Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 10-Aug-2020 | Report No: PIDA30014

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Myanmar	P174386	Additional Financing to Myanmar COVID-19 Emergency Response Project	P173902
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Myanmar COVID-19 Emergency Response Project	EAST ASIA AND PACIFIC	07-Aug-2020	10-Aug-2020
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Ministry of Planning, Finance, and Industry	Ministry of Health and Sports

Proposed Development Objective(s) Parent

To respond to the threat posed by COVID-19 and strengthen national systems for public health emergency preparedness in Myanmar.

Components

Hospital Preparedness to Respond to COVID-19
Capacity Building, Risk Communication and Community Engagement
Project Management and Monitoring & Evaluation

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	7.67
Total Financing	7.67
of which IBRD/IDA	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	7.67

Pandemic Emergency Financing Facility	7.67

Environmental and Social Risk Classification

Substantial

B. Introduction and Context

Country Context

Myanmar, with a population of around 54 million, embarked on multiple transitions since 2011 from a planned to an open market economy, from military to civilian rule, and from conflict to peace. These complex transitions are ongoing. With greater economic openness and reforms accompanying the transition, Myanmar has witnessed remarkable economic growth, with GDP growing at 7.3 percent per year on average, or 6.4 percent in per capita terms between 2011/12 and 2015/16. The poverty headcount declined from 48 per cent in 2005 to 25 percent in 2017. Non-monetary welfare also improved. The proportion of people using candles and kerosene as a source of lighting declined from 40 percent in 2010 to 7 percent in 2017. Reforms in the telecommunication sector led to a dramatic increase in mobile phone ownership from 4.8 percent to 81.5 percent, with the majority being internet-connected smart phones.

The benefits of these transitions, however, have not been widely shared. Growth has not been as pro-poor or inclusive as it could have been; it has disproportionately benefited those with capital, land and education, who typically are less poor and in urban areas. Myanmar's agricultural sector has lacked the momentum needed to support broad based rural poverty reduction, and structural transformation remains slow. Despite the strong economic performance and poverty reduction, 15.8 million people remain poor and an additional 6 million are barely above the poverty threshold in 2015. These two groups, which represent the bottom 40 percent of the population, are considered vulnerable to falling into poverty, not least because of shocks, such as illness and natural disasters. The majority of the poor in Myanmar are found in rural areas; 38.8 percent of the rural population are poor, compared to 14.5 percent of the urban inhabitants. The agriculture sector continues to hold the key for progress in rural Myanmar, as it accounts for about 70 percent of jobs in rural areas and in poor households.

The country's human capital development also trails behind. According to the Human Capital Index (HCI) 2018, a child born in Myanmar today could expect to be only about half (47 percent) as productive in adulthood if he or she enjoyed complete education, full health, and a well-nourished childhood.[1] HCI rating is slightly higher for females (49 percent) than for males (45 percent). Myanmar, therefore, faces a pressing need to intensify investments in human capital. Despite improvements in spending on health and education, a lagging coverage of quality essential services, especially in remote and disadvantaged communities, hinder the potential of Myanmar's people to contribute to and benefit from the economy.

[1] HCI includes measures of health, nutrition, and education such as the rate of survival of children under five, adult survival rate, stunting prevalence, years of school completion, and learning outcomes.

Conflict, fragility, and gender disparity remain significant challenges. Conflict continues to affect a significant portion of Myanmar, around one-third of 330 townships. Advancement toward durable peace has been slower than planned, although there has been some progress. A Nationwide Ceasefire Agreement was signed in 2015 by eight of the more than 20 major ethnic armed organizations (EAOs), and two more have signed since. EAOs have been engaged in a struggle over many decades to preserve their languages and cultures while retaining control over political and economic life in their areas.

Myanmar Sustainable Development Plan (MSDP). To address the systemic development challenges in Myanmar, the Government developed the MSDP 2018-2030 to provide a long-term vision of a peaceful, prosperous and democratic country and an overall coherent framework for the policies and institutions necessary to achieve genuine, inclusive and transformational growth. Under the Pillar 3 on People and Planet, the MSDP calls for strengthening of the country's health systems to reach Universal Health Coverage (UHC) in a pro-poor manner.

Sectoral and Institutional Context

Myanmar has made significant improvements in health outcomes over the past decade, particularly in the reduction and management of communicable diseases such as malaria, HIV/AIDS, and TB. Mortality rates for infants, children, and mothers have all fallen substantially. Life expectancy at birth has risen steadily from just 43 years in 1960 to 66 years in 2015 (World Bank 2017a). Between 2010 and 2016, the rate of childhood stunting declined from 35 to 29 percent (though this is still high). Despite these improvements, health outcomes remain poor in comparison to other countries in the region. For example, Myanmar did not achieve its 2015 Millennium Development Goal targets for under-five mortality and maternal mortality. Factors contributing to this relate to difficult terrain, conflict in border areas, and health systems challenges related to financing, human resources, state of physical infrastructure, and information gaps, as well as low demand and utilization of essential services. If improvements in maternal and child health continue at the same pace as before, Myanmar will struggle to meet the Sustainable Development Goal (SDG) targets by 2030.

Large disparities in health outcomes mask the national averages. The under-five mortality rate across states and regions ranges from 44 per 1,000 live births in Mon State, to 104 in Chin State—more than a two-fold difference. The same degree of variation is also observed for neonatal and infant mortality rates. Populations in urban areas also consistently fare much better than rural residents. For example, under-five mortality in urban areas is 42 per 1,000 live births, compared to 80 in rural areas. Areas of the country that are both largely rural and affected by conflict have some of the largest disparities in healthcare access and health outcomes. These areas are largely in the seven States of the country (i.e. Chin, Kachin, Kayah, Kayin, Mon, Shan and Rakhine), which are also ethnically diverse. In addition, significant gender gaps in terms of access to quality health care persists. Myanmar Demographic and Health Survey 2015-16 noted that 31 percent of women aged 15-49 reported not wanting to go (or travel alone) to seek health care, and when it came to under five children suffering from diarrhea, boys (74 percent) are more likely than girls (61 percent) to be given oral rehydration therapy or increased fluids as a treatment. Maternal mortality is higher among the poor and uneducated women, not only because they do not recognize pregnancy complications but also because they face financial, physical and cultural barriers to seeking care in a timely manner.

Both supply and demand-side factors contribute to poor access and low utilization of health services. Service Availability and Readiness Assessment, which was carried out in 2015 by Ministry of Health and Sport (MOHS) with technical assistance from WHO, suggests that the quality of health and nutrition services is inadequate; on

average, only 43 percent of health care facilities have the requisite amount of essential medicines, 37 percent have appropriate diagnostic capacity, and just 41 percent have enough basic amenities. There was also large variation across types of facilities, with tertiary hospitals (specialist, general, and private hospitals) faring better than facilities at the township level and below (township hospitals, rural health centers, and subcenters). Across the board, however, few facility types were found to be fully able to deliver high quality care. On the demand side, a substantial portion of people do not seek care when they need it, because of financial barrier and concern about availability and quality of services.

Health spending in Myanmar, in local currency terms, has increased steadily in the past five years in support of the government's goal of UHC. The government health budget has climbed to roughly one percent of GDP (from an average of 0.2 percent prior to 2012). MOHS also has steadily expanded its allocation to recurrent operational budget, compared with the capital budget over the Fiscal Year (FY)15/16 – FY17/18 period. This increase in operational budget demonstrates the MOHS commitment to make available sufficient operations and maintenance budget to sustain the capital investment. Despite these improvements, however, Myanmar still relies heavily on out-of-pocket spending, which, according to the National Health Plan, comprises about 70 percent of total health spending. The Myanmar Living Condition Survey estimates that 1.7 million people are pushed into poverty annually due to their out of pocket spending on health care.

COVID-19 Epidemiology in Myanmar. As of July 12, 2020, Myanmar has registered a total of 331 confirmed cases of COVID-19, including 6 deaths. These confirmed cases are spread across the country – found in all regions (Ayerarwady, Bago, Magway, Mandalay, Nay Pyi Taw, Sagaing and Yangon) and all states (Kachin, Kayin, Chin, Mon, Shan and Rakhine), except Kayah state. Among all the affected regions and states, Yangon Region constitutes about 72 percent of the total confirmed cases. Despite lower number of confirmed cases reported and declining number of observed cases in the country recently, Myanmar recognizes and acknowledges that the country still faces a higher risk of simultaneous, exponential growth in locally transmitted cases in different parts of the country due to possibility of asymptomatic population, those in an incubation period of the COVID-19 virus or among migrant workers who recently returned from countries in the region.

The relatively low COVID-19 morbidity and mortality number in Myanmar is reflective of the Government of Myanmar (GOM)'s rapid response through: (i) effective surveillance, contact tracing and strong quarantine measures introduced since the first case emerged in the country on March 23, 2020; (ii) a Thingyan celebration and large public gatherings were banned and all entertainment businesses were ordered to close in the second week of March 2020; a stay-at-home order in some townships in Yangon, where COVID-19 infections were found to be high, was imposed, and a nighttime curfew was announced in larger cities of Myanmar (Yangon and Mandalay); and (iii) a strong health response, which included strengthening national facilities for clinical management and preventive measures through the public health system, in addition to a continuation of active surveillance, contact tracing and testing. Development partners were also mobilized to support the preparation of the Contingency Plan. The Plan considers government resources as well as all committed donor financing for the health sector, including financing from the parent Project and the Additional Financing (AF) to the Essential Health Services Access Project (EHSAP), and allows for a strengthened coordinated health response to COVID-19. However, a large gap still remains in meeting the level of response the country needs to attain for the pandemic, both in terms of adequate resources and in reaching the most vulnerable populations in hard to reach, and conflict-affected areas.

The GOM's overall health sector approach to responding to the COVID-19 pandemic could be found in the Contingency Plan which details the governance and coordination systems and processes, as well as an operational

plan for responding to the disease through the four phases of preparedness, containment, control and mitigation, and stand-down. It also aligns with the WHO guidance and establishes the MOHS as the lead agency in responding to the crisis.

As of today, GOM has formed a number of committees in response to the COVID-19 pandemic: a) National Central Committee to Prevent, Control and Treat COVID-19 led by the State Counsellor; b) COVID-19 Control and Emergency Response Committee led by First Vice President; c) Committee to Coordinate and Collaborate with Ethnic Armed Organizations to Prevent and Control and Treat COVID-19 chaired by Vice-Chairman of the National Reconciliation and Peace Center; and d) Working Committee to Address the Possible Impacts of Covid-19 on the Country's Economy chaired by the Union Minister of Investment and Foreign Economic Relations. In addition to these Union level committees, COVID-19 Control and Emergency Response Committees were established at state/regional levels headed by the state/regional ministers of Social Affairs, with state/region health directors as the secretary. All these GOM's effort reflected the level of seriousness and the need to coordinate across a broader range of key stakeholders in the country to respond to the COVID-19 pandemic. Using the whole-of-nation approach in responding to the COVID-19 pandemic, GOM has also mobilized various resources across all sectors such as reserve and emergency fund of government, contributions of development partners, United Nations agencies, international organizations, foreign missions and countries, private companies, associations and individual donors.

Investments under the parent Project and AF are expected to significantly contribute to improving the country's response to public health emergencies as well as to build stronger health systems that are more resilient to such emergency. In particular, investments in prevention and control activities, health facility and laboratory infrastructure and systems to manage infectious diseases, health worker capacity and awareness of risk factors associated with the spread of COVID-19 and other infectious diseases, and establishment of emergency response mechanisms are expected to go a long way in building sustainable systems for pandemic preparedness that shall be continued beyond the project period.

Proposed Development Objective(s)

Original PDO

To respond to the threat posed by COVID-19 and strengthen national systems for public health emergency preparedness in Myanmar.

Current PDO

To respond to the threat posed by COVID-19 and strengthen national systems for public health emergency preparedness in Myanmar (unchanged)

Key Results

The PDO and the PDO level indicators will remain unchanged but the relevant targets will be adjusted to reflect the scope of the AF. In addition, several additional intermediate outcome indicators are being proposed to capture the scaled-up activities under the AF:

(a) Increased testing capacity in 16 state/regional level laboratories (of which 50 percent in conflict-affected states);

(b) Number of hospitals in conflict-affected states with improved isolation and triage capacity;

(c) Number of health workers trained in risk communication and community engagement of pandemic response (of which 60 percent from partner organizations, including Ethnic Health Providers (EHPs), disaggregated by gender).

D. Project Description

The AF aims to expand the scope of the parent Project in its effort to support the GOM in strengthening the COVID-19 response, with special attention to conflict affected areas and hard to reach population. The AF will continue to support the priorities under the Contingency Plan and enhancing other priority actions for COVID-19 response, including: (i) upgrading laboratory capacity, prioritizing the conflict-affected states with hard to reach areas in line with the PEF focus; (ii) intensifying risk communication and community engagement in close collaboration with EHPs and civil society organizations (CSOs); (iii) supporting coordination and collaboration between the MOHS and non-government health actors such as EHPs and CSOs at both national and subnational level; (iv) capacity building and training of health workers on COVID-10 response, targeting MOHS & partner organizations including EHPs and CSOs; and (v) operations support and logistics. In addition, given the significant remaining gaps in enhancing hospital readiness to respond to public health emergency, the AF would complement the efforts under the parent Project in supporting the readiness of a few selected hospitals in hard to reach and conflict-affected areas, mainly focusing on provision of medical equipment and supplies to support their triage and isolation capacity[2]. As the PEF's objective is to support surge response in the health sector for COVID-19, with a short implementation timeframe, activities to be supported under this grant will focus on those that can be rapidly and effectively implemented, expand the scope of the parent Project, and complement other ongoing efforts of COVID-19 response and health system strengthening in the country.

Component 1: Strengthening Hospital Capacity

Subcomponent 1.1: Strengthening hospital capacity at central and state/regional level across the country (US$48.5 million, original credit). This subcomponent will include all activities outlined under component 1 of the parent Project, i.e., supporting the key activities related to clinical management and health care services and infection prevention and control identified and prioritized in the Contingency Plan; enhancing hospital preparedness and surge capacity through increasing the availability of well-equipped intensive care unit (ICU) beds with trained health staff to operate them; increasing the number of state/regional level hospitals with an ICU facility to improve access to intensive clinical care services; and refurbishing and equipping these ICUs.

Subcomponent 1.2: Strengthening hospital and laboratory capacity to serve conflict-affected and hard to reach areas (US$5.07 million, AF). This subcomponent will be supported through the PEF AF, to further strengthen response and testing capacity for COVID-19 with attention given to conflict-affected and hard to reach areas. This will be done through two main activities. First, the subcomponent will finance provision of medical equipment and supplies in four township level hospitals to upgrade the emergency departments (triage area) and isolation wards as well as high dependency units. In addition, it will finance supplies needed for waste management, as

[2] The priority expressed by MOHS is in the three township level hospitals in Rakhine, Kachin and Shan North states; if further resource and time permit within the timeframe, one or two more hospitals may be added.

well as other basic requirements, including water tank and water filtration system. Second, this subcomponent will support strengthening of laboratory capacity at state/regional level hospitals prioritizing those that serve hard-to-reach and conflict affected areas.

Component 2: Capacity Building and Community Engagement

Subcomponent 2.1 Enhancing Capacity, Coordination and Engagement on Clinical Care (US$1.0 million, Original Credit) will finance activities initially foreseen under Component 2 of the parent Project, namely: (1) developing national guidelines on clinical treatment, infection prevention and control, health care waste management, and tailored patient referral protocols at State/Region and hospital level; (2) providing training for health workers from MOHS, private sector and EHPs in clinical management, infection prevention and control, health care waste management and referrals; and (3) supporting regular information sharing and coordination of responses between public health and clinical teams within MOHS, as well as across the various public and private (profit and non-profit) agencies through ICT platforms and regular coordination meetings at union and region/state level. The subcomponent will also support information dissemination to the public and private health providers and the general public about the ICU and high dependency unit facilities and hospital preparedness and provide information on how to notify and refer suspected cases to the designated hospitals.

Subcomponent 2.2 Strengthening Risk Communication and Community Engagement (US$0.6 million, AF) will complement the activities under subcomponent 2.1 with a focus on training of health workers to communicate with and educate the general public about COVID-19. The AF will also support IEC material development/adaptation in local language, especially for EHPs and NGOs working in conflict-affected areas, to ensure that the contents reflect the relevance of specific areas they are operating in. Some of these materials will focus on referral protocols, which are developed under the parent Project, to help promote awareness and collaboration on referral among the health actors and people living in conflict-affected areas. Media advocacy to deliver key risk communication messages, including in local ethnic media outlets, as well as panel discussions that include representatives from CSOs and EHPs will also be supported. Mechanisms for systematic review and timely response to feedback will be established, so that MOHS can feasibly manage and take appropriate action on feedback received from the public.

Subcomponent 2.3. Cross Sectoral Coordination and Capacity Strengthening on COVID-19 response (US$1.60 million, AF). The subcomponent will support cross-sectoral coordination at central and state/regional levels, including Inter-Ministerial Committee Meetings, as well as state/regional level Coordination Meetings to coordinate national responses, including non-government stakeholders such as NGOs, CSOs, EHPs. The subcomponent will also support the post action review of COVID-19, involving sectors that oversee the national response and plan. Complementing subcomponent 2.1, subcomponent 2.3 will focus its capacity building activities of health workers (both from MOHS and partner organizations, including EHPs and CSOs) on COVID-19 response more broadly, including risks communication, disease surveillance, identification of contacts, case notification and reporting.

Component 3. Project Management and M&E **E (US$0.5 million, original credit+ US$0.4 million, AF)**

The component will continue to support project-related management functions including planning, budgeting, reporting and coordination across the various levels and units within MOHS. The component will also continue to strengthen the capacity of the Project Management Team to enable them to perform their day-to-day project management function, including procurement, contract management, work planning and budgeting.

Table 1. Revised Project Cost and Financing with original IDA Credit + AF

Project Components	Original IDA financing (US$, millions)	PEF grant AF	Original IDA + PEF grant AF (US$, millions)
Component 1: Strengthening Hospital Capacity	**48.50**	**5.07**	**53.57**
Subcomponent 1.1: Strengthening hospital capacity at central and State/Region level across the country	48.50		48.50
Subcomponent 1.2: Strengthening hospital capacity in conflict-affected and hard to reach areas		5.07	5.07
Component 2: Capacity Building and Community Engagement	**1.0**	**2.2**	**3.2**
Subcomponent 2.1: Strengthening Clinical Care Capacity at Hospitals	1.0		1.0
Subcomponent 2.2: Strengthening Risk Communication and Community Engagement		0.60	0.60
Subcomponent 2.3: Cross Sectoral Coordination and Strengthening on COVID-19 response		1.60	1.60
Component 3: Project Management and M&E	**0.50**	**0.40**	**0.90**
Total Project Costs	***50.00***	***7.67***	***57.67***

Project beneficiaries of the AF will remain the same as the parent Project and will include people who are infected by COVID-19 and their families; people who are at higher risk of getting ill, such as the elderly and people with chronic health conditions, hospitalized, and dying from COVID-19; medical and emergency personnel; and health care facilities. While the parent Project also includes beneficiaries living in conflict affected areas and IDPs in temporary shelters, the AF will have a stronger focus on populations in Kayin, Kayah, Mon, Shan (North, East, South), Kachin, Rakhine, Chin States; as well as partner organizations operating in these areas, including CSOs and EHPs.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	

Projects in Disputed Areas OP 7.60

Summary of Assessment of Environmental and Social Risks and Impacts

E. Environmental and Social

Consistent with the Environmental and Social Framework (ESF) policy, Environmental and Social activities will be timed and sequenced to fit the needs and risks of the AF, with a particular focus, similarly to the parent Project, on (i) medical waste management; (ii) worker safety; (iii) community health and safety; and (iv) communications and stakeholder engagement. The project will achieve consistency with the relevant Environmental and Social Standards (ESS), particularly ESS1, ESS10, ESS2, ESS3 and ESS4, ESS7, through application of an ESMF which has been updated to include the AF activities, and standardized and streamlined Environment and Social documentation as much as feasible, such as development of a ICWM Plan drawing on new guidelines and work supported by the Bank's ongoing health sector investment program. Given that dissemination of information to the affected and neighboring communities is essential, the existing parent Project stakeholder engagement plan has been updated to reflect the AF focus on most vulnerable groups in conflict areas.

E. Implementation

Institutional and Implementation Arrangements

The MOHS will continue to be the implementing agency, with DMS being the key technical implementing department, as well as the Medical Care Division and National Health Laboratory under DMS being responsible for the clinical and hospital-based services and strengthening of laboratory capacity respectively. The DPH will be added as another key department given the AF's additional focus on capacity building of health workers on COVID-19 response, risk communication, community engagement, multisectoral coordination, and other activities that fall under the responsibility of technical units under DPH, namely the Central Epidemiological Unit and Health Literacy Promotion Unit.

The Project Management Team (PMT), as outlined under the parent Project, will continue to provide timely guidance and operational support to all the implementing units and divisions at central, state/region and township levels. To adjust to the expanded scope of the project, additional resources for fiduciary management & social/environmental safeguards will be considered to meet the increased needs. Currently, PMT includes, in addition to the Project Director and Project Manager, designated staff responsible for key areas such as financial management, procurement and distribution, planning, monitoring and reporting, environmental safeguards, social safeguards, medical care and medical referral system/pathway. Additional short-term external human resources for logistics, capacity building and monitoring may be recruited to ensure timely implementation.

The Project Oversight Committee (POC) will continue to provide oversight and guidance, being the executive umbrella structure established by the MOHS to oversee IDA-financed operations, including the ongoing EHSAP its AF, as well as the M-CERP. Project coordination within MOHS and across various stakeholders will be carrie using the existing platforms, such as MOHS Central Containment Committee for COVID-19 response at the unic level and Multi-Sectoral Coordination Committee at the state/regional level. To facilitate further collaboration reflect the PEF governance and implementation needs, additional member in POC and PMT will be considered, including representatives

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