implementation of Component 1, such as strengthening of monitoring and evaluation (M&E) arrangements, including studies and surveys, and technical assistance for independent verification. These activities will be carried out in early 2015, which is one of the reasons why the DLI targets have been kept modest for that year.

135. Component 2 would finance activities over the four year period, as in the table below:

Table 5. Component 2 Financed Planned Activities (2015-2019)

Area	Key Activities	Responsibility
Health Financing (US$ 1.2M)	• Development of Health Financing Strategy • Strengthening national health expenditures data/BOOST • Health Financing training of National, Regional/State • Courses on health economics • UHC Policy Research	DHP
Skills for Reproductive Maternal Health (US$ 2.5 M)	• Scholarship fund for well-performing midwives • Update on Operational Policy for Reproductive and Maternal Health • Development of guidelines • Scaling up training on key skills for midwives and auxiliary midwives and community workers	DOH
Skills for Integrated Management of Childhood Illnesses (US$ 2.5 M)	• Update on Operational Policy for Child Health • Development of guidelines • Scaling up training on key skills for midwives and auxiliary midwives and community workers	DOH
Essential Package of Services (US$ 500K)	• Consultations • Workshops • Consultants to draft package	DOH
Health Information systems (US$ 1.0 M)	• Consultants to review system • Training	DHP
Financial Management (US$ 2.0 M)	• Development of training materials based on SOPs • Development of guidelines for internal audit • Training on FM SOPs (Central, Region/State, and Township) • Computer procurement • Training on computer basic skills • Information systems	DOH (Budget)
Internal Audit (US$ 500K)	• Development of guidelines • Consultant • Training	MOH

Area	Key Activities	Responsibility
Procurement (US$ 300K)	• Development of training materials • Training on Procurement SOPs (Central, Region/State, and Township)	DOH
Inclusive and Integrated Planning (US$ 1.0M)	• Development of Training materials on Community Engagement Planning Framework and social analysis • Training of State/Regions, township teams • Materials for Health Committees • Training of Health Committees members	DOH (Planning)
Management/ Leadership (US$ 700K)	• Courses on leadership for Central, State/Region Health Departments (internal and in other countries) • Study Tour	DOH
Communications on UHC and project (US$ 1.0M)	• Development of communications strategy • Implementation of communications strategy	DOH (Health Education)
Health Care Waste Management (US$ 2.0M)	• Development of health care waste management policy and guidelines • Training on health care waste management • Equipping health facilities with health care waste management supplies	DOH (Occupational and Environmental Health)
Independent Verification (US$ 800K)	• Selection of independent verification agency (4 years) • Verification process	Firm to be contracted by MOH

Component 3: Contingent Emergency Response (US$0 M)

136. A component with a provisional allocation of zero US dollars is included under this project that will allow for rapid reallocation of credit proceeds in the event of an eligible crisis or emergency under streamlined procurement and disbursement procedures. In the event of an emergency, financial support could be mobilized by reallocation of funds from component 2 and/or application for additional financing. In the case of such reallocation, the component 2 activities would be reviewed and revised as necessary.

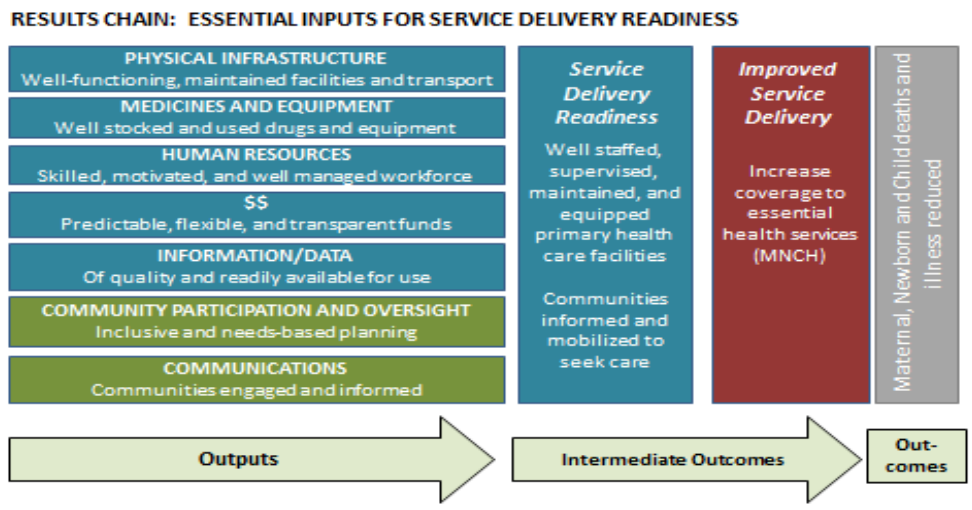
IDA Financing Complements Support from Other DPs

137. IDA financing complements the support of other donors and DPs. The table below lists some of the key donors and their support.

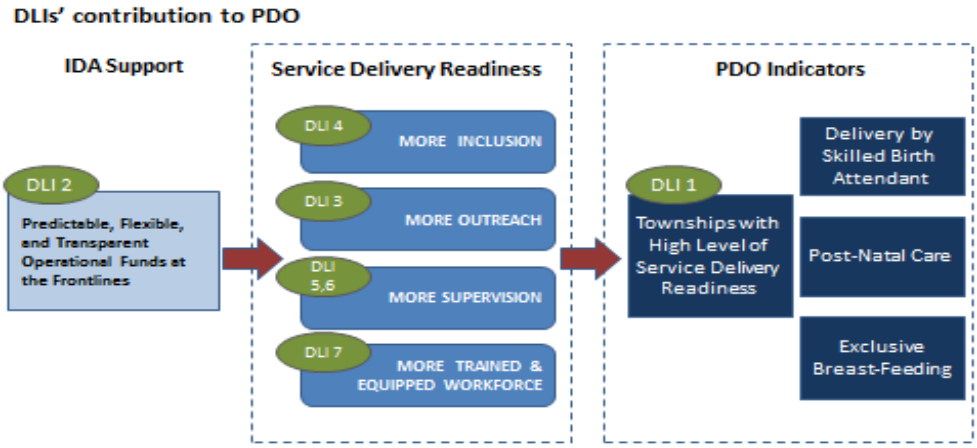
Table 6. Support from DPs

Development Partners	Commitment (US$)	Time Frame	Ongoing focus areas
3MDG Fund	330 million	2012-2016	Maternal newborn and child health HIV, TB, Malaria Health System Strengthening
Global Fund	432 million	2011-2016	HIV, TB, Malaria
JICA	100 million (incl: 5-7 million of technical cooperation)	2013-2018	Major Infectious Disease Control (Blood safety for HIV/AIDS, TB community DOTS promotion, Malaria capacity building & promotion) Strengthening capacity of technical teams for basic health staff Health System Strengthening at Central, State and Township level (Kayah) Hospital (tertiary) construction and rehabilitation Rural health centers (primary) rehabilitation in whole Magway region Equipment provision to general hospitals in Yangon and Mandalay (Top level of medical care facilities)
Global Alliance for Vaccines and Immunization	40 million	2012-2016	Health system strengthening for immunization (support travel allowances for basic health staff)
United States Agency for International Development	20 million	2013-2015	DHS Supply Chain Management (SCMS) AIDS, malaria, and TB (PEPFAR) Midwifery training (JSI)

138. The following schematic shows the results chain for Component 1, demonstrating how the proposed inputs (flexible and predictable funds to the peripheral level of health care services) will lead to the desired result of improved service delivery, quality, and performance, and thereby increase the access to and utilization of services. MNCH services require many inputs. Flexible, predictable and transparent funds at the PHC level will fill a critical gap, but it is just one ingredient, which will address access barriers, e.g., health providers will be able to travel more often to the communities, to conduct outreach. This vital input would be complemented by others, being already provided by GOM and other DPs. The WBG is continuing to collaborate with MOH and coordinate with other DPs, who are providing other inputs, such as medicines and commodities.



139. The graphic below shows the DLIs' Contribution to the PDO.



ANNEX 3: IMPLEMENTATION ARRANGEMENTS
ESSENTIAL HEALTH SERVICES ACCESS PROJECT

INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

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

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

142. ***Oversight, implementation guidance and support*** will be through existing mechanisms of GOM. The National Health Committee, the highest health policy making body, will be updated regularly, in particular where coordination with other ministries such as Finance, Labor (Social Security Board), Planning, and Civil Service Board is essential. Within MOH the Executive Committee (EC), consisting of the Minister, two Deputy Ministers, the Director Generals and other senior officials, will have the oversight responsibility of the proposed project. The EC will be informed about the project implementation by Director General, DOH, supported by the PSC.

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

144. Within the Ministry of Health, International Health Division (IHD) would assist the selection and recruitment of consultants and Central Medical Store Depot (CMSD) for procurement of goods. MOH will appoint a focal coordinator in IHD and a focal coordinator at CMSD to handle the procurement.

145. ***State/Region level.*** The project will support the state/regional health departments in supervising the township health departments, communicating to communities about the increased funds to the frontlines, coordinating government and external aided programs, and collaborating with non-governmental actors, including ethnic organizations.

146. ***Township level***, led by the TMO and their teams, are responsible for planning, budgeting, implementation, and reporting on all primary care services within the township, and for the management of all basic health staff and facilities. As the lowest administrative unit with drawing rights, TMOs will be responsible for overseeing the increased funds for operational

costs and ensuring that funds are provided to basic health staff at the facilities below in a transparent and accountable manner.

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

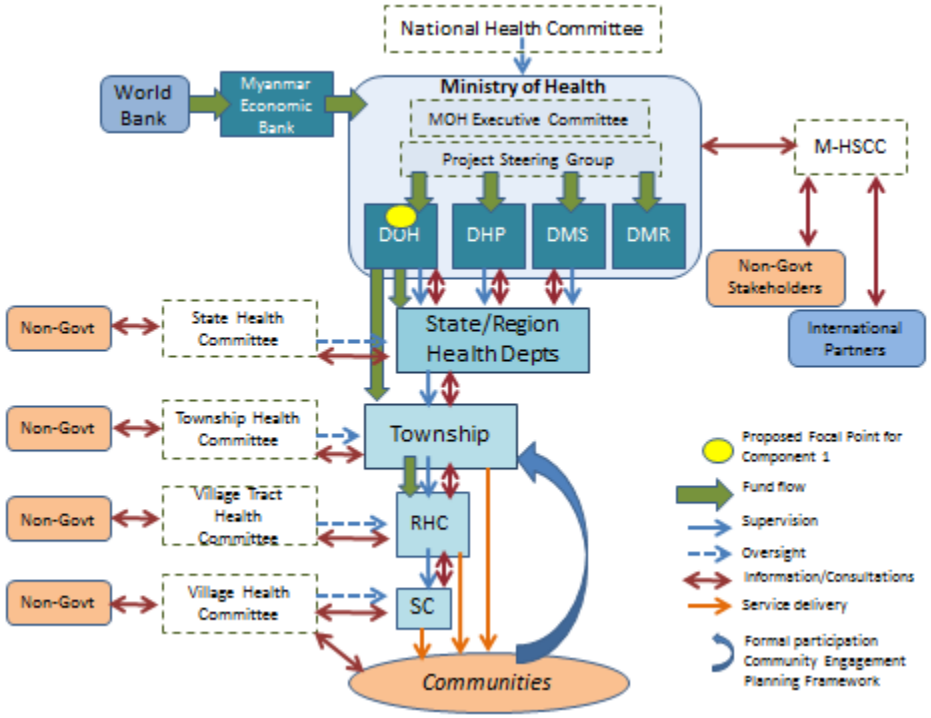
148. ***Coordination with DPs and NGOs.*** GOM is now a signatory of the IHP+ and there is a need to activate this partnership by finalizing a code of conduct and a country-level memorandum of understanding among the DPs and between the DPs and MOH. Common sector monitoring framework, joint annual reviews, and joint financing agreements will take time to develop, as DP coordination is still at an early stage. However, GOM has taken strong initiatives in this area, by the establishment of sector working groups, including the Myanmar Health Sector Coordinating Committee (M-HSCC), chaired by the Minister. Technical and Strategy Groups on various key areas, including one on Health Systems Strengthening, under the M-HSCC, will allow detailed technical and operational discussion to move towards harmonization of external assistance. The project preparation has been carried out in close consultation with DPs, both through M-HSCC and in other forums outside of that committee. The WBG has been working in partnership with health sector DPs even before the project preparation began (e.g., a mapping exercise and joint consultations on UHC held in partnership with WHO). Many bilateral donors are waiting for the WB-financed operation to strengthen the government systems prior to channeling their funds through these.

149. The project supports health service provision at township level in an integrated manner, i.e., the comprehensive township health plans will also reflect the activities by GAVI, 3MDG Fund, and NGOs. MOH is working with DPs on a uniform format and process for such plans, ensuring broad-based participation and inclusive consultation.

150. During consultations regarding the project design, NGOs and private sector indicated that the WBG should focus on supporting the government's policies and processes to become more coherent and consistent and improve its communication. This would, in turn, facilitate NGOs and private sector in delivering services.

151. Detailed arrangements, in particular the roles and responsibilities of each level and mechanism, and terms of reference are in the OM. The first draft of the OM has been prepared by MOH and agreed at negotiations; the OM will be a "living document" updated from time-to-time as necessary with WB approval. The OM would be a comprehensive reference document which guides the implementation of the project. In addition, SOP are also being developed for specific aspects, and will be annexed to the OM. For instance, FM SOP applies to township and below levels, and applies to Government funds as well as IDA funds.

Figure 2. Organizational chart of implementation arrangements



RESULTS MONITORING

152. The project will incorporate a strong system of M&E for three main reasons: (a) to ensure effective and timely implementation according to plan and apply mid-course corrections where needed; (b) to measure the achievement of results envisaged in its objectives and learn lessons for future operations; and (c) to provide a robust basis for the disbursement of IDA funds, which will largely depend on the achievement of DLIs.

Approach to monitoring

153. To avoid imposing too much additional reporting burden on the MOH, and to ensure alignment with existing GOM systems, the project took account of the indicators and data sources already being used by ongoing programs – of GOM and other DPs, e.g., Commission on Information and Accountability indicators that the government uses to monitor maternal and child health, indicators used by Health Systems Strengthening Project supported by the Global Alliance for Vaccine Initiative, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the 3MDG Fund. Where appropriate, IDA core indicators are also included.

154. Data on most indicators will be collected routinely from the HMIS. The HMIS needs considerable strengthening. For example, service delivery indicators tend to lack denominators, there appears to be no use of data for planning at the facility level, the practice of setting targets is weak, and there is a lack of supervision of data quality. Technical assistance, from the WB or DPs, will work to improve HMIS data quality over the project life.

155. A mid-term review (MTR) will be undertaken at the end of two years of project implementation (instead of the annual review of that year). Unlike the annual reviews, the MTR would not only assess progress made in the given year, but cover project implementation right from credit effectiveness till that time. Moreover, the MTR would be used as an opportunity to review / revisit the project objectives and strategies and consider any restructuring / redirection that may be needed in design and content.

Approach to evaluation

156. To monitor PDO indicators and intermediate indicators on an annual basis, the project will draw on the routine HMIS since this information is most regularly available. However, routine HMIS data has its limitations in terms of evaluating project impact – it typically doesn't reflect population outcomes and there are usually data quality issues – and, so, to assess the effect of the project on UHC goals, data collected through the routine HMIS will be complemented by household surveys that are large enough to be representative at the national, and in many cases state/region, level.

157. Key survey data needed includes information on household living standards/poverty, health expenditure, MNCH service utilization and outcomes, utilization of general preventive and curative care services, and health insurance coverage. Measuring improvements in health service quality will also require facility surveys. Baseline data will be provided by:

(a) MPLCS (planned for late 2014) which will include information on living standards/poverty, health expenditure, utilization of general preventive and curative services, and health insurance.
(b) DHS (planned for early 2015, with preliminary results expected by June 2015, final report 2016) will include a wide variety of information on MNCH health outcomes and health care utilization, as well as general health service utilization.
(c) Service availability and readiness assessment (SARA), planned for 2014.

158. Since the full results of these surveys will not be available until at least a year after survey implementation, the interim baseline figures for the project will be derived from the 2009/10 MICS and 2009/10 IHLCA surveys, as well as from the HMIS.

159. The source of follow-up ("endline") data is not yet certain. Another round of DHS or MPLCS would be possible surveys to determine endline. If by mid-term review, it appears unlikely that there will be another nationally-representative survey towards the end of the project period, the WBG will work with partners to finance a follow-up survey, even if relatively small in scale.

Table 7. Surveys to Measure Attainment of Project Objectives

Key UHC Information	Past Surveys		Planned Surveys	
	2004/05	2009/10	2014	2015
Poverty	IHLCA	IHLCA	MPLCS	
Living standards	MICS	MICS		DHS
Health expenditure	IHLCA	IHLCA	MPLCS	-
MNCH service and outcomes (women and	-	MICS	-	DHS

children)				
Health care utilization (all demographics)	-	-	MPLCS	DHS
Facility quality	-	-	SARA	
Insurance coverage	-	-	MPLCS	-
Household demographics	IHLCA	IHLCA MICS	MPLCS	DHS

Existing surveys

160. The ***IHLCA*** survey is a nationwide survey of more than 18,660 households to determine poverty levels, household living conditions and MDG indicators for Myanmar. Initially a joint project between UNDP and the Ministry of National Planning and Economic Development in Myanmar, the survey was later joined by UNICEF and the Swedish International Cooperation Agency. Two rounds of the IHLCA have been conducted in Myanmar: I in 2004-05 and II in 2009-10. Half of the number of interviewed households in 2009/10 was the same households as in 2004-05, allowing for poverty dynamics analysis. The survey was a nationwide representative sample of 18,660 households. The sample size is sufficient for estimates that are representative at stage/region level by urban/rural disaggregation. Modules include household characteristics, housing, education, health, consumption expenditure, household assets, labor and employment, business, finance and savings.

161. The ***Myanmar MICS*** survey 2009-2010 is a nationally representative survey designed to provide estimates at national level, for urban and rural areas and for each of the 17 states and divisions. It focuses on the situation of women and children, including maternal and child health, as well as household living conditions. Data collection was mainly undertaken between October 2009 and March 2010, although data were collected from 4 clusters already in June 2009. A sample of 29,250 households was selected, of which 29,238 households were successfully interviewed. Data were collected for indicators at household level, as well as for 38,081 individual women aged 15 to 49, and 15,539 children under 5. Data are disaggregated by gender, area of residence, education level and wealth quintile.

162. The ***Household Income and Expenditure Survey*** was conducted by Government (Central Statistical Organization) in 1989, 1997, 2001, 2006 and 2012. It includes information on household characteristics, income, household expenditure (including on health expenditure) and consumption. Data are not publicly available.

Planned surveys

163. The ***MPLCS***, planned for late 2014, supported by the WBG, is termed a "mini-Living Standards and Measurement Survey (LSMS**)**" because of its more limited sample size and scope of topics. Measurement of household consumption expenditure, in order to derive poverty estimates, stands central and at time of writing it had not finally been decided which other modules will be included.

164. The ***DHS***, planned for early 2015, to be implemented with the support of USAID and other donors, will include the core DHS modules related to maternal and child health, but also some additional modules that are yet to be finalized. At the time of writing, there is likely to be a module on men's health and conflict; the health expenditure module is unlikely to be included.

165. The ***Service Availability and Readiness Assessment***, planned for 2015, and supported by the 3MDG Fund, will assess the availability of key health inputs (equipment, drugs,

commodities, staff) at facility level, quality of service delivery and readiness to implement key health interventions. A data quality audit may or may not be included.

Approach to verification

166. The project M&E system will also include an independent verification mechanism by a third-party to assess progress on DLIs and compliance with the OM. This is a core aspect of project design as the disbursements are dependent on the DLI achievement. MOH will contract an international firm / organization to carry out an independent sample based survey of filled checklists by the township and State Teams to verify the veracity of the results. Detailed terms of reference, sampling methodology and presentation of results will be detailed in the OM. Financing for this will come from Component 2. The selection of the organization will be carried out in accordance with the IDA guidelines.

FINANCIAL MANAGEMENT AND DISBURSEMENT ARRANGEMENTS

167. ***The overall FM risk*** is assessed as 'high'. The main risks are associated with: (a) limited and weak capacity of the townships to manage the larger scale of operational budget; (b) inadequate documentation of policies and procedures and limited participation of service delivery units in budget preparation process; (c) lack of mechanism for allocation of budget to the service delivery levels (allocation seem to be on equal basis irrespective of coverage and access); and (d) applicable government rules on travel allowance rates are inadequate.

168. ***Risks mitigation measures*** are proposed and included as part of the technical assistance component for capacity building, DLI and results framework for strengthening the FM and internal audit capacity. Key actions are to: (a) develop the FM policies and procedures especially for township and below level as well as increase the State Health Department role in review and consolidation of budget and financial report and developed the basis of funds allocation to front line service level; (b) recruit an additional accounts staff at the township to cope with the increase of work volume; (c) provide of training to accounts staff at all levels on the developed FM policies and procedures; and (d) strengthen the internal audit function of MOH. Moreover, the FM risks are also mitigated as part of the program design by phasing the resource transfers to a manageable states, township and below level after the policies and framework are developed and training conducted in year one, then scaling up year on year to cover all states and townships in year four of the program.

169. ***Staffing***. The accounts staffs and capacity at the central and state level are assessed as adequate to also manage the increase in funding from the proposed program. The capacity gap is however identified at the township level where there is only one clerk who is not only responsible for accounting but also administration and other non-medical related work as assigned by the TMO. Additional staff, such as a trained account staff, will be required to be recruited for township level to support increased level of funding as a result of the project. The role of the additional account staff have been defined in their TORs and OM, which, among other things, is to assist TMO to check and verify the accounting transactions as prepared by the clerk and from service delivery level before submission for his/her approval, as well as consolidation of budget and reporting. The accounting related work at service delivery level below the township is being managed by the head of the respective facility and oversight by the health committee with representatives from the villagers. This level has experience in managing

the funds from local donation and they have a fundamental knowledge and capacity of keeping a simple cash book to track receipt, expenses and balance. The service delivery level was assessed as having minimum capacity to manage the additional funds by using the same oversight function from the health committee.

170. ***Planning & Budgeting***. The work plan and budget for recurring cost at the MOH are prepared using a bottom up approach from the township level, the lowest level of budgetary unit in Myanmar PFM setting (and not service delivery unit), up to the central Department with a copy to State Health Department. The gaps identified in this area include: (a) the work/activity plan (i.e. micro plan) and budget is not connected and the planned activities have not been costed and included in the budget; (b) lack of participation of service delivery level in budget preparation process; (c) no formula use for allocation of resources to the facilities; and (d) limited role of State Health Department in review and consolidation of budget. These gaps will be addressed as part of the enhanced FM policies and procedures which have been included in the OM. The existing government budgeting system will be followed for Component 1 and supplemented by the SOP for FM.

171. The budget for Component 2 will be prepared specifically for the project by the respective implementing departments to address the capacity gaps identified at the beginning of the Project. The budget will be consolidated by the Minister's office and a copy of which will be sent to the WB for review and no objection prior to implementation.

172. ***Fund flows***. Three separate DAs will be opened for the Project at the Myanma Economic Bank, all in Myanmar Kyat. The Project funds will be advanced to DA – A for Component 1, to DA-B for DOH activities of component 2 and DA-C DHP activities of component 2 respectively, with variable ceilings. The funding will be channeled as follows:

(a) For Component 1, DOH will transfer funds from DA (Kyat) to its own MD Account (in Kyat) where they will be comingled with Government funds, and using the existing government system, funds will be channeled to States/Region Health Departments and townships. Fund-flow arrangements from township to the service delivery level will be guided by SOP for FM.

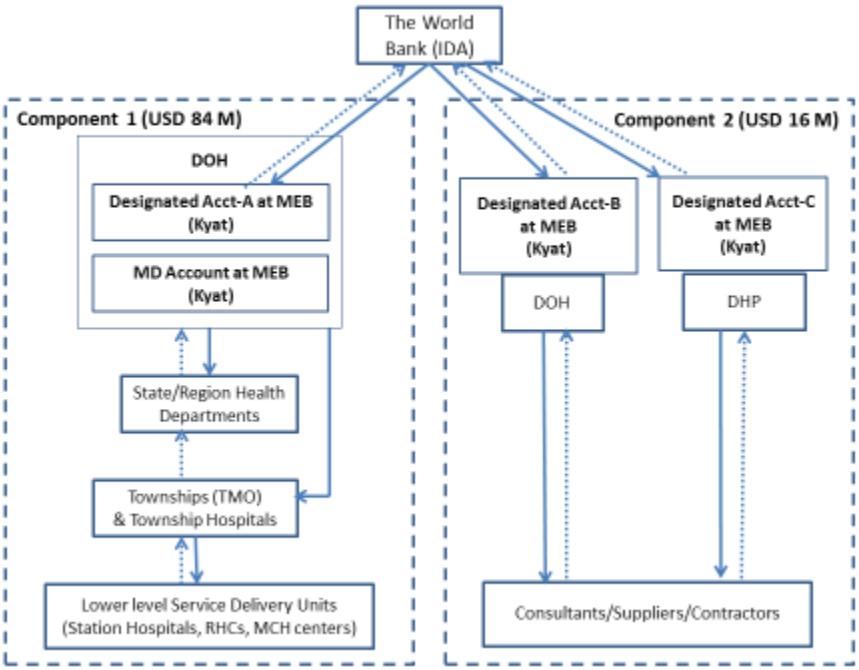
(b) Component 2, expenditures will be incurred by DOH and DHP, for the project activities that these two departments will be responsible for, from DA–B (Kyat) and DA–C (Kyat), respectively

173. ***Internal control procedure***. The existing procedures of the government under the applicable financial rules and regulations will be used to support the implementation of this program. One of the risks identified is the fact that these government internal control policies and procedures are not documented in any procedures manual, but the application of the rules and regulations have been assessed as strong and robust. The key limitation in this area as assessed was on the travel allowance where the allowable rates are far below the cost of living and which does not seem to encourage the travelling, supervision and outreach related activities that are critical for service delivery.

174. ***Recording and reporting***. It has been indicated in the recent Public Expenditure and Financial Accountability report and IMF analysis that there is a high level of integrity in terms of accuracy of financial records and financial statements in Myanmar despite using a manual system. The MOH's financial system is adequate; they have the internal control processes, and

reporting in place that will be able to support the FM requirements of the program. The use of Excel processes may be used to support their accounting and reporting until the government introduces computerized accounting systems proposed under the Public Financial Management project. Though the consolidation of monthly reporting at the DOH was not 100 percent completed and experienced delays, the six-monthly reports was completed for the Office of the Auditor General audit purposes on time. For the program, the IUFRs will be forwarded by MOH (using their existing consolidation structure by the finance unit of the Minister's office) to the WB on a six-monthly basis. The IUFRs will be prepared in a format and content similar to the MOH's current financial reports, thus helping reduce potential reporting delays. The deadline for submission of IUFRs to the WB is 60 days after the semester end (using government's financial year, 1 April – 31 March) in the first fiscal year and 45 days in subsequent years.

Figure 3. Fund-flow diagram



175. ***Internal Audit***. The Internal Audit Committee at MOH was formed by the Ministry's letter issued on 12 July 2013. The committee is chaired by the Deputy Minister and consists of eight members, one secretary and one associate secretary. The members are the management level officers of different departments and mainly health related functions. The Internal Audit Division was formed in the respective central functional departments, but they have not been staffed and do not yet function. It appears that significant capacity building is needed in this area as the function is new and the functional structure should be revisited to match a minimum required independence that allows this work to be carried out objectively with adequate quality assurance.

176. ***External Audit***. The Office of the Auditor General of the Union of Myanmar is the supreme audit institution and has offices from central, state down to township level. The Office of the Auditor General conducts the audit for MOH at central, state and township level on a semester basis. For the year-end audit (March 31st), work normally starts in June or July and may

take about two months on average to finalize and issue the audited report. The Office of the Auditor General has been assessed as capable of carrying out audits of the WB funded projects and programs. For this project, the audited financial statements for the project will be audited by the Office of the Auditor General as part of their regular audit. The MOH will forward copies of the audited report and auditors' management letter to the WB within 6 months after the end of the financial year (i.e. 30 September).

Implementation Support and Supervision Plan

177. Implementation support for FM functions will be provided more frequently to the task and client teams in the first year of project implementation. The strengthening of the internal audit unit targeted in the first year will also allow the WB team to partner with the internal audit unit for them to carry out more frequent reviews and monitoring of the FM activities of the project. The WB will then limit its review to at least bi-annually thereafter depending on the updated project FM risk assessment and progress with implementation of the FM capacity building program. The FM missions will include reviews of the continuous adequacy of the FM arrangements, progress with FM capacity building activities, adequacy and timeliness of preparation of IUFRs and progress in implementation of agreed FM actions and recommendations from project audits. The table below identifies the FM actions require

Table 8. FM Actions

Required actions	**Timing**
Development of SOPs for FM	*Draft Completed at Negotiation*
Format and content of IUFRs agreed with MOH	*Completed at Appraisal*
Audit arrangements, including modalities for health facility coverage, agreed with the Office of the Auditor General	*Completed at Appraisal*
Appointment of staff of appropriate level to assist the health departments in the carrying out of financial management functions	*March 31, 2015*

Eligible Expenditure Program for Component 1 -DLI Based Approach

178. As the project seeks to provide flexible and predictable funding for operational expenditures, it will use the GOM budget lines under the "Current Budget and Expenditure" but will not finance any capital budget lines and others items included in the following negative list. For purposes of IDA disbursement under the proposed project, the **negative list** will include (i.e., the EEP will exclude) the following:

(a) Any capital expenditures, including the procurement of major medical equipment, or vehicles.
(b) Any new constructions, renovations, (except minor repairs, maintenance works, and renovations undertaken within the existing foot-print of health facilities) or roads repairs.
(c) Any activities that will involve construction of new or expansion of existing buildings and structures, or other activities that will require an expansion of the physical area on which the health facility is located.
(d) items that would generate radioactive healthcare waste during operation or use of pesticides
(e) Any expenditure towards activities already being financed by other DPs / donors.

(f) Any expenditure related to weapons and ammunition.
(g) Budget line 0403 – Maintenance of roads
(h) Budget line 0507 – Gratuity
(i) Budget line 0508 – Gifts and Donation
(j) Budget line 0601 – Entertainment Expenses
(k) Budget line 0317 – Animal Food
(l) Budget line 0330 – Foreign consultants

179. By excluding the above types of expenditures from the EEP, the project seeks to finance primarily the following types of inputs at the PHC level: travel allowances, utility bills (electricity, phone, internet, etc.), local labor/contractual services for the operation of health facility, minor maintenance/repairs/refurbishment of health facilities, vehicles and equipment, and essential consumables that are locally available such as vehicle fuel, office supplies, soap, cleaning supplies, gauze, gloves, syringes, etc. This is an illustrative list of what constitutes operational expenditures; other types of expenditures not foreseen here may also be financed, as long as those are not in the negative list[14].

Disbursement Arrangements-for Component 1 -DLI Based Approach

180. Project funds will be advanced to DOH through a separate DA maintained at the Myanma Economic Bank with a Variable Ceiling. DOH will further channel the funds to States/Regions and to townships. The advance made on credit effectiveness, up to 100 percent of the value of DLIs envisaged to be achieved in the first year. The advance funding for subsequent years will be contingent upon the achievement of DLIs and documentation of advances previously made based on the IUFRs, which would demonstrate that GOM expenditures towards EEP in the prior year exceeded the IDA advances.

DLI reporting and verification

181. Disbursements against DLIs will follow a clear annual process. The project is expected to become effective in November 2014 and make its first advance in January 2015 based on withdrawal application from GOM, up to the maximum of 100 percent of the value of DLIs to be achieved before March 2016. For subsequent annual review periods, MOH will forward to IDA a report on achievement of the DLIs (during the prior fiscal year, i.e., April 1 to March 31) not later than May 31 of each year; the independent verification of the DLI report by the third party agent should be completed by July 15 and the third party agent's verification report of the DLI achievements would be provided to the WB by July 31 each year. The WB will then confirm evidence of DLI achievement and expenditure against agreed eligible expenditures. On confirmation, by August 15, the DOH can forward withdrawal application for their next advance, which will be supported by the IUFR for the prior fiscal year, the reconciliation of the DA and other documents specified in the Disbursement Letter. Delays in submission of DLI reports and verification, as well as the documentation of prior advances, will delay the subsequent releases of funds following the initial disbursement.

[14] Within the GOM Budget classification, all recurrent budget categories 02, 03, 04, 05 and 06 are included in the Eligible Expenditure Program , except those budget lines (sub-categories) that are excluded by the negative list.

182. Disbursements withheld due to non-achievement of DLIs in a given year may be released in subsequent years once the DLI target is achieved. Partial achievement of a DLI target will result in a partial disbursement on a pro-rated basis. Disbursements for any DLI will be capped at the amount allocated for that year for the concerned DLI target, i.e. over-achieving the DLI targets will not lead to ever increasing disbursements and dipping into the allocation of the following year. The WBG, in consultation with GOM, may cancel or reallocate funds in case of severe underachievement. At the end of the project, in case of under-achievement of any DLIs, GOM will either reimburse IDA the amounts proportionate to the values of those DLIs or request an extension of the closing date to enable complete fulfillment of the relevant targets.

Eligible expenditure reporting and verification (through IUFR)

183. MOH will provide the WB with IUFRs documenting eligible expenditures by June 30 (covering the previous Myanmar fiscal year[15]). The template of the IUFRs was agreed with MOH during negotiations. Eligible expenditures will be audited and the report forwarded to the WB by September 30 each year, starting in 2015 (six months from the close of the Myanmar fiscal year). Any verified discrepancies between the audited accounts and the IUFR as well as any ineligible expenditure identified will need to be reimbursed to IDA.

Disbursement calendar and GOM budget cycle

184. In an effort to synchronize the disbursement of IDA funds with the GOM's budget cycle, the following calendar of actions has been developed. DLI measurement and reporting will be done annually, as they relate to the GOM's fiscal year (April 1 to March 31), with verification carried out by July 15, and disbursement of next year's advance completed by end-August.

[15] Except the first year which covers the period January 2015 through March 2016.

Table 9. Disbursement-Related Steps

Date	IDA disbursement-related steps
FIRST YEAR	
September, 2014	MOH includes project-related costs in budget request to MOF for the subsequent fiscal year.
January 15, 2015	MOH forwards withdrawal application to IDA for Component 2 for year 1
January 31, 2015	IDA advances up to 100% of the estimated expenditures for component 2 in 2015-16 (US$ 4 million).
March 15, 2015	MOH forwards withdrawal application to IDA for Component 1 for year 1.
March 31, 2015	IDA advances up to 100% of the value of all DLI targets to be achieved in 2015-16 (US$ 21 million).
September 30, 2015	GOM forwards Audited Report for fiscal year 2014-15. MOH submits to MOF, its requests for supplemental budget for FY 2015-16. MOH includes project-related costs in budget request to MOF for the subsequent fiscal year.
November 15, 2015	MOH forwards IUFR for the semester ending September 30, 2015 to IDA demonstrating adherence to EEP.
SUBSEQUENT YEARS	
May 15	MOH forwards IUFR for the entire year ending March 31, demonstrating adherence to EEP.
May 31	MOH forwards DLI report for prior fiscal year (April - March).
July 15	Independent Verification completed by third-party agency.
July 31	Independent verification of DLI report forwarded to the WB, which then confirms to GOM the amount to be advanced – see formula Annex 3.
August 15	GOM forwards withdrawal application based on the agreed amount to be advanced, together with supporting documentation.
August 31	IDA release advance for next fiscal year.
September 30	GOM forwards to IDA, the Audit Report for previous fiscal year. MOH submits to MOF requests for supplemental budget. MOH includes project-related costs in budget request to MOF for the subsequent fiscal year.
November 15	MOH forwards IUFR for the semester ending September 30 to IDA - demonstrating adherence to EEP.

185. On project completion, the final DLI achievement for 2018-19 would be verified by the third party agency by June 30, 2019. In case of under-achievement of targets (for the total duration of the project), GOM would need to reimburse IDA an amount equivalent to the value of under-achievement, unless the closing date (June 30, 2019) is extended. The WBG, in consultation with GOM, may cancel or reallocate funds in case of severe underachievement.

Table 10. Verification Protocols for DLIs

DLI 1	Indicator Identification Data and Compliance information
Indicator	Number of Townships in which the Township hospital and at least 60% of other Health Facilities have met a minimum Readiness Level of 14 out of 20 to provide essential maternal, neonatal and child health services.
Compliance condition	The DOH has a proper standing instruction and guidance of the composition of essential MNCH services. The State and Regional Team must have visited the township and provide appropriate technical input to the Township Team. The Township Team to be furnished with the necessary equipment and consumables that will be needed for essential MNCH services.
Compliance specification	The guidance provided must have detail specification of all approaches for ensuring a comprehensive MNCH services. The guidance and instruction for the Township Team must include process and procedures to follow for the underprivileged and ethnic groups. Provision of equitable services to be the underline principle.
Means of verification	Instructions from the DOH and State/Regional level to Township and training programs related to essential MNCH services to the needy staff.
Compliance verification procedure	Independent assessor may review all the township reports and visit randomly selected townships and health facilities at village level, ensuring that the guidelines, essential supplies and skill are readily available.
Expected target compliance	50 townships by 1st April 2016, 100 townships by 1st April 2017, 200 townships by 1st April 2018 and 300 townships by 1st April 2019
Responsible Department or Position	DG, DOH and Director, MCH

DLI 2	Indicator Identification Data and Compliance information
Indicator	Number of Townships in which the Township hospital and at least 80% of the other Health Facilities have received Health Facility Grants in accordance with the Project Operations Manual
Compliance condition	Government agrees the disbursement arrangement and allocation formula for townships based on its number of outreach and underserved areas
Compliance specification	The township must have an established Comprehensive Township Health Plan, drawn collectively among the partners and communities under the supervision and guidance of Township Health Committees and State/Regional Health Department.
Means of verification	Costed Township Health Micro-Plan and ensuring the use of additional fund for operational purpose within the frame of EEP, and timely, accurate and complete financial reports from THD and below..
Compliance verification procedure	Availability of budget and guidelines for an effective utilization of Health Facility Grants. Demonstrated that GOM expenditure on agreed EEP exceeded the amount advanced by IDA and evidence of additional IDA fund reflected in GOM allocation; and both be documented in IUFR.
Expected target compliance	50 townships by 1st April 2016, 100 townships by 1st April 2017, 200 townships by 1st April 2018 and 300 townships by 1st April 2019
Responsible Department or Position	DG-DOH; Director-Planning; Director-Public Health

DLI 3	Indicator Identification Data and Compliance information
Indicator	Number of Townships in which at least 80% of the required number of antenatal and postnatal visits and deliveries have been carried out by basic health staff in accordance with the Project Operations Manual.
Compliance condition	The township must have identified the outreach and ethnic groups' areas with a detail demographic pattern including the age, sex, topographic situation, endemicity of specific infections and tendency of any epidemic diseases.
Compliance specification	A proper guideline to be developed at the township level based on the prevailing situation of the local area. Ensure any transport facilities to reach the un-reached and also consumables and equipment. An outreach visit calendar to be available, and adjusted to the seasonal constraint.
Means of verification	Out-reach calendar for all health facilities
Compliance verification procedure	TMO instruction and guidelines note to all health facilities and including the reporting format after each visit.
Expected target compliance	50 townships by 1st April 2016, 100 townships by 1st April 2017, 200 townships by 1st April 2018 and 300 townships by 1st April 2019
Responsible Department or Position	DG-DOH, Director-Public Health, Director-Medical Care

DLI 4	Indicator Identification Data and Compliance information
Indicator	Number of Townships in which the Township Health Departments have prepared an annual integrated and inclusive Township Health Plan in accordance with the Project Operations Manual and the CEPF.
Compliance condition	The main prerequisite for a township Health Planning is to conduct the environmental assessment and social assessment and consult with local communities and other stakeholders. SA identifies the demand and supply of available health services, gaps and constraints for the vulnerable and ethnic groups. Availability of baseline data – previous year health information of respective locality.
Compliance specification	Records of previous issues and impact of health services to various social groups, local area ad-hoc surveys, interviews with communities and close discussion with township and village tract health committees.
Means of verification	Social Analysis Survey Report, township map showing vulnerable areas, hard to reach and ethnic groups. Discussion forum with communities and meeting records with Township/Village health committees.
Compliance verification procedure	Outcome of SA and consultations documented in the Comprehensive Township Health Plan and measures proposed to undertake for hard to reach community and special consideration to the ethnic groups in enhancing the fairness of equity issue.
Expected target compliance	50 townships by 1st April 2016, 100 townships by 1st April 2017, 200 townships by 1st April 2018 and 300 townships by 1st April 2019
Responsible Department or Position	DG-DOH, Director – Planning DOH, Director-Public Health, Director EOH

DLI 5	Indicator Identification Data and Compliance information
Indicator	Number of Townships in which all rural health centers and at least 50% of rural health sub-centers have been supervised at least twice in the Fiscal Year by the Township Health Department medical officers using the supervision checklist in the Project Operations Manual.
Compliance condition	Favorable Service facilities, availability of medical consumables and convenient livelihood facilities for staff will determine the level of readiness for services for the assigned community. Thorough review of previous visit reports and records, and assess if any follow up actions have already been undertaken. What are the planned activities which are forthcoming?
Compliance specification	The calendar of supervisory visit to villages synchronizes as much as possible with the tour program of concerned staff in the local area.
Means of verification	Check list of the Township Team for RHC/Sub-Center supervisory visit. The team should have a good consultation among themselves, and have a proper division of labor. (See sample check list)
Compliance verification procedure	Township Team visits the health facility as per plan and where ever possible the Team should also organize meetings with village tract council and village tract health committees – both before and after the supervisory visit.
Expected target compliance	50 townships by 1st April 2016, 100 townships by 1st April 2017, 200 townships by 1st April 2018 and 300 townships by 1st April 2019
Responsible Department or Position	DG-DOH, Director – Public Health, State/Regional Health Department

DLI 6	Indicator Identification Data and Compliance information
Indicator	Number of Townships in which the Township Health Departments have been supervised at least twice in the Fiscal Year by State/Region Health Department officials using the supervision checklist in the Project Operations Manual.
Compliance condition	Favorable Service facilities, availability of medical equipment and essential medicines and convenient livelihood facilities for staff will determine the level of readiness of services for the assigned township. Thorough review of previous visit reports and records and assess if any follow up actions has already undertaken. What are the planned activities which are forthcoming?
Compliance specification	The calendar of supervisory visit to townships should synchronize as much as possible with the tour program of concerned staff in the local area: TMO & THO
Means of verification	Check list of the State/Regional Team for township supervisory visit. The team should have a good consultation among themselves, and have a proper division of labor. (See sample check list)
Compliance verification procedure	State/Regional Team visits the township hospital and other health facilities as per plan and where ever possible the Team should also organize meetings with Township Administrative Council and Township Health Committee – both before and after the supervisory visit.
Expected target compliance	50 townships by 1st April 2016, 100 townships by 1st April 2017, 200 townships by 1st April 2018 and 300 townships by 1st April 2019
Responsible Department or Position	DG-DOH, Director – Public Health,

DLI 7	Indicator Identification Data and Compliance information
Indicator	Number of Townships in which at least 60% of midwives have been trained to deliver basic emergency obstetric and neonatal care and integrated management of childhood illnesses.
Compliance condition	Conduct training program in Basic Emergency Obstetrics and Neonatal Care and IMCI. The training program should be taken up in rotation for the MWs so as to attend maternal cases in the local area. The necessary equipment and consumables should be provided. Special guidance to be provided for MWs attending hard to reach areas.
Compliance specification	MWs have been trained for emergency obstetrics and neonatal care and ICMI and the necessary equipment and consumables are readily available.
Means of verification	Reports of MW who had provided emergency obstetric and neonatal care
Compliance verification procedure	TMO and HA – on their routine visit, meet with the village tract health committee and community of the local area and if possible with the incumbent who has under taken the treatment - may assess the level of satisfaction.
Expected target compliance	50 townships by 1st April 2016, 100 townships by 1st April 2017, 200 townships by 1st April 2018 and 300 townships by 1st April 2019
Responsible Department or Position	DG-DOH, Director – MCH, Director – Public Health

Table 11. Disbursement Matrix

Disbursement Linked Indicators, targets and values

All years are calendar years

DLI	2015-16	2016-17	2017-18	2018-19	Total amount linked to DLI
	CUMULATIVE TARGETS				
DLI 1: Number of Townships in which the Township hospital and at least 60% of other Health Facilities have met a minimum Readiness Level of 14 out of 20 to provide essential maternal, neonatal and child health services.	50 **DLI value: US$ 4 M**	100 **DLI value: US$ 4 M**	200 **DLI value: US$ 4 M**	300 **DLI value: US$ 4 M**	**US$ 16M**
DLI 2: Number of Townships in which the Township hospital and at least 80% of the other Health Facilities have received Health Facility Grants in accordance with the Project Operations Manual	50 **DLI value: US$ 4 M**	100 **DLI value: US$ 4 M**	200 **DLI value: US$ 4 M**	300 **DLI value: US$ 4 M**	**US$ 16M**
DLI 3: Number of Townships in which at least 80% of the required number of antenatal and postnatal visits and deliveries have been carried out by basic health staff in accordance with the Project Operations Manual.	50 **DLI value: US$ 3 M**	100 **DLI value: US$ 3 M**	200 **DLI value: US$ 3 M**	300 **DLI value: US$ 3 M**	**US$ 12M**

DLI	2015-16	2016-17	2017-18	2018-19	Total amount linked to DLI
	CUMULATIVE TARGETS				
DLI 4: Number of Townships in which the Township Health Departments have prepared an annual integrated and inclusive Township Health Plan in accordance with the Project Operations Manual and the CEPF.	50 **DLI value: US$ 2 M**	100 **DLI value: US$ 2 M**	200 **DLI value: US$ 2 M**	300 **DLI value: US$ 2 M**	**US$ 8M**
DLI 5: Number of Townships in which all rural health centers and at least 50% of rural health sub-centers have been supervised at least twice in the Fiscal Year by the Township Health Department medical officers using the supervision checklist in the Project Operations Manual.	50 **DLI value: US$ 3 M**	100 **DLI value: US$ 3 M**	200 **DLI value: US$ 3 M**	300 **DLI value: US$ 3M**	**US$ 12M**
DLI 6: Number of Townships in which the Township Health Departments have been supervised at least twice in the Fiscal Year by State/Region Health Department officials using the supervision checklist in the Project Operations Manual.	50 **DLI value: US$ 2 M**	100 **DLI value: US$ 2 M**	200 **DLI value: US$ 2 M**	300 **DLI value: US$ 2 M**	**US$ 8M**

DLI	2015-16	2016-17	2017-18	2018-19	Total amount linked to DLI
	CUMULATIVE TARGETS				
DLI 7: Number of Townships in which at least 60% of midwives have been trained to deliver basic emergency obstetric and neonatal care and integrated management of childhood illnesses	50 **DLI value: US$ 3M**	100 **DLI value: US$ 3 M**	200 **DLI value: US$ 3 M**	300 **DLI value: US$ 3 M**	**US$ 12M**
Maximum annual disbursement	**US$ 21 M**	**US$ 21 M**	**US$ 21 M**	**US$ 21 M**	**US$ 84M**

Disbursement Arrangements-Input Based Approach for Component 2

186. The primary disbursement methods will be Advances and Direct Payments. Reimbursements and Special Commitments will also be made available. Two separate DAs (both in MKK and to be managed by DOH and DHP respectively) will be opened at the Myanma Economic Bank. Supporting documentation required for eligible expenditures paid from the DAs are Summary Sheets with Records and SOEs. Reimbursements will also be documented by SOEs. Direct Payments will be documented by Records. The frequency of reporting of expenditures paid from the DAs shall be once every six months. The ceiling of the DAs will be Variable.

187. The ***formulas*** for calculating the amount to be advanced for each year

For component 1:

(a) For year 1, the advance amount would be the sum of values for the 7 DLIs, i.e., US$21 million
(b) For the subsequent years, the following would be calculated for each DLI:

DLI Value for upcoming year X % of DLI target achievement in the prior year (subject to a maximum of 100%)

Then, these amounts would be summed up across the 7 DLIs to get the total amount to be advanced.

For Component 2:

(a) For year 1, the amount to be advanced into the DA-B + DA-C would be 100% of the estimated expenditure under Component 2, i.e., US$4 million.
(b) For the subsequent years, the following formula would be applied:

Estimated expenditure for upcoming year – unspent balance from the amount advanced to the DA-B + DA-C in the prior year.

Disbursement Arrangement - All Components

188. The minimum application size for Reimbursements, Special Commitments and Direct Payments will be equivalent to US$50,000.

189. The project will have a Disbursement Deadline Date (final date on which the WB will accept applications for withdrawal from the Recipient or documentation on the use of Credit proceeds already advanced by the WB) of four months after the Closing Date of the project. This "Grace Period" is granted in order to permit the orderly project completion and closure of the Credit account via the submission of applications and supporting documentation for expenditures incurred on or before the Closing Date. Before the WB closes the Credit account (two months after the Disbursement Deadline Date), the Recipient must provide supporting documentation satisfactory to the World Bank that shows the expenditures paid out of the DAs. Expenditures incurred between the Closing Date and the Disbursement Deadline Date are not eligible for disbursement, except as otherwise agreed with the WB. All documentation for expenditure forwarded to IDA for disbursements will be retained and be made available to the

external auditors for their annual audit, and to the WB and its representatives if requested[16]. In the event that auditors or the WB implementation support missions find that disbursements made were not justified by the supporting documentation (including IUFRs, SOEs, and DLI reports), or are ineligible (either due to non-adherence to EEP or due to under-achievement of DLIs in the case of Component 1), the WB may, at its discretion, require the Recipient to: (a) refund an equivalent amount to the WB; or (b) exceptionally, provide substitute documentation evidencing other eligible expenditures.

190. Disbursements from the Credit shall be made against the following expenditure categories:

Table 12. IDA Credit Expenditure Categories and Amounts

Expenditure category	IDA US$ Equivalent (million)	IDA Percentage of Financing (inclusive of taxes)
(1) Eligible Expenditure Programs under Part 1 the Project	84.0	100%
(2) Goods, non-consulting services, consultants' services (including audits), Training and Workshops; and Operating Costs under Part 2 of the Project	16.0	100%
(3) Emergency Expenditures	0	100%
Total	100.0	

191. Operating Costs means reasonable costs required for the day-to-day coordination, administration and supervision of Project activities, including leasing and/or routine repair and maintenance of vehicles, equipment, facilities and office premises, fuel, office supplies, utilities, consumables, communication expenses (including postage, telephone and internet costs), translation, printing and photocopying expenses, bank charges, publications and advertising expenses, insurance, Project-related meeting expenses, Project-related travel, subsistence and lodging expenses, and other administrative costs directly related to the Project, but excluding salaries, bonuses, fees and honoraria or equivalent payments of members of the Recipient's civil service.

[16] The General Conditions require the Recipient to retain all records (contracts, orders, invoices, bills, receipts, and other documents) evidencing eligible expenditures and to enable the WB's representative to examine such records. They also require the records to be retained for at least one year following receipt by the WB of the final audited financial statement required in accordance with the legal agreement or two years after the closing date, whichever is later. Recipients are responsible for ensuring that document retention beyond the period required by the legal agreement complies with their government's regulations

Disbursement for Component 3: Contingent Emergency Response

192. No withdrawal shall be made under Component 3 until the government has: (a) declared that a crisis or emergency has occurred, and the WB has agreed with such determination; (b) prepared and disclosed all safeguards instruments required for activities under Component 3 of the Project, if any, and the government has implemented any actions which are required to be taken under said instruments; (c) established adequate implementation arrangements, satisfactory to the WB, including staff and resources for the purposes of said activities; and (d) has prepared and adopted the Contingent Emergency Response Implementation Plan, acceptable to the Bank and annexed to the OM, so as to be appropriate for the inclusion and implementation of activities under Component 3. The CERIP will be developed during the first year of project implementation or in any event prior to the release of any funds under Component 3.

193. **Disbursements** would be made either against a positive list of critical goods and/or against the procurement of works, and consultant services required to support the immediate response and recovery needs of GOM. All expenditures under this component, should it be triggered, will be in accordance with OP/BP 10.00 and will be appraised, reviewed and found to be acceptable to the Bank before any disbursement is made. All supporting documents for reimbursement of such expenditures will be verified by the internal auditors of GOM and by the implementing agency, certifying that the expenditures were incurred for the intended purpose and to enable a fast recovery following the crisis or emergency, before the withdrawal application is submitted to the Bank. This verification would be sent to the Bank together with the application.

PROCUREMENT

194. Procurement under the project will be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 and the "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011, and provisions stipulated in the Financing Agreement.

195. Spending under Component 1 of the project will be limited to categories of operational expenditures (such as internal travelling allowance; labor charges for health facility contract works; renting vehicles or machinery; transport charges; office supplies; postage, telegram and telephone; electricity; consumable expenditures). At the state/region level, the bulk of funds will be used for operation costs for the purpose of administration and supervision, and procurement will be very limited. At the township level, each township hospital will receive about US$36,000 per year and the fund will be used for operational expenditures (travel allowances, utility bills (electricity, phone, internet, etc.), local labor/contractual services for the operation of health facility, minor maintenance/repairs/refurbishment of health facilities, vehicles and equipment, and essential consumables that are locally available such as vehicle fuel, office supplies, soap, cleaning supplies, gauze, gloves, syringes, etc.). In case some of the items have to be procured, it is expected that the value of each procurement will be small (not more than US$ 200). At the lower than township level, each facility will receive about US$9,000 per year and the fund will be used for the same items as for the township hospitals and the value of each procurement will be even smaller (less than US$ 100).

196. Due to the nature of the programs being supported, which consists of very small value procurement carried by a large number of states/regions, township hospitals and health centers at the village level, it is not feasible for MOH to prepare a procurement plan for the program. Decisions to conduct purchases at the township and below levels are made by TMOs with the participation of the community representatives. To date, there have been no clear procedures in writing and procurement has been done with limited transparency through an informal (and undocumented) solicitation of prices.

197. Budgets will be approved by the TMOs with the participation of community's representatives and posted publicly on an information board in each hospital and health center. Specific procedures of procurement (quotations) which would be acceptable to the WB have been specified in the OM. The result of procurement will also be posted publicly. Annual expenditure reports will be signed off by the hospital and health center committee, which has community representation. The community involvement is expected to contribute a reasonable level of accountability. This will be further enhanced by the development of budgets that will be made public by posting on the notice boards. The institutional arrangements under the project will be further strengthened through training programs to ensure that the hospital and health centers are procuring in line with the procedures in the OM for eligible expenditure categories and that spending is publically transparent. The documentary records provide the amount of funds used for different items as part of FM procedures.

198. Grouping of contracts at the township level is not feasible because it would involve different hospitals and health centers scattered over the township. The WB team and MOH will discuss options for future strengthening of the procurement systems for future operations.

199. For Component 2 of the project MOH will prepare a capacity building plan, including TA, studies/analytical work, training, and South-South exchanges, and a procurement plan acceptable to IDA (revised only in concurrence with IDA); thresholds will be prescribed for prior review. Component 2 will not entail any works; only goods and services – both consulting and non-consulting services—which would be procured based on the WB's Procurement and Consultant Services Guidelines.

200. In the event that Component 3 may finance goods, works and consultant services required for immediate response, procurement will be arranged following the related World Bank procedures and will be further detailed in the project CERIP.

201. The capacity assessment was conducted of the DOH and selected townships. The main risks identified include:

(a) There is no official regulation on procurement in writing in the Ministry of Health for the implementation agencies to follow.
(b) All the agencies do not have experience with implementing procurement following the World Bank Guidelines.
(c) There are practices in "open tender" which deviate from the WB Guidelines, such as negotiation after bid opening, ceiling prices, etc.

202. The proposed mitigations include:

(a) An OM has been developed which specifies the detailed procedures of procurement for Component 1.
(b) Procurement of Component 2 will follow the WB Guidelines.

(c) When necessary, consultant(s) may be hired to assist the implementation.
(d) The project will include capacity building component.
(e) The World Bank team will provide training to the project implementation agencies at the early stage of implementation.
(f) Independent verification will be included in the project.

203. In the event of an eligible crisis or emergency Component 3 may finance a positive list of critical goods and/or the procurement of works, and consultant services required to support the immediate response. The simplified procurement arrangements for these expenditures will be further detailed in the CERIP.

204. The overall project risk for procurement is high because (1) huge number of hospitals and health centers will do procurement (purchase); (2) there is no clear procedures of procurement at township and village levels; and (3) this will be the first project financed by the WB in the sector and all the entities of MOH do not have experience with the World Bank procurement procedures.

205. **Procurement Plan.** The MOH has prepared a detailed procurement plan for the first 18 months of Component 2, which provided the basis for the selected procurement procedures. This plan has been discussed with the Bank as summarized below. The plan will be updated with the Bank's prior concurrence, annually or as required, to reflect changes in implementation needs and improvements in institutional capacity.

206. **Date of Bank's approval of the Procurement Plan:** August 26, 2014

Goods and non-consulting services

207. **Prior Review Threshold**: Procurement Decisions subject to Prior Review by the World Bank as stated in Appendix 1 to the Guidelines for Procurement:

Table 13. Prior Review Threshold

S/N	**Procurement Method**	**Prior Review Threshold US$**	**Comments**
1.	ICB (Goods)	*All*	
2.	Shopping (Goods)	*The first contract*	
3.	Framework Agreement (Goods *)	-	
4.	Direct Contracting	*All*	
5.	Community Participation	-	

(*) According to procedures acceptable to the Bank.

208. **Reference to (if any) Project Operational/Procurement Manual:** Operational Manual and SOP to be acceptable to the Bank

Table 14. Summary of the Procurement Packages planned during the first 18 months after project effectiveness

1	2	3	4	5	6	7
Ref. No.	**Description**	**Estimated Cost US$**	**Packages**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Comments**
1	Summary of the ICB (Goods) packages	509,600	2	No	Post	
2	Summary of the other (Goods) packages	600,000	TBD	No	Post	

Selection of Consultants

209. **Prior Review Threshold**: Selection decisions subject to Prior Review by the Bank as stated in Appendix 1 to the Guidelines Selection and Employment of Consultants:

Table 15. Prior Review Threshold

	Selection Method	**Prior Review Threshold**	**Comments**
1.	QCBS/QBS	US$ 50,000	
2.	CQS, LCS	US$ 50,000	
2.	Single Source (Firms/Individual)	All	
3.	Individual	US$50,000, SSS above US$10,000 and fiduciary positions	

Table 16. Consultancy Assignments with Selection Methods and Time Schedule

1	2	3	4	5	6
Ref. No.	**Description of Assignment**	**Estimated Cost US$**	**Packages**	**Review by Bank (Prior / Post)**	**Comments**
1.	Summary of number of contracts that will be let under QCBS	800,000	1	Prior	
2.	Summary of number of contracts that will be let under CQS	315,000	4	Prior	
3.	Summary of number of contracts that will be let under Individual Consultant	362,000	33	Post	

210. **Frequency of Procurement Supervision.** Field procurement supervision will be conducted as part of the regular implementation support missions, which will be conducted at least twice a year. The Bank will periodically undertake the ex-post review by a procurement specialist.

ENVIRONMENTAL AND SOCIAL (including safeguards)

211. The overall objective of the WB'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 groups, women and other vulnerable communities. Two of the WB's safeguards policies apply to this project: The WB's operational policy (OP 4.01) (a) to assess the project's potential environmental and social risks and impacts in order to enhance positive impacts and to prevent, minimize, mitigate or compensate for adverse environmental impacts; and (b) the WB's operational policy (OP 4.10) on indigenous peoples (ethnic groups) aims to design and implement projects in such a way that ethnic groups (a) do not suffer adverse effects during the development process and (b) receive culturally compatible social and economic benefits. MOH briefly assessed the environmental and social impacts and issues concerning the proposed project, which found that the project would have limited adverse impacts. The environmental and social assessments informed the preparation of the following instruments: EMP and CEPF. These documents and the preliminary social assessment were made available to the public through disclosure on June 23, 2014 at MOH's website and through emails to a broad selection of stakeholders invited to the public consultations. Public meetings were held in Yangon and Mawlamyine on July 7 and 8, 2014 to present the objectives of these safeguards documents and to allow input from the relevant stakeholders, including civil society organizations, NGOs, international NGOs and research institutes. The final EMP and CEPF were disclosed in-country on August 28, 2014 and in the InfoShop on August 24, 2014. Further site specific social analysis will be undertaken and consultations will be held with relevant stakeholders, to seek their feedback during project implementation.

212. Apart from the above two, no other safeguard policies apply to the proposed project.

Environmental Safeguards

213. The WB's operational policy 4.01 on environmental assessment aims to assess the project's potential environmental risks and impacts in order to enhance positive impacts and to prevent, minimize, mitigate or compensate for adverse environmental impacts. The proposed project is expected to provide direct financing to existing operational budget linked primarily to operation and maintenance of health care facilities. No new construction or expansion of existing health facilities will be financed given the weak capacity of the MOH to implement relevant environmental safeguard provisions. However, the project may include financing for small-scale rehabilitation of existing health care facilities within the same foot print or financial support for new health care equipment for primary care use (e.g., syringes). Such support might generate minor temporary site-specific environment impacts (e.g., dust, noise) and/or contribute to increased health waste, which needs proper management and disposal. General hazards to communities that are identified as being associated with poor health-care waste management include (a) injuries from sharp waste material to all categories of health workers and waste handlers; (b) risks of infections outside health care facility for waste handlers, scavengers and the general public, and spread of antibiotic resistance; and (c) risks associated with hazardous chemicals, drugs, being disposed or managed improperly by those handling wastes at all levels.

214. Additional health risks may involve those linked to dismantling of asbestos containing materials in the case of renovated facilities that might have roofs made of asbestos. Those that will perform such rehabilitation works will need to be trained in and be aware of the health risks

related to occupational asbestos exposure and implement the relevant international recognized standards and best practices.

Environmental Assessment findings

215. An Environmental Assessment was prepared based on person-to-person interviews of relevant stakeholders[17], direct observation of activities during field visits at selected health care facilities in Yangon region (Twantay township) and Chin State (Paletwa township) and Mon State (Ye township), and brief desk literature review. The samples drawn in the two Region and State visited include the township hospitals, RHC[18] and sub-rural health centers[19]. The project is nationwide in scope, though the achievement of DLIs would be measured in a progressively increasing number of townships; the selection criteria for the first 50 townships for 2015 and the next set of townships for 2016 and 2017 would be agreed with GOM. Criteria will include poverty rates, remoteness and geographic distribution.

216. The brief assessment carried out as part of the project preparation pointed out various limitations in the current health sector relevant to project activities as listed below:

(a) Inadequacies in the legal, regulatory, policy and administrative framework of healthcare waste management and treatment;
(b) Incomplete information about current health legislation, technical guidelines and other policies linked to possible environmental impacts (and their management) generated by health care activities in Myanmar;
(c) Relatively simple/minimal health-care waste management practices in health care facilities with regard to handling inclusive of waste pre-treatment, collection, storage, transportation and final disposal;
(d) Health-care waste at the source of generation is not classified according to its type for easy treatment and final disposal;
(e) Poor compliance with health-care waste characterization related waste quantities and composition and limited information on waste generation;
(f) Lack of segregation of waste according to categories
(g) Insufficient knowledge on and practice of health-care waste minimization, reuse and recycling approach at township and sub-levels;
(h) Lack of regional/centralized disposal facility to handle large quantities of healthcare waste
(i) Lack of code of conduct and low level of awareness of technical guidelines for universal precaution and safety measures at primary health care level;
(j) Lack of written standards for waste operation procedures
(k) Insufficient resources for training and education of health care personnel and public awareness relating to healthcare waste management, which is required to be included in future Comprehensive Township Health Plan.

[17] Township Health Department Medical Officer; Environmental Health Personnel; Health Visitor from local Maternal and Child Health Center; Mon Women Network; Deputy Medical Director; Deputy Director of Nay Pyi Taw City Development Committee for waste management sector, Deputy Director of Medical Care; Basic Health Staff, etc.
[18] Phayaghi (Twantay), Aryutaung (Ye)
[19] Kanbe (Twantay), Tu Myaung (Ye)

217. Overall, the practices in health-care waste management are not satisfactory thus, individuals handling health-care waste, health care personnel and communities are potentially at risk. Further, availability of appropriate equipment and technologies to deal with health-care waste treatment and final disposal is limited and almost inexistent.

218. There is some awareness at all levels, which aims at protecting health workers, visitors to health care facilities and communities living within the vicinity of health-care waste generation. The majority of the health care facilities visited do try to make an effort and take responsibility with limited resources for the waste they generate to the environment and the public to ensure safe, sustainable and culturally acceptable methods for collection, storage, and transportation, much less on pre-treatment and final disposal both within and outside their premises.

219. Type of waste produced at the visited HCFs include: (a) non-risk health care waste or domestic waste made of all wasted that are not contaminated with infectious or pathogen agents (food residues, paper, cardboard and plastic wrapping); (b) Pathological waste, infectious waste as well as items that have been used for medical care; (c) Sharps, mainly, but not exclusively, auto-disable or disposal syringes with needles that are collected in general in separate cardboard boxes; (d) pharmaceutical waste that consists in outdated drugs or expired unfinished drug solution; and (e) chemical waste (from disposal of chemical reagent from laboratory inside hospital).

220. Current health-care waste including infectious wastes such as swabs, syringes, blades, old medicine, contaminated gloves and other medical care waste, are sometimes either dumped in pits or simply thrown behind the facilities. Some of the wastes are burnt (e.g., disposable syringes, parts of human body) while others are simply buried. There is no segregation of waste and all is mixed and kept in plastic bags. Due to this infectious nature of the waste, the possibility of occupational infections seems high. There is no proper mechanism of disposal of pressured containers (e.g. inert gas, oxygen, aerosol cans) although there is awareness of the danger from explosion if accidentally punctured during burning in incinerator. The blood waste is packed in bottles and thrown in the common pit with other type of waste. Generally, facilities for management and disposal of waste observed vary from one health facility to another ranging from outdated incinerators to open air burning sites as there are no air pollution abatement facilities; placental pits, as well as open ditches; and use of public sewers lines for infectious liquid disposal.

221. The health care facilities visited were relatively clean but had modest or inadequate old equipment (pressure and temperature gauges containing mercury; electric cooking pots, and hospital beds). In the absence of adequate infrastructures and equipment, some of the medical waste (drugs, vials) is dropped into a pit without segregation, and burnt periodically. The disposal of sharps is usually a big issue but it was found to be generally satisfactory. However, staff from hospital experienced cuts or puncture of skin while handling sharp disposal cases. It is important to develop a culture in all health care facilities that will encourage appropriate behavioral change among communities, health officers, and all stakeholders.

222. The health facilities visited did not have roofs or other structures made of asbestos. However, ECOPs include provisions on the need to ensure worker safety procedures and international guidelines for those who dismantle and remove asbestos containing materials as part of this project implementation. The WB “Good Practice Note: Asbestos: Occupational and

Community Health Issues" dated May 2009 has been annexed to the Environment Management Plan and shared with implementing agency.

223. The health care facilities have township health profile information available in forms of brochures or maps with graphs and tables placed on the walls. Such profiles include information on nutrition, reproductive health, prevention and control of common childhood diseases, expanded program on immunization, leprosy, tuberculosis and malaria (percentage of cases), health impact indicators, and hospital service and administrative indicators. The environmental health situation of the respective township is reported as percentage of coverage of sanitary latrines in urban and rural areas. The water supply needed for health care facility activities is an issue as well as the proper waste water management system from latrines.

Environment Management Plan implementation

224. The primary healthcare teams and facilities receiving funds for renovation works will follow ECOPs (Annex 2 of the Environment Management Plan) during implementation of these activities; those facilities receiving capacity building and health items/medical equipment are responsible for developing simple healthcare waste management and implementing this plan during operation phase. The plan will cover segregation; collection, treatment and disposal of healthcare waste as well as responses to occupational exposure to hazardous materials (annex 3-4 in the Environment Management Plan present sample health care waste management plans/ procedures).

225. TMO and BHS will coordinate activities to ensure that the project investments comply with national environmental management requirements and the WB's safeguard policies. Local communities will be encouraged to undertake monitoring (including on ECOPs implementation) and participate in project activities as feasible.

226. Capacity building on environment management plan implementation including solid healthcare waste and occupational Health and Safety training will be provided to HCFs and communities as part of project implementation.

227. Public consultation on the draft EMP was held on July 7 (Yangon) and 8 (Mawlamyine), 2014. See discussion of the consultations below

Social Assessment

228. The preliminary social assessment was undertaken in order to better inform the project design by identifying broad social issues relevant to the project, and to address WB safeguard requirements. The SA included an assessment of potential risks and social impacts of proposed project activities as per the WB's operational policy on environmental assessment (OP 4.01) and to identify and assess particular issues and risks concerning ethnic groups following the requirements of the WB's operational policy on indigenous peoples (OP 4.10). Consultations under the SA were conducted with relevant stakeholders including ethnic group organizations and NGOs working with ethnic groups, mainly at a national level, and should be recognized to provide only preliminary analysis and overview of pertinent issues. Further social assessments and consultations will be integrated into project implementation as described in the Community Engagement Planning Framework (CEPF). The Assessment, however, has identified critical gaps to be filled during project implementation. It informed project design and the preparation of the CEPF, aimed to enhance project outcomes for the poor and disadvantaged groups, such as ethnic groups, disabled, migrants and women.

229. ***Social Assessment Findings***

230. The Social Assessment report provided an overview of social dimensions concerning health sector services and practices in Myanmar, including particular issues concerning access by ethnic groups, and the project's potential impacts and risks identified. It assessed the legal and institutional framework applicable to ethnic groups and the health sector and provides a brief overview of the demographic, social, and cultural characteristics of Myanmar, including ethnic groups, with a focus on health related data. The Assessment also identified key stakeholders and institutional arrangements in the project relevant health activities and levels, identified vulnerable and under-served population groups, and assessed constraints and main factors affecting access to, and quality of, health services for remote communities and ethnic groups. The main findings from the preliminary social assessment include:

(i) ***Key sector issues and constraints***:

(a) Vulnerable and under-served population groups identified under the health sectors are women and children, ethnic groups, internally displaced population groups such as Muslim communities in Rakhine State and populations in Kachin State, migrant and post-disaster groups.

(b) Constraints or barriers that prevent people from accessing public health services and prevent a more equitable participation of ethnic groups and vulnerable groups include: affordability, remoteness, culture and language, conflict and post-conflict areas, limited capacity of health system and staff, and weak information system. Muslim populations in Rakhine State, both those living in the camps and in the villages, are constrained in accessing health services due to disruption of NGO service delivery and controlled mobility.

(c) Planning and implementation system especially at the township and lower level is weak. Township, Village Tract and Village health committees are in place, but are often inactive and with poor participation of women and vulnerable groups. The committees could be strengthened to play a stronger role in engaging community members and improving health services. The township planning system should be improved to provide a better understanding of the local health situation and provide a basis for targeted services especially to vulnerable groups.

(d) Overlapping of different health service providers such as from the government, ethnic health organizations and private sector. Alternative health system, particular those managed by ethnic group organizations, may have concern about sustainability or their health services in the changing context.

231. ***Project Impacts***. The provision of health services supported by the project is not expected to have adverse impacts on ethnic groups or other vulnerable groups. Rather, it is expected to help address the issue of impaired health service access for ethnic and religious minorities by strengthening inclusion, both system wide and in States and selected Townships from hardship and conflict affected areas. Consultations with NGOs representing ethnic groups did not reveal opposition to the proposed project. However, some risks and concerns were raised including language and cultural barriers and concerns that the Government's efforts to reach its universal health coverage goals may replace current health service providers organized by ethnic group organizations.

232. ***Key Recommendations***: (a) enhancing cooperation and coordination between the government health system and alternative health care providers; (b) improving participatory

planning to include community members and other stakeholders in the planning process; (c) improving data collection that incorporate social and poverty variables, and be disaggregated by sex, socio-economic status and ethnicity; (d) improving monitoring system by including consumer and civil society participation; (e) improving capacity and training of health managers and providers; and (f) developing health education materials in group languages.

233. ***Free, prior and informed consultations with ethnic groups***: A key requirement of OP 4.10 is to obtain broad community support from ethnic groups, as identified under the policy, for project activities affecting them (whether adversely or positively). However, since specific Townships have not been identified yet, it is premature to obtain such broad community support. Free, prior and informed consultations will be undertaken during project implementation and social analysis will be undertaken, including screening for the presence of ethnic groups. Similarly, the required site-specific plans to address particular issues pertaining to ethnic groups will be prepared during implementation. These requirements will be integrated into existing processes, which will be enhanced and modified through support from the project. Township health planning will include social analysis and consultations, and the Township Health Plans will include elements of an ethnic group Plan when ethnic groups are present in the township.

234. Consultations with ethnic group organizations during project preparation have not revealed any opposition to the proposed project and improved health services are in demand in ethnic States as well as in the seven Regions of Myanmar. NGOs and ethnic group organizations do not deliver health services that are any different from government delivered services, although the institutional and operational aspects differ.

Community Engagement Planning Framework

235. Under OP 4.10 the borrower is responsible for preparing an instrument that summarizes the findings and recommendations of the SA and consultation process, and that provides measures to ensure that adverse impacts are avoided or mitigated and that the project provides culturally compatible social and economic benefits to ethnic groups and other vulnerable communities. The CEPF was developed, based on the SA findings and consultations, to address these requirements as well as to enhance the participatory planning at township and village levels and enhance equitable benefits to health services supported by the project.

236. The CEPF includes the elements of an "Ethnic Groups Planning Framework" required under OP 4.10 and procedures for a practical social assessment and consultation process during project implementation that provides for the informed participation of local communities and community support to project financed activities. It includes the following elements:

(a) Description of project objectives, Components and activities.
(b) Description of the social dimensions of the project, including potential positive and adverse effects of project activities on ethnic groups.
(c) The process undertaken for social analysis and consultations to inform project interventions at appropriate levels (State/Region, township, Village Tracts and Villages), including screening for the presence of ethnic groups and "free, prior, and informed consultation" with ethnic groups. The local planning process supported by the project mainly uses existing structures, such as township and Village Health Committees, but is designed to be inclusive of all relevant stakeholders, including poor and remote community representatives.

(d) The community engagement process in project financed activities to enhance project outcomes and provide equitable benefits. This may include a process for preparing and disclosing township health plans that incorporate findings and recommendations from the SA and consultation process, and working with township and village health committees.
(e) Institutional arrangements for implementing the framework, including capacity building where necessary.
(f) Grievance Redress Mechanism.
(g) Monitoring and reporting arrangements.

237. The CEPF addresses key issues identified under the SA. It builds on, and improves, existing mechanisms including MoH processes for local planning, establishment of health committees, and preparation of Township Health Plan. It identifies processes for enhancing community engagement:

(a) ***Strengthening participatory planning for Townships***. Townships are required to prepare Township Health Plans building on health plans from lower levels. MoH will improve coordination between DPs working at Township level, and measure to unify the various processes and templates into one improved planning process and plans. The unified health plan will involve a simple consultation and social analysis process with the objectives of enhancing the delivery of township health services, which would be more equitable and more inclusive.

(b) ***Preparation of a Township Health Plan***: Based on the findings of the community engagement and social analysis process, the Township Health Plan (THP) will be prepared. Broad community support[20] to Township Health plans will be achieved through the participatory planning process and the involvement of township and village health committees in the preparation of the THP. Health committees at the local level will be revised to ensure that opinions of the vulnerable groups including disabled, migrants, women and ethnic group organizations are integrated in the township health planning process. In areas with ethnic groups the THP includes elements of an Ethnic Group Plan.

(c) ***Implementation and monitoring of the Township Health Plan***: MoH will: i) strengthen village health committee to include more representatives from the community; ii) disseminate THP to Township stakeholders and communities; iii) assign the Township Medical Officer (TMO) to have overall responsibility for the implementation of the THP by coordinating with the Township, Village Tract and Village Health Committees; and vi) monitor the implementation of the THP on a regular basis.

(d) ***Broadening stakeholder consultation***. The MOH will undertake broad stakeholder consultations during implementation of this Component to seek input from stakeholders on systems strengthening and other elements supported by the project, such as development of health financing strategy and essential health

[20] OP 4.10 requires that broad community support are obtained from affected, whether positively or adversely, ethnic minority communities. This requirement is achieved through the planning process for the THP as described in this CEPF.

package. The consultations will involve a broad section of stakeholders with the aim of including representatives of different social groups, including vulnerable and under-served population groups, such as ethnic groups, women, internally displaced populations and migrants.

(e) ***Strengthening capacity of the MOH*** to implement CEPF and the Project effectively. The MOH, with support from the WB, will provide training for TMOs and other relevant stakeholders on the elements of the CEPF, particularly with regard to the community engagement and social analysis process, preparation and implementation of the THP, including on strategies to enhance the participation of local communities and health committees, and broader consultations and engagement of stakeholders.

238. MOH has integrated these elements in the OM. Township Health Plans will be submitted to the WB for review and approval. Given the large number of THPs, a sample of at least 10 percent will be randomly selected for WB review. In addition, the Project has set the disbursement link indicator (DL4) incorporating CEPF requirements into the THP - "Number of townships in which the THD have prepared an annual integrated and inclusive health plan in accordance with the OM and CEPF". The DLI measures more than inclusiveness as required under the CEPF, and also covers the aspect of integration of various health plans at the township level, resulting in one common township health plan. .

Public Disclosure and Consultations

239. As part of the social assessment and for project design, extensive consultations were undertaken with diverse group of stakeholders, including government entities, civil society organizations such as international, national and regional NGOs, professional associations and ethnic group organizations, and other sector specialists. Such consultations have been incorporated into the CEPF and project implementation. The majority of the consultations were done in parallel with the SA, which also included consultations with selected ethnic group organizations and NGOs and field visits to two townships with ethnic groups.

240. Consultations on the draft safeguards documents (EMP, SA and CEPF) were carried out in July 7 and 8 in Yangon and Mawlamyine respectively; the documents were disclosed on MOH's website and forwarded to a wide range of stakeholders invited to the public consultations. The main relevant suggestions regarding the EMP included the need for the project investments and design to consider integration of waste minimization methods as well as avoidance to finance and use unsafe burners/stoves or incinerators for health care waste disposal and treatment (see recommendations concerning social aspects discussed above under the SA and CEPF). Below is the summary of the consultations.

Summary of Public Consultations on the Proposed WB-Financed Health Project

Table 17. Schedule of the public consultation meetings

Date	Time	Venue	Participants
July 7	10:00 – 12:00 hrs	Yadanar 3, Park Royal Hotel, Yangon	Local NGOs and Civil society orgs
July 7	14:00 – 16:00 hrs	Yadanar 3, Park Royal Hotel, Yangon	International NGOs
July 8	14:00 – 16:00 hrs	Shwe Myint Mo Tun Hotel, Mawlamyine, Mon State	Local NGOs and Civil Society Orgs

241. ***Purpose of the Meetings.*** To consult and seek feedback from stakeholders' on the Ministry of Health (MOH) proposed health project financed by the WB, and its safeguard draft documents on Social Assessment, Community Empowerment planning Framework (CEPF) and Environmental Management Plan (EMP).

242. ***Participants*.** Total 109 participants from local NGOs, Civil Society Organizations, International NGOs, MOH, and WB.

243. ***Presenters.*** Dr. Yin Thandar Lwin, Director (Public Health), Department of Health (DOH), MOH; Dr. Thuzar Chit Tin, Deputy Director (Public Health), DOH, MOH; and U Htay Win, Deputy Director, Occupational and Environmental Health, DOH, MOH

244. ***Documenters:*** Hnin Hnin Pyne and Nang Mo Kham from the WB

245. ***Resource Panel:*** (i) Thant Sin Htoo, Deputy Director (Planning), Department of Health Planning, MOH; (ii) Wut Mon, Deputy State Health Director, Mon State Health Department; (iii) Hnin Hnin Pyne, Task Team Leader, WB, (iv) Nang Mo Kham, Human Development Specialist, WB, and (v) Kyaw Soe Lynn, Communications Officer, WB.

Program

246. ***Welcoming Remarks*:** Dr. Yin Thandar Lwin, Director of Public Health from DOH, MOH welcomed participants and introduced the purpose of the meeting – to seek inputs and feedbacks from the participants on the project design and the draft safeguard documents.

247. ***Presentations*:** Three presentations were given by the respective officials from MOH. The first presentation on the rationale and design of the project was given by Dr. Yin Thandar Lwin (see Annex 2 for powerpoint presentation). The second presentation on preliminary social assessment report and draft Community Empowerment Planning Framework (CEPF) was delivered by Dr. Thuzar Chit Tin. The third and last presentation on Environmental Management Plan was given by U Htay Win.

ANNEX 4: OPERATIONAL RISK ASSESSMENT FRAMEWORK (ORAF)
MYANMAR ESSENTIAL HEALTH SERVICES ACCESS PROJECT

1. Project Stakeholder Risks						
1.1 Stakeholder Risk	**Rating**	**High**				
Description: The reform agenda in the health sector is ambitious and, although Government commitment is high, it may prove difficult to ensure speedy implementation.	Risk Management: An intensive dialogue between the Bank and the implementing agency at central and state/regional levels will be continued during implementation so that implementation support can be provided in a timely manner by the Bank and TA. A political economy analysis was carried out to identify stakeholders, their positions and interests, strengths and weakness and devise appropriate measures to mitigate possible resistance to change					
	Resp: Both	Status: In Progress	Stage: Both	Recurrent: √	Due Date	Frequency: Continuous
2. Implementing Agency (IA) Risks, including fiduciary risks						
2.1 Capacity	**Rating**	**High**				
Description: The Bank will rely on Government structures and systems, such as financial management, for project implementation. There is a risk that these systems may not be strengthened in a timely manner to achieve project objectives.	Risk management: Fiduciary assessments—Financial Management and procurement—at central and township levels have been carried out during preparation. The assessments meet World Bank fiduciary policy guidance and good practice for IPF operations and the fiduciary arrangements for the project reflect the findings and conclusions of these assessments. Guidelines, capacity building and implementation support will be provided during implementation. These activities have been identified and costed in the implementation plan.					
	Resp: Both	Status: In Progress	Stage: Both	Recurrent: √	Due Date:	Frequency: Continuous
2.2 Governance	**Rating**	**High**				
Description: Oversight of the funds to the facilities below township may be	Risk management: The project is designed to improve transparency of fund flow to townships and below by using a simple formula (clearly defining the amount and fund flow) and to involve communities in oversight,					

<table>
<tr><td rowspan="3">weak.</td><td colspan="6">strengthening social accountability. It also builds capacity for health staff to implement a more integrated and inclusive township planning processes.</td></tr>
<tr><td>Resp: Both</td><td>Status: In Progress</td><td>Stage: Both</td><td>Recurrent: √</td><td>Due Date:</td><td>Frequency: Continuous</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="7">3. Project Risks</td></tr>
<tr><td>3.1. Design</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="3">Description:
There is a risk that DLIs are not achieved or that the focus on DLIs could distract from improving processes and the quality of inputs.</td><td colspan="6">Risk Management:
The project will provide capacity building to improve data and processes. DLIs have been selected to track both progress on improving processes as well as outputs.</td></tr>
<tr><td>Resp: Both</td><td>Status: In Progress</td><td>Stage: Both</td><td>Recurrent: √</td><td>Due Date:</td><td>Frequency: Continuous</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td rowspan="3">Description:
To ensure selectivity, only key indicators have been included as DLIs. This could take attention away from other important indicators that are not linked to these DLIs.</td><td colspan="6">Risk Management:
Non DLI indicators of importance have been included in the Results Framework, which would also be monitored on a regular basis.</td></tr>
<tr><td>Resp: Both</td><td>Status: In Progress</td><td>Stage: Both</td><td>Recurrent: √</td><td>Due Date:</td><td>Frequency: Continuous</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td>3.2 Social and Environment</td><td>Rating</td><td colspan="5">High</td></tr>
<tr><td>Description:

Environment. Negative environmental impacts due to increased coverage of MNCH services, i.e. increased health care waste.

Ethnic Groups, minorities, and other vulnerable population.</td><td colspan="6">Risk Management:
Environment. An Environmental Management Plan has been prepared, including a plan to address health care waste. To ensure effective implementation, the project would finance capacity building and consumables needed to manage health care waste by facilities at the township and below.

Ethnic groups, minorities, and other vulnerable and under-served populations. The project design mitigates this risk by supporting inclusive planning through the Community Empowerment and Planning Framework (CEPF) and through transparency and accountability of fund flows. Extensive consultations were held with CSOs and a wide range of stakeholders, including public consultations on the CEPF on July 8 and 9, 2014. The CEPF provides for a continuous consultation process</td></tr>
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<td>There is a risk that poor, vulnerable and under-served populations, especially ethnic groups and vulnerable communities in the border areas of States, such Shan, Rakhine, and Kachin do not benefit from the project. Also, hard-to-reach areas (due to geographic and security constraints) could be left out of the programs unless special care is taken to include them.</td>
<td>throughout project implementation. The framework will be implemented to ensure that social analysis (identifying ethnic minorities and other vulnerable groups, their needs and existing gaps) and consultations are undertaken at township level and that the findings are incorporated into the planning and budgeting process. Improved Township Health Plans will include required elements of an Ethnic Minority Plan in townships with ethnic minorities.

The project would help address the issue of impaired health service access to ethnic and religious minorities by strengthening inclusion, both system wide and in States and selected Townships from hardship and conflict affected areas: (i) Township health plans incorporating CEPF and community involvement in service delivery are pre-requisites for receiving health facility grants; (ii) IDA disbursement is linked to the quality of township health plans and adherence to CEPF; and (iii) the project will supportintensive capacity building—training and technical assistance—to selected townships to facilitate effective implementation of CEPF as part of township health plans; and (iv) States, such as Mon, Rakhine, and Kachin, will be provided with additional resources to promote inclusive and convergence of service provision by government and non-governmental actors.

Furthermore, to mitigate risks of exclusion of vulnerable groups in the Rakhine State, the Government has taken actions as follows: (i) a plan has been prepared to improve access to health services in the Rakhine State, including for vulnerable groups; (ii) the Ministry is meeting with NGOs on a regular basis; (iii) international NGOs, whose services were disrupted, are continuing to provide services in collaboration with the public sector facilities; and (iv) full resumption of international NGOs is under process. The Bank will continue to work with other partners in supporting the Government to provide inclusive services in the Rakhine State.
<table>
<tr><td>Resp:
Both</td><td>Status:
In Progress</td><td>Stage: Both</td><td>Recurrent:
√</td><td>Due
Date:</td><td>Frequency: Continuous</td></tr>
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<tr><td>3.3. Program and Donor</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="3">Description:
There is a risk that lack of consultation and close coordination with other donors and development partners involved in the sector stretch MOH and other involved agencies' implementation capacity and prevent important synergies.</td><td colspan="6">Risk Management:
The design of this project has taken place in the context of intensive coordination of Bank support with other agencies, working under IHP+ principles. The project will finance institutional strengthening to ensure government systems are enhanced. IDA financing of operational expenses at the frontlines of service delivery closely complements, as well as enhances, the support of UN agencies, international NGOs, and bilateral donors. IDA support selectively focuses on recurrent costs, not covering areas where Government and DPs are already engaged, namely construction and major rehabilitation and repair of hospitals, RHC and sub-centers (SC), supply chain management, procurement of drugs, and information systems.</td></tr>
<tr><td>Resp:
World Bank</td><td>Status:
In Progress</td><td>Stage: Both</td><td>Recurrent:
√</td><td>Due Date:</td><td>Frequency: Continuous</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td>3.4 Delivery Monitoring and Sustainability</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="3">Description:
Regular monitoring systems may not have the capacity to provide timely and valid information.</td><td colspan="6">Risk Management:
Independent verification will be done annually of the results achieved. Where necessary, monitoring and additional surveys will be carried out with technical assistance if needed.</td></tr>
<tr><td>Resp:
Both</td><td>Status:
In Progress</td><td>Stage: Both</td><td>Recurrent:
√</td><td>Due Date:</td><td>Frequency: Continuous</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="7">Overall Implementation Risk Rating: High</td></tr>
<tr><td colspan="7">Description:
Implementation risk is high because the capacity of the MOH and other involved agencies to put in place all systems for smooth project implementation requires significant strengthening.</td></tr>
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ANNEX 5: IMPLEMENTATION SUPPORT
MYANMAR ESSENTIAL HEALTH SERVICES ACCESS PROJECT

248. The WB will provide implementation support in coordination and collaboration with other DPs; the WB implementation support team will include Senior Human Development Specialist (TTL) and Human Development Specialist, both of whom are located in the WBG Yangon Office. Procurement and FM support will be provided from the Bangkok office. This proximity will allow for frequent and timely support to the MOH and close interactions with other DPs. The team will also work closely with the new Health, Nutrition, and Population Global Practice, and draw upon needed international expertise as needed.

249. In addition to the IDA Credit, WB will also provide technical assistance, training, knowledge-sharing and other such support with its own resources (WB Budget) and Reimbursable Advisory Services with the 3MDG Fund, plus Trust Fund resources to be mobilized as necessary. Moreover, as several DPs (bilateral and multi-lateral, including the United Nations agencies) are actively engaged in the health sector of Myanmar and keen to be working in a coordinated fashion, discussions are ongoing to identify technical assistance needs and provide the necessary support jointly and/or leverage each other's contribution synergistically. Such support is needed at the policy level as well as at the operational levels.

250. **Areas of Technical and Operation Support.** Tentatively, the following areas have been identified as needing technical assistance/capacity building/South-South learning (see Table 18). In addition, the WB health team will collaborate and coordinate with other WB financed operations to see how the implementation support could be leveraged and synergized.

Table 18. Main Focus of Implementation Support

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First 12 months	• Health financing • Financial Management • Procurement • Inclusive and integrated township health planning • Community engagement and social accountability • M&E • Communications • Skills for MNCH	• Health Economics • Financial Management • Procurement • Participatory planning • Health information systems • M&E • Communications • Training	$ 200,000	JICA 3MDG Fund WHO USAID UNICEF UNFPA GAVI
12-48 months	• Health financing • Financial Management and Internal audit • Procurement	• Health Economics • Financial Management • Procurement • Participatory	$300,000	JICA 3MDG Fund WHO USAID GAVI Global Fund

	• Inclusive and integrated township health planning • M&E • Health care waste management	planning • Health information systems • M&E • Waste Management		

Table 19. Skills Mix Required (4 years)

Skills Needed	No. of Staff Weeks	No. of Trips	Comments
Health Financing	24 weeks	12	Global/Regional based support
Financial Management and Internal Audit	40 weeks	24	Regional/Country based support
Procurement	18 weeks	10	Regional/Country based support
Inclusive and integrated township health planning	20 weeks	10	Global/Regional/Country based support
Community engagement and social accountability	12 weeks		Global/Regional based support
M&E	20 weeks	12	Global/Regional based support
Communication	10 weeks	4	Global/Regional/Country based support
Health Care Waste Management	6 weeks	6	Global/Regional based support

Table 20. Partners

Name	Institutions/Country	Role
JICA	Japan	UHC support, health information systems
3MDG Fund	United Kingdom, Australia, USA, Norway, Sweden, Denmark, and European Union	Township health planning, social accountability, community engagement, financial management, and capacity building at the state/region and township levels
WHO	UN agency	Township health planning, UHC, health care waste management
UNICEF	UN agency	Skills training for Child Health
UNFPA	UN agency	Skills training for Reproductive and Maternal Health
USAID	Unites States	Procurement, health information, training of basich health staff, supply chain management
GAVI		Township health planning, financial management
Global Fund		Capacity building at the state/region and township levels

ANNEX 6. ECONOMIC AND FINANCIAL ANALYSIS
MYANMAR ESSENTIAL HEALTH SERVICES ACCESS PROJECT

The project's expected contribution to development.

251. The goals of ending poverty and boosting shared prosperity can be realized only if households no longer risk impoverishment through payment for health services, and their education and work opportunities are not unduly constrained by illness. A project that contributes to UHC - defined by the World Health Report 2012 as a situation where all people who need health services (prevention, promotion, treatment, rehabilitation, and palliative) receive them, without undue financial hardship – will, therefore, have a direct impact on poverty, both in the short-term, but also over the long-term through its role in human capital formation.

Rationale for public sector provision / financing of health care.

252. The pervasiveness of market failures, externalities and spillover effect – and of inequities in the provision (and financing) of health services – provides a clear rationale for public intervention in the health sector on both efficiency and equity grounds. This argument holds particularly strongly for this project which focuses mainly on improving service delivery at the lower levels of care (i.e., on primary and secondary prevention) by (a) pushing substantial additional operational resources to frontline service providers; and (b) supporting policy changes and institutional reforms that enhance the enabling environment in which these providers operate.

Market failures / efficiency

253. First, many of the health programs that are implemented by these frontline providers can be considered public goods. Investments in vector control and mass health promotion campaigns fall into this category. Similarly, many health interventions are merit goods, meaning that they create large positive spillover effects (e.g. vaccination), produce greater social benefits than private benefits (e.g. family planning), and should have significant interpersonal utility values (e.g. medical services provided to vulnerable populations). Second, capital markets for health goods and service are typically imperfect, yielding lower rates of long-term investment than are optimal from society's perspective. Third, consumers of health care typically do not know enough about the benefits of health care (especially preventive care), with the result that they may underinvest or make inappropriate choices. These market failures in health care and health financing mean that government intervention can raise welfare by improving the way that these markets function.

254. By providing additional (flexible) resources to these providers, it is expected that this project will enable frontline providers to better implement these interventions listed above. For example, the budget could finance the transportation of commodities, information and awareness campaign, the provision of travel allowances to support outreach to those not yet seeking need care, and facility maintenance costs.

255. While the project aims to predominantly support the public sector, there is an important role for the private sector in the delivery of health care in Myanmar, and even in its financing, and the project will help to create the enabling conditions for the private sector to contribute to UHC. Through reforms at the national level, for example, the project will help to strengthening the role of the MOH as regulator of private care (e.g. supporting the development of the criteria for licensing and accreditation of both public and private facilities, as well as the development of

a health financing strategy), thus facilitating the introduction of various types of public-private partnerships.

Equity

256. An even stronger argument than the efficiency argument for public investment in improving the health in Myanmar is the equity argument. There are at least three dimensions to the equity challenge in Myanmar.

257. First, access to services is inequitably distributed, across income groups, and also by urban-rural area, with a dearth of care in the remote areas where 70 percent of the population live. As can be seen in Table 21, access to health care is highly inequitably distributed, and not justified by variation in the incidence of illness. Access to maternal and child health services, i.e. essential preventive care, is also inequitable distributed, with especially large differences between rich and poor in institutional delivery rates.

Table 21. Illness and Health Care Seeking Behavior, 2009-10 (percent; Kyat)

	All	Poorest	Q2	Q3	Q4	Richest
Any illness or injury	8.5%	7.5%	7.8%	8.3%	9.6%	9.9%
Any acute illness	7.7%	6.6%	7.0%	7.4%	8.7%	9.2%
Any chronic illness	2.6%	2.6%	2.4%	2.3%	2.8%	2.9%
Seeking care when ill	78.2%	67.3%	76.6%	77.8%	82.1%	87.4%
Seeking care in public facilities	27.6%	30.7%	32.2%	25.9%	27.5%	22.7%
Seeking care in private facilities	43.4%	32.8%	32.8%	45.6%	48.1%	54.1%

Source: IHLCA 2009/10; results reported in Myanmar Public Expenditure Review
Note: Results are presented for means standardized for age and sex by direct method; quintiles are based on expenditure data.

258. Second, there appear to be very little financial protection. At 60 percent of total expenditure, out of pocket payments are the dominant form of health financing in Myanmar and in the absence of any prepayment mechanisms, such as health insurance, households face a real risk of incurring large medical care expenditures – expenditure that is potentially impoverishing and catastrophic[21]. Analyses of the IHLCA 2009/10[22] data illustrate the lack of financial risk protection. As can be seen in Table 22, when catastrophic expenditure payments are defined as 10 percent of the total expenditure, as it commonly is, 21 percent of households incur catastrophic health expenditure and those who do exceed the threshold do so by, on average, 26 percent (i.e. spend 47 percent of their household budget on health care). An alternative threshold for catastrophic expenditure, i.e. 40 percent of non-food expenditure, puts the level of catastrophic expenditure at the very similar level of 18 percent.

[21] The methodology and approach used for this analysis is derived from O'Donnell, Owen, Eddy van Doorslaer, Adam Wagstaff, and Magnus Lindelow (2007): "Analyzing Health Equity Using Household Survey Data", The World Bank.

[22] This analysis was undertaken for the health chapter for the Myanmar Public Expenditure Review. At the time of the writing of the PAD, the IHLCA data were being re-cleaned and new consumption aggregates calculated which may affect the conclusions with respect to equity in access, financial protection and benefit incidence.

Table 22. Incidence and Intensity of Catastrophic Health Payments, 2009-10

Catastrophic payments measures	Threshold budget share				
Out-of-pocket spending *as share of total expenditure*	5%	10%	15%	25%	40%
Head count	35.46%	20.58%	14.11%	7.60%	
Standard error	0.86%	0.71%	0.59%	0.45%	
Overshoot	6.72%	5.37%	4.50%	3.47%	
Standard error	0.73%	0.72%	0.71%	0.69%	
Mean positive overshoot	18.94%	26.09%	31.92%	45.70%	
As share of non-food expenditure					
Head count			42.27%	29.05%	18.23%
Standard error			0.89%	0.81%	0.67%
Overshoot			22.35%	18.87%	15.41%
Standard error			2.33%	2.31%	2.29%
Mean positive overshoot			52.87	64.96%	84.50%

Source: 2009/10 IHLCA survey

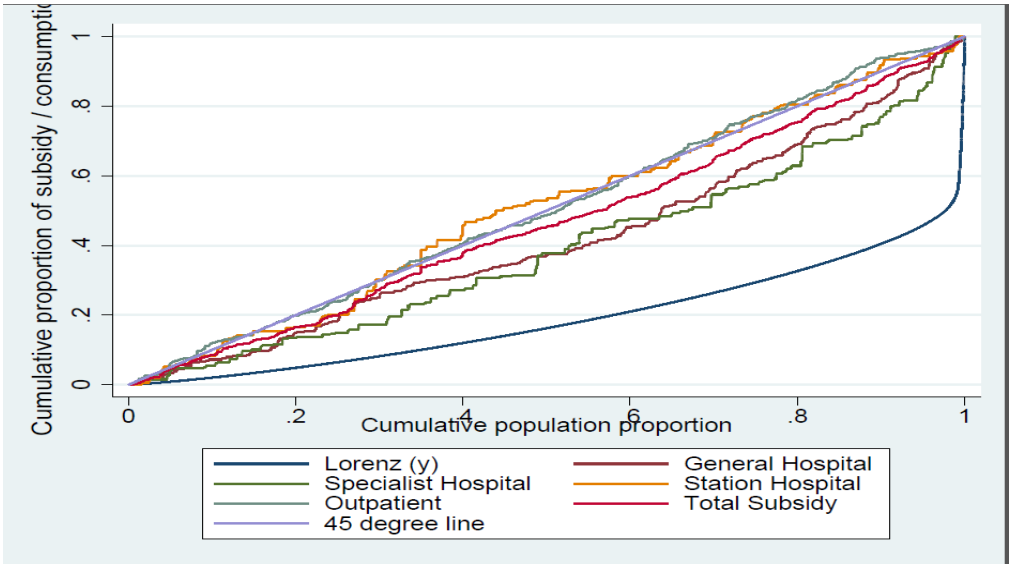
259. Third, benefit incidence analysis suggests that health spending is pro-rich at higher levels of care, but encouragingly slightly pro-poor at the lower levels of care where this project will concentrate its investments. Using a combination of the IHLCA 2009/10 data for information on health service utilization patterns and 2009/10 NHA for public health expenditure, the subsidy concentration curves (see Figure 4) and concentration indices general hospitals, specialized hospitals, SHs; and outpatient care at lower levels (i.e. rural health centers, maternal health centers and public clinics) can be generated[23]. Using sing the concentration index[24], it is found that the facilities where health spending is most pro-poor are the lower levels of ambulatory care (with a concentration index of -0.012), followed by SHs (-0.008). Spending on general hospitals (+0.165) and specialized hospitals (+0.219) is, by contrast, strongly pro-rich. Public spending on health as a whole is slightly pro-rich (+0.070).

260. By investing in service delivery at the lower levels of care (both through quality improvements and operational budget), the project intends to increase both the utilization of primary services by the poor and the amount of government financing going to the primary levels, which together should contribute to making government health spending at that level even more pro-poor. By increasing the volume of resources flowing to this level vis-à-vis other levels, it will also help to make overall (public) health expenditure more pro-poor, thus effecting a redistribution of spending toward a more socially desirable equilibrium and contributing to poverty alleviation.

[23] Unit costs are obtained by dividing aggregate expenditures by the weighted sum of utilization reported in the IHLCA survey data, where weights are expansion factors indicating how many individuals in the population are represented by each sample observation. Expenditure on each individual is thus quantity of health care consumed at the specific facility multiplied by unit cost. Living standards are approximated by household consumption per equivalent adult

[24] The concentration index is a summary measure of inequality. Positive values indicate concentration of subsidies among the better-off, while negative values indicate a concentration of subsidies among the poor. The larger the number, the greater the degree of concentration/inequality there is. Values close to zero are generally interpreted to be neither pro-rich nor pro-poor, regardless of sign.

Figure 4. Concentration Curves for Health Sector Subsidies and Lorenz Curve of Household Consumption, 2009-10

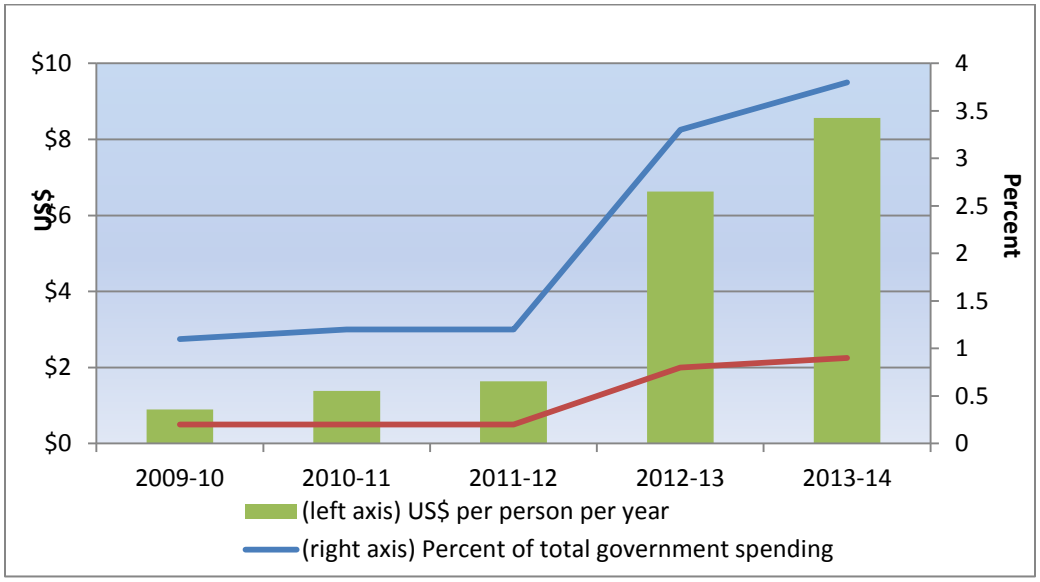


261. Overall, the design of the project is strongly pro-poor: (a) it focuses interventions and financing on the lowest levels of service delivery (i.e. facilities at township level and below) which are disproportionately used by the poor, which should make overall GOM health spending more pro-poor; (b) it focuses on the health services (and health outcomes) that are most inequitably distributed (such as reproductive health); (c) the introduction of a resource allocation formula that allocates more money to facilities in "hardship" townships (i.e. the hardship premium); and (d) ensuring that the allocation of project funds to S/RHDs results in a distribution that advantages the S/RHDs of the (ethnic) states, relative to their size. In addition, the fact that at least 20 percent of the DLI achievement in any given year should be in the "hardship" states (i.e. approximately proportional to their population share) would ensure that the poor are not left behind in project implementation. Finally, the project will explicitly monitor the effect on the poor in the results framework, by disaggregating the PDO indicators by poor and non-poor.

The financing gap – at macro and micro level

262. Myanmar spent an estimated 1,137 billion kyats on health in 2012-13. Total health spending has increased by 41 percent over the last five years, mainly as a result of increases in government expenditure which has grown by 480 percent over this period. However overall levels of health spending remain low at only 2.4 percent of Gross Domestic Product which, even taking recent increases into account, is the lowest in the East Asia region. In 2013-2014, government health spending was equivalent to only US$8 per capita which, while an enormous increase from 2009-2010 when it was less than US$1 per capita, is also low by regional and global standards. While out of-pocket spending has fallen since 2009-10, it remains very high at 60 percent of total health spending.

Figure 5. MOH Expenditure on Health (2009-10 to 2013-14)



263. These figures suggest a history of chronic underinvestment in the health sector and that current levels of financing are likely insufficient to provide needed health services. Consequently, while there may have been recent increases in expenditure, there is a need for further increases in investment in the health sector (including through external sources). This project, with a US$100 million investment over four years (or average 25 million each year) through the public sector translates into an increase of US$0.42 per capita per year or a 5.25 percent increase over the current per capita government financing level. This increase is relatively small and thus likely to be sustainable, especially since overall health spending is low as a share of GDP. Nevertheless, the rapid scale-up of health spending in recent years raises questions about the absorptive capacity (for planning and efficient resource allocation) of the sector. Thus, from the perspective of the project investment decision, the data confirm the need for both (a) additional health financing (since current levels remain low on a nominal, as a share of GDP, and per capita basis); and (b) the capacity-building and technical assistance envisaged by the project (Component 2) to help channel the increases in government spending toward their most efficient uses.

264. At the micro-level, i.e. township level, there is also scarcity of resources. According to Ministry of Health data, in 2013-14, each township, which consists of more than one hospital and many health centers, receives a budget of only US$180,000 per year on average, of which almost US$120,000 goes to salaries, leaving only US$62,000 for annual operational expenditures. This operational budget was a six-fold increase over the US$10,000 operational budget of the previous year, with the additional funds supporting the distribution of medicines under the free drug program. Still, this is a very low level of budget with which to operate quality facilities. The majority of project funds (Component 1) will be used to push additional operational budget down to the township level, at an annual average level of around US$50,000 per township, effectively more than doubling the budget available with which to deliver services at the frontline. Component 1 will also support planning activities to help facilities used these additional funds efficiently.

Additional value-added of the WBG support

265. Beyond the direct contribution of the proposed health sector investments to Myanmar's economic development, the WBG's support has additional value-added. First, the majority of funds from other DPs working in the health sector currently bypass government budgets in the implementation of their projects. Consequently, this project is in a unique position in that it pushes it funds to the frontlines using government systems and, in the process, uses this investment to strengthen related government systems such as FM, information systems and procurement. Strengthening the underlying systems will also enhance the efficiency of the use of existing resources, as well as encourage the use of government systems by other DPs. Second, investments by the project in strengthening institutional and policy development capacity at the national and state/regional levels, will help the government to use the increases in health resources (both own resources and external resources) more efficiently and equitably. Third, since the proposed activities are not currently been undertaken by other DPs, the proposed investments are not duplicative. Fourth, the WBG can leverage expertise form across the Group to support health investment (e.g. social protection and labor practices to support health workforce reform; governance practice to support accountability mechanisms), and seek synergies with programs implemented by other sectors, including services provided by IFC, to bring value to the client. Finally, as the first donor investment that provides support to all regions and across key areas of national UHC capacity-building, it provides a programmatic framework of engagement along which alignment of partners can be pursued.

ANNEX 7. SUMMARY OF MEETINGS WITH STAKEHOLDERS
ESSENTIAL HEALTH SERVICES ACCESS PROJECT

266. During project preparation many stakeholders were consulted about Universal Health Coverage, key challenges facing the sector, their interventions, the project design and its implementation arrangements. The stakeholders include national professional associations (e.g. Myanmar Medication Association, Myanmar Nurse and Midwife Association, and Myanmar Health Assistant Association), members of the Parliament, National League for Democracy health network, UN agencies, bilateral donors, multilateral funds, and international and local NGOs focusing in health service delivery.

267. Key points are summarized below.

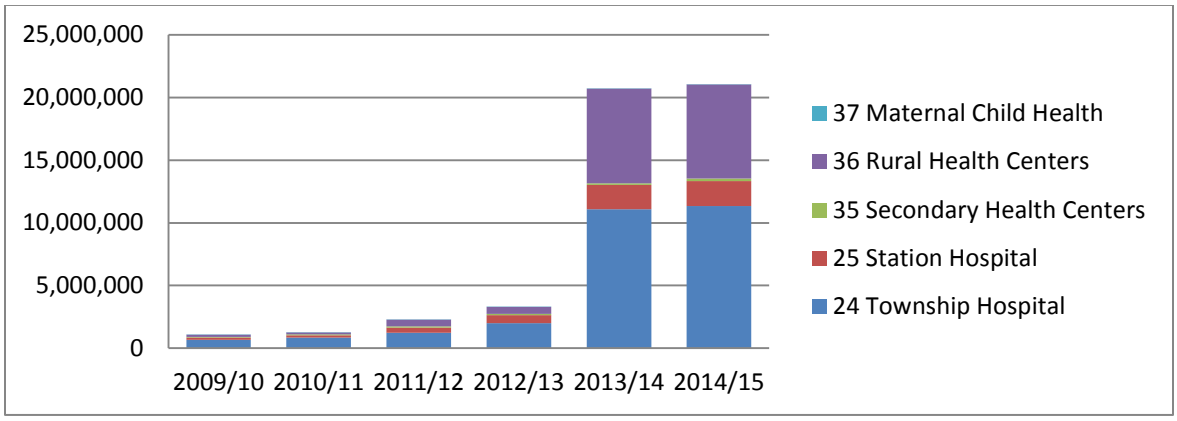
- Strengthen decentralization of decision-making and resources of public health system down to state and region level, with central level more focused on oversight, governance and regulation
- Reduce fragmentation at township level by supporting a comprehensive and evidenced-informed township health planning process, building capacity at township to identify problems, prioritize and plan
- Strengthen linkages among different levels and actors (i.e. Central/Union level plan, Ministry plan, General Administration plan, external aid/agency plan)
- Focus on primary care as it has received less attention and resources and functioning primary care is the best way to cut down health care expenditure
- Stress the important role of the private sector (for profit and NGO) in health service delivery and help improve its quality of care
- Strengthen convergence of services being delivered by government and ethnic authorities
- Strengthen human resources by improving technical knowledge and skills of health care providers at townships and below, decentralizing recruitment to lower levels of government, systematically including volunteer health workers as part of the service delivery, and assisting MOH, state/region and township health staff to become better managers instead of providers of health care
- Improve transparency and accountability through enhanced participation of civil society organizations at township level (i.e. coordination meetings, planning) and national level, and support for the "Health Budget Transparency & Accountability" as Myanmar government has made a commitment to meet Open Government Partnership standards
- Improve transportation to expand physical access

ANNEX 8: NEED-BASED RESOURCE ALLOCATION FOR THE HEALTH DEPARTMENTS OF TOWNSHIPS (HEALTH FACILITY GRANTS), STATES AND REGIONS
MYANMAR ESSENTIAL HEALTH SERVICES ACCESS PROJECT

Justification

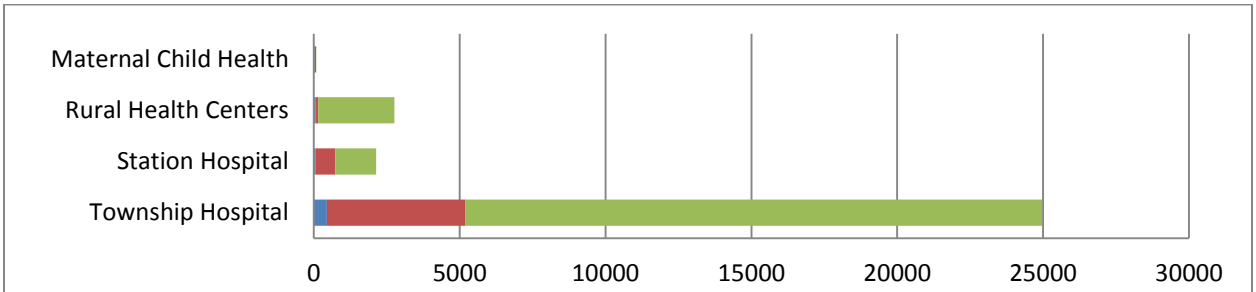
268. In recent years, the MOH has dramatically increased spending on the operational budget (i.e. budgets codes 02, 03, 04, 05 and 06) of facilities at township level and below.

Figure 6. Spending on the Operational Budget by facility type and year (US dollars)



269. Yet, overall, operational budgets remain small. Also, since the recent operational budget increases have been concentrated mainly on the maintenance line item (04), facilities continue to receive especially small allocation for travel allowances and other goods and services. For example, in FY 2014-15, rural health centers had, on average, only US$5 per month towards travel allowance and US$7 per month for goods and services. It should be noted that the operational budget for sub-centers is subsumed under RHC (cost-center code 36).

Figure 7. Composition of budget, by facility type, 2014/15, US dollars



	Township Hospital	Station Hospital	Rural Health Centers	Maternal Child Health
02 Travel Allowance	441	48	64	27
03 Goods and Services	4745	679	81	43
04 Maintenance	19777	1407	2614	5

270. The amount and types of expenditures on all the health facilities in a Township are at the discretion of the TMO, which is the lowest level at which drawing and disbursing rights exist. Facility managers below the TMO have no drawing rights or spending authority. Facilities therefore do not receive their allocated funds in cash or through bank accounts; rather, they need to submit their requests to the TMO and await his/her approval and action to meet their needs; this results in delays as can be expected. As the budget allocations are made by type of facilities, all the RHCs in a Township get a combined allocation (under the TMO's budget), it is not transparent as to how much each individual facility is expected to receive. Finally, there is no flexibility for the facilities (or even the TMO), to move funds across budget categories (or even sub-categories) according to changing needs.

271. As the allocation to the Townships and the health facilities below are not based on a formula or predetermined criteria, they do not get a predictable budget around which they can plan activities and expenditures. In addition to making the allocation predictable, the existence of a formula based on widely accepted easy-to-understand criteria for which indisputable data are available would enhance transparency and accountability. With effective communication, such a predictable allocation could also inform communities about the resources that the Government is providing to their health facilities, thus empowering the communities (through their health committees) to demand and access better services.

The four principles (STEP) informing the design of a resource allocation formula

272. Recognizing that the resource allocation formula could, and should, change over time, we identify four key principles (Simplicity, Transparency, Equity and Predictability) that inform the formula.

(a) *Simplicity:* Rather than aiming for perfection from the start, get money flowing to township level and below based on a "good enough" formula, using easily available data, and work on refining the formula later (as and when more reliable data are available on all relevant variables); monitor the outcomes and learn by doing.
(b) *Transparency*: The allocation formula – and the resultant resource allocations – should be easy to communicate and easy to understand, by people working at all levels of the health system and by the general public. It should also be based on data that are beyond dispute – so that no one will question the resulting allocations.
(c) *Equity:* Allocate resources according to population need and consider giving more resources to the poorer and more needy areas (e.g. hardship townships). In later years, once the census data are available, the formula might be adjusted for population and/or population density – to provide more resources for sparsely populated townships requiring more outreach travel.
(d) *Predictability*: The timing of funding and the amount of funding must be predictable in order to facilitate planning. There should be a shift from reimbursement of expenses incurred to regular advance payments to the facilities.

Resource allocation formula for Year 1: Health Facility Grants

Township level and below

273. IDA funds (of US$15 million per year) will be added to the government funds on the government budget. If government financing for the operational budget stays the same as in 2014-15 (equivalent to around US$20 million), IDA will effectively double the operational budget going to the township level and below. Realistically, we expect that the government will continue to increase the operational budget going to these levels, with the result that the IDA contribution will be a declining share of the overall operational budget over time. Importantly, the same allocation formula (described below), fund flow mechanisms and reporting rules will apply to both the IDA funds and government funds (being comingled, the source of funds would be indistinguishable to the TMOs and facility managers).

274. The operational budget (02, 03, 04, 05 and 06) would vary by (a) facility type; and (b) whether the facility is located in a hardship township or not. Data are drawn from the MOH's 2011 health facility list and the government's list of areas in which hardship allowances are paid to civil servants (as issued by the Ministry of Home Affairs); MOH is developing a list of "hardship townships", based on sector-specific criteria, and it could be applied as and when available.

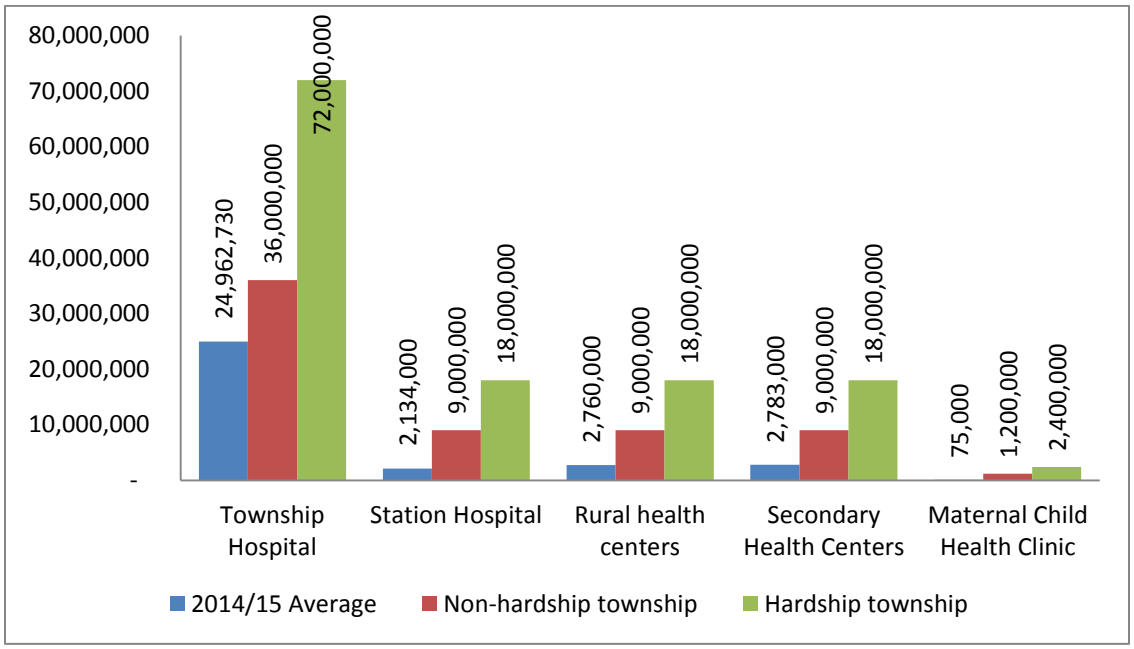
275. Figure 8 shows a possible distribution of the $35 million annual allocation to the operational costs for health facilities at the township level and below, based on the types and numbers of such facilities in the 330 townships and their distribution across "hardship" and "non-hardship" townships. The allocation ratios across different facility types is subject to review, based on the relative priorities/needs; the proposed amounts in Figure 8 represent a preliminary suggestion based on discussions between the teams of the WBG and MOH.

Figure 8. Facility-specific Allocation in Year 1 (in kyat)

	Non-hardship township	Hardship township (100% more)
Township Hospital	36,000,000	72,000,000
SH	9,000,000	18,000,000
Rural health centers	9,000,000	18,000,000
Secondary Health Centers	9,000,000	18,000,000
Maternal Child Health Clinic	1,200,000	2,400,000
School Health Programs	1,200,000	2,400,000

276. The formula satisfies the four STEP principles (simplicity, transparency, equity, predictability). Each type of facility will receive a substantially higher budget than it has received in previous years (see figure 9 below). The relative increase for the RHCs is much bigger than for township and SHs, reflecting the emphasis on primary care.

Figure 9. Fixed Annual Allocation to Each Facility at Township Level and Below, Compared to 2014/15 budget, kyat



Resource allocation formula: State and Region Health Departments

277. The project brings an additional US$24 million (US$6 million per year) for S/RHDs. The formula for allocating these funds across S/RHDs is:

(a) 200,000 per S/RHD pear year (for a total of US$3.4 million annually)
(b) An additional allocation proportional to number of townships under the S/RHD (for a total of around US$2.4 million annually).

(c) Capping the total allocation per S/RHD at US$400,000 per state/region to avoid exceptionally high allocations to large regions such as Yangon and Mandalay, with predominantly urban populations.

278. The net effect is an allocation that varies between US$200,000 and US$400,000 per year

279. Importantly, both the formula for the allocations to township level and below and the formula for the allocation to states/regions are intended to be reviewed and updated every year, based on empirical information on their effects.

ANNEX 9: OUTLINE OF THE OPERATIONS MANUAL
MYANMAR ESSENTIAL HEALTH SERVICES ACCESS PROJECT

1. *Introduction*
   - 1.1 Health status in Myanmar
   - 1.2 Health Financing
   - 1.3 Challenges
   - 1.4 Health reforms towards UHC
2. *Design and approach of WBG support to GOM's Strategic Directions to UHC*
3. *Project Objective and components*
   - 3.1 Component 1: Strengthening Service Delivery and Utilization at the Primary Health Care Level
   - 3.2 Component 2: System Building, Capacity Development and Program Support
   - 3.3 Component 3: Emergency contingency response
4. *Project Implementation Arrangements*
   - 4.1 Organization structure
   - 4.2 Operational guidelines for Oversights
5. *Township Health Planning*
   - 5.1 Concept and Scope of the Township Health Plan
   - 5.2 Assessment of safeguards
   - 5.3 Identification for priority areas for intervention
   - 5.4 Costing and financing of the plan
   - 5.5 Implementation framework
   - 5.6 Monitoring and evaluation
6. *Disbursement, Fund Flow, Financial Management*
   - 6.1 Disbursement
   - 6.2 Fund Flow
   - 6.2.1 Disbursement and fund flow – IDA to MOH
   - 6.2.2 Fund flow from Central to State/Regional Health Department
   - 6.2.3 Fund flow from Central to township level
   - 6.2.4 Fund flow from THD to facilities below township
   - 6.3 Eligible expenditure reporting and verification
   - 6.4 Financial management
   - 6.5 Budgetary Control
   - 6.6 Accounting
   - 6.7 Financial Reporting
7. *Monitoring and Evaluation*
   - 7.1 Monitoring and Evaluation System
   - 7.2 Third Party Verification of DLI
   - 7.3 Monitoring and Evaluation Framework
   - 7.4 Technical Working Group for Monitoring and Evaluation
   - 7.5 Mid-Term Evaluation
8. *Procurement*
9. *Safeguards*

Annexes to the OM

1. Essential Package of Reproductive Health Interventions
2. TMO supervisory checklist for RHCs and Sub-Centers
3. State/Regional supervisory checklist for Township Hospitals and Health Facilities

4. Interim Unaudited Financial Reports – Central Level
5. Suggested Financial Management Templates – Township Level and below

6. SOP for fund flow mechanism from TMO to lower level facilities
7. Terms of Reference of all levels of Health Committees
8. Terms of Reference for Finance Staff
9. Terms of Reference for Independent Verification
10. Monthly Monitoring Report from RHC/Station Health Unit
11. Monthly Monitoring Report for Township level

12. Result Framework and Monitoring
13. DLI Reporting form
14. Implementation Plan – Institutional Strengthening &Capacity Building – Component 2
15. Environment Management Plan (EMP)
16. Community Engagement Planning Framework