



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 09-Apr-2020 | Report No: PIDA29102



BASIC INFORMATION

A. Basic Project Data

Country Myanmar	Project ID P173902	Project Name Myanmar COVID-19 Emergency Response Project	Parent Project ID (if any)
Region EAST ASIA AND PACIFIC	Estimated Appraisal Date 09-Apr-2020	Estimated Board Date 23-Apr-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Planning, Finance, and Industry	Implementing Agency Ministry of Health and Sports	

Proposed Development Objective(s)

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 and Community Engagement
Project Management and Monitoring & Evaluation

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	50.00
Total Financing	50.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00
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IDA Credit	50.00
Environmental and Social Risk Classification	
Substantial	
Decision	

Other Decision (as needed)

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

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.



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.

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.

Rakhine State has also seen particularly high levels of violence. Over the past decades, Rakhine State has seen multiple rounds of conflict, with violent events in August 2017 leading to the forced displacement of more than 730,000 Muslims who self-identify as Rohingya into Bangladesh. It is estimated that about 600,000 Muslims remain in the State, a number that includes the vast majority of the close to 130,000 internally displaced persons. In addition, starting January 2019, the fighting between the Myanmar military and the Arakan Army has escalated leading to further internal displacement. The country's conflict-affected border zones face many forms of disadvantages, such as limited access to basic services and infrastructure, including clean water, education, health care, and electricity. Lack of access to markets is also closely correlated with geographical area/location, ethnicity, religion, and citizenship status. The almost one million people affected by humanitarian crisis and internal displacement in Chin, Kachin, Kayin, Rakhine and Shan States face many challenges that place them at higher risk for COVID-19. Overcrowded shelters and limited hygiene facilities in camps and temporary shelters, restrictions on freedom of movement, lack of livelihoods, coupled with malnutrition and limited access to essential services, including healthcare, have increased people's exposure to risk. Active conflict in Rakhine and Chin, sporadic clashes in Northern Shan and explosive hazard contamination in all conflict-affected areas, including Kachin, continues to severely impact abilities to reach tens of thousands of people with assistance and protection services. Broad restrictions on the grounds of insecurity in eight Townships of Rakhine in response to escalated armed conflict between the Arakan Army and government forces since 2019 have deprived large numbers of people from critical services. Humanitarian operations have already been either suspended or limited in scale in areas where there is an active conflict. The United Nations Secretary-General has called on warring parties to stop the artillery, end the airstrikes and fight against the common enemy, COVID-19.

Although gender equality indicators have slowly improved in recent years, social norms of unequal roles and responsibilities of men and women affect access to services and labor market. According to Myanmar Living Condition Survey, female labor-force participation in 2017 was estimated at 55 percent of women over age 15. Although gender equality indicators have slowly improved in recent years, social norms of unequal roles and responsibilities of men and women affect access to services and labor market. According to Myanmar Living Condition Survey, female labor-force participation in 2017 was estimated at 55 percent of women over age 15. As research shows that disease outbreaks make existing inequalities and gender discrimination worse,² COVID-19 may greatly impact women in Myanmar. Expected gendered impacts of the pandemic include the increase of inter-personal violence/gender-based violence and the simultaneous decrease in available services, and increased care burdens for women and girls, particularly due to shelter-in-place or self-isolation orders.³

² Fraser, E. 2020. Impact of COVID-19 Pandemic on Violence Against Women and Girls. VAWG Helpdesk Research Report No. 284. 16 March, UKAID.

³ Care. 2020. Gender Implications of Covid-19 Outbreaks in Development and Humanitarian Settings.



Furthermore, due to women's frontline interactions as caregivers and healthcare providers, they face a higher risk of exposure to COVID-19.⁴

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

⁴ UNFPA. 2020. Covid-19: A Gender Lens. March, UNFPA, p. 2.



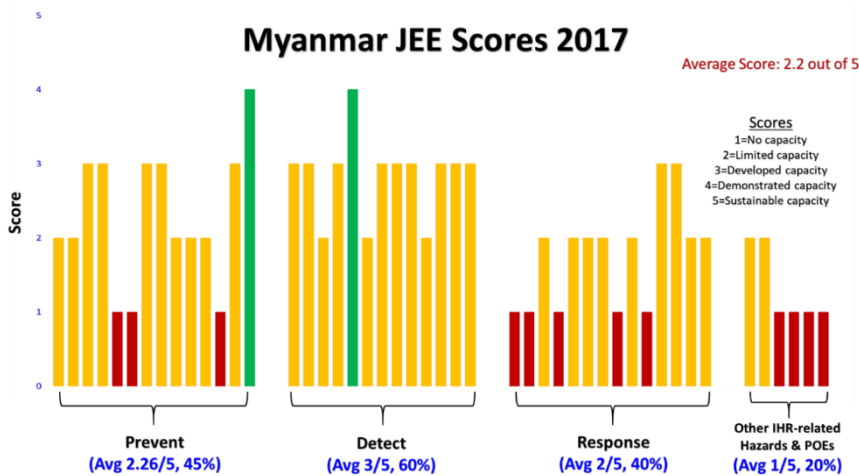
than facilities at the township level and below (township hospitals, rural health centers, and subcenters). Across the board, however, few facility types were found to be fully able to deliver high quality care. On the demand side, a substantial portion of people do not seek care when they need it, because 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.

Development Assistance for Health in Myanmar focuses mostly on public health, such as control of communicable diseases (AIDS, TB, and malaria) and strengthening delivery of reproductive, maternal, child, and newborn health services (including immunization). The majority of the external financing is directed to vertical disease/condition specific programs and is off-budget. It is largely managed and implemented by United Nations (UN) agencies and international non-governmental organizations (NGOs), referred to as Implementing Partners, which in turn sub-contract local NGOs and community-based organizations (CBOs). The largest share of development assistance for health comes from the Global Fund against AIDS, Tuberculosis, and Malaria (GFATM), Access to Health Fund (ACCESS), GAVI, Japan International Cooperation Agency (JICA), ADB, and IDA. UN agencies continue to play a significant role as technical partners to MOHS. The GFATM, with the most recent grant financing of US\$215 million, and GAVI, with US\$100 million, will be implemented over the next three to four years. ACCESS is a pooled fund of about US\$190 million from four bilateral donors—United Kingdom, USAID, Switzerland, and Sweden—that aims to improve maternal and child health and to increase coverage of HIV/AIDS, tuberculosis (TB), and malaria programs among vulnerable populations in conflict affected regions of the country. New external sources of financing for health are limited in number and relatively small in amount.

Pandemic Preparedness and Response Readiness. Myanmar was one of the first countries to conduct the Joint External Evaluation (JEE), a process developed by WHO to assess a country’s capacities to prevent, detect and

rapidly respond to public health risks. JEE helps to identify the most critical gaps within the human and animal health systems. Myanmar had an average score of 2.2 out of 5, compared to the global average of 2.8. On the Global Health Security Index, Myanmar ranked 72 out of 195 countries with an overall score of 43.4 out of 100; however, in the category of “sufficient & robust health system to treat the sick & protect health workers,” Myanmar’s score was





considerably lower, 19.5 out of 100. As of March 20, 2020, Myanmar has a total of 220 Intensive Care Unit (ICU) beds at the central level, 146 ICU beds at the Region and State Hospitals, and 17 at the Waibagi infectious disease specialist hospital, and a total of 249 ventilators. This translates into 0.71 ICU bed per 100,000 population and 0.46 ventilator per 100,000 population. This is considered very low, when compared to countries in the region. ICU bed capacity in South Korea is 10.6 beds per 100,000 population, China (3.6 beds) and India (2.3 beds).⁵ Italy had 12.5 ICU beds per 100,000 and Germany 29.2.⁶

Building on the JEE process, Government of Myanmar (GOM) developed the multi-sectoral National Action Plan on Health Security (NAPHS) in 2018 under the leadership of MOHS. The five-year plan was estimated to cost US\$158 million for scaling up health security activities. The plan, however, was only partially financed, and therefore, has yet to be fully implemented. A few key noteworthy activities implemented included launching of the Field Epidemiology Training Program and the amendment of the Prevention and Control of Communicable Diseases law, which governs and regulates public health measures and interventions for managing public health emergencies as well as outbreaks of infectious diseases.

COVID-19 Epidemiology in Myanmar. After the WHO declaration of COVID-19 as a global pandemic on March 11, 2020, Myanmar had its first confirmed case only on March 23. As of April 8, at the time of submission of this document, a total of 1,340 people has been tested, of which 22 cases and 3 deaths have been confirmed. With support from WHO, US-CDC, Thailand and Japan, Myanmar's National Health Laboratory (NHL) began testing on Feb 20, 2020, and prior to this capacity, MOHS relied on Thailand. Despite the apparent low number of confirmed cases in the country, the government and development partners recognize and acknowledge an elevated risk of a national outbreak and rapid spread, given long and porous borders and vibrant trade and migration with China and Thailand.

Given the considerable likelihood of COVID-19 taking root in the country, GOM began intensifying public health measures in mid-March 2020. The measures include closing of borders, suspension of visa on arrival, screening incoming travelers at all point of entries, including three international airports, quarantining individuals with travel history to affected countries and/or contact history with confirmed cases, and isolating suspected cases at designated hospitals. The government has issued an appeal to the public to avoid crowds and not to organize sizable events (not more than five). All the ministries and government offices have been instructed to cancel or postpone large meetings, workshops, events and ceremonies, including hosting/sponsoring of water festival activities. As of March 16, 2020, movie theaters and entertainment venues, except for restaurants, have been shut down until further notice, and all state and private educational institutions from preschool through university level have closed until April 30.

In early February, MOHS presented, with support from WHO, a flash proposal to mobilize resources for immediate response from February to April 2020. The proposal, which was estimated to cost US\$4.8 million, emphasized activities related to intensifying surveillance at the community level and points of entry, scaling up

⁵ Phua, Jason et al. Critical Care Bed Capacity in Asian Countries and Regions. *Critical Care Medicine*. 1. 10.1097/CCM.0000000000004222.

https://www.researchgate.net/publication/338520008_Critical_Care_Bed_Capacity_in_Asian_Countries_and_Regions/citation/download [accessed on 29 Mar 2020]

⁶ Wallace DJ et al. Critical care bed growth in the United States. A comparison of regional and national trends. *Am J Respir Crit Care Med*. 2015;191(4):410–416. doi:10.1164/rccm.201409-1746OC <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4351597/> [accessed on 29 Mar 2020]



risk communication, including health education campaigns, and procuring non-pharmaceutical medical and laboratory supplies. MOHS was able to mobilize grant financing to cover the majority of the proposal.

As for the next phase, MOHS prepared the Myanmar Health Sector Contingency Plan on COVID-19 and Other Emerging Respiratory Illnesses (the Contingency Plan), based on the two existing endorsed national plans, namely the National Strategic Plan for Zoonotic Influenza and Human Influenza Pandemic Preparedness and Response (2017) and the 2018 NAPHS. Fully aligned with WHO recommendations and requirements, the Plan outlines a comprehensive health sector response to COVID-19 from April 2020 to December 2021 and offers guidance on priority areas and actions that need to be taken for adequate prevention and response to a probable community transmission of this virus. It addresses all phases: (i) preparedness; (ii) containment; (iii) control and mitigation; and (iv) stand-down. It also contains an operational plan, as well as guidance on the governance arrangements of the response. It is estimated that US\$156 million will be needed to finance the Contingency Plan fully and currently US\$76 million has been mobilized, thus leaving the financing gap of US\$80 million.

Upon the declaration of COVID-19 as a global pandemic, Myanmar formed the National-Level Central Committee on Prevention, Control and Treatment of Coronavirus Disease 2019. Created by the Presidential Order (45/2020) dated March 13, 2020, the Committee subsumes all the functions of the earlier central committee led by two Union Ministers. The primary objective of the Committee is to spearhead the national response effort and coordinate within the public sector and with private sector and civil society to control and manage an outbreak of COVID-19 in Myanmar. It demonstrates commitment from the highest political level to tackle COVID-19 outbreak. Chaired by the State Counselor, the committee consists of the Union Ministers from many key ministries⁷, Chairperson of Nay Pyi Taw Council, Social Affairs Ministers of Regions/States, and Permanent Secretaries from Ministries of Health and Sports and Office of Union Government.

Several coordination mechanisms are functioning for internal and external stakeholders. The internal coordination focuses on the close collaboration and communication between the different geographic and political levels of the government—central, region/state (R/S), district and township. As for the external coordination, in accordance with the International Health Regulation's requirement, Myanmar continues to report the situation of COVID-19 to WHO and to work closely with the international community through existing mechanisms in the health sector, such as the Myanmar Health Sector Coordinating Committee's Health Cluster. In addition, WHO regularly convenes the development partners involved in supporting the emergency response. UN partners are also developing a Country Preparedness and Response Plan to further coordinate the assistance

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To respond to the COVID-19 outbreak and strengthen national systems for public health emergency preparedness in Myanmar

⁷ Home Affairs, Border Affairs, Commerce and Trade, Defense, Education, Ethnic Affairs, Health and Sports, Hotels and Tourism, Labour, Immigration and Population, Investment and Foreign Economic Relations, International Cooperation, Information, Planning, Finance and Industry, Transport and Communications, Religious Affairs and Culture, and Social Welfare, Relief and Resettlement.



Key Results

Specifically, the proposed project would help fill a critical gap in the financing for the Myanmar Contingency Plan, which is to enhance hospital preparedness and surge capacity in order to reduce the spread of COVID-19, protect health workers, and minimize the severity of COVID-19 illness and associated deaths. As such, progress towards the achievement of the PDO would be measured by the following indicators:

- Number of acute healthcare facilities with isolation capacity
- Number of acute health care facilities with triage capacity
- Number of diagnosed cases treated in health facilities

D. Project Description

The project activities are defined by the Contingency Plan and the mapping of the planned financing from the Government's budget and key partners in the health sector, such as GAVI, GFATM, ADB, ACCESS and WB. In addition to development assistance, GOM has also received about US\$2.35 million of in-kind and cash contribution from Myanmar businesses and prominent individuals. The majority of the development assistance has been mobilized for case detection, risk communication, and national laboratory strengthening. Take the example of testing; with assistance from UN, US-CDC and ACCESS, an approximately 50,000 more tests kits supported by UN agencies are expected to arrive in Myanmar in the coming weeks. In addition, approximately 100,000 test kits are in the pipeline for Myanmar, supported by the governments of Singapore, China and Japan; multilateral donors such as ACCESS, GFATM, GAVI and private contributions. US-CDC is also helping MOHS secure the US Food and Drug Administration-approved GeneXpert test kits, as Myanmar plans to expand the testing sites during April 2020 using the GeneXpert machines and cartridges financed by GFATM. As of March 26, 2020, the country has about 10,000 tests kits. Another example is the support to EHPs for implementation of the COVID-19 response in EAO areas, which will be borne by ACCESS and GAVI, working through its UN and international NGO Implementing Partners. Furthermore, the mapping also helps to enhance the complementarity of the proposed project to the support of other Development Partners.

The design of the proposed project is also informed by lessons learned and good practices in terms of promoting inclusion and sound implementation, fiduciary and safeguards arrangements from the ongoing EHSAP and applied in its proposed AF.

Component 1: Hospital Preparedness to Respond to COVID-19 (US\$48.5 million)

Component 1 aims to provide immediate support to strengthen the public health care system, focusing on hospital preparedness at the central and region/state level hospitals across the country to provide optimal medical care, maintain essential health services, and minimize risks for patients and health personnel. Specifically, the Component would support the key activities related to clinical management and health care services and IPC, identified and prioritized in the Health Sector Contingency Plan.

As of mid-March 2020, MOHS has on average 0.71 ICU bed per 100,000 population and 0.46 ventilator per 100,000 population. Given the increasing number of confirmed cases in the country, there is an urgent need for enhancing hospital preparedness and surge capacity through increasing the availability of well-equipped ICU



beds with trained health staff to operate them. Detailed assessment on the preparedness of referral hospitals to respond to public health emergencies is being carried out with technical assistance from WHO, which will supplement the findings of a rapid analysis undertaken by the Department of Medical Services (DMS) as part of the project preparation. The investments under the proposed project will make an additional 338 ICU beds (including ventilators and other essential equipment) available across the country –80 additional ICU beds at the central hospitals and 258 additional beds at region/state level hospital. In summary, the project will increase the capacity of R/S level hospitals to provide effective and inclusive intensive clinical care services. The emphasis on making more and fully functional ICU facilities and beds available at the state and region level gives priority to increasing access to people in rural, remote and conflict-affected areas, who are unlikely to access central level facilities. The distribution of ICU beds to be supported will be approximately proportionate to the total population of the respective R/S with every R/S receiving an additional six ICU beds at minimum.

Intensive care units (ICU) will be refurbished and fully equipped at the central and region/state level public hospitals. These hospitals, which range from 200 beds to 2,000 beds, are designated as key referral hospitals to provide acute care services for COVID-19 patients in accordance with the Health Sector Contingency Plan and have adequate number of human resources to operate and deliver services of an ICU facility for lower level public and private health facilities in their respective locations⁸. There will be no new construction but will involve minor works to retrofit or refurbish existing wing or room within the existing hospital infrastructure and footprint. There is no new land acquisition. Medical equipment for the ICU facilities will also include autoclaves for IPC, and this support at the referral hospitals level will be complemented by the support under the proposed EHSAP AF, which aims to strengthen the IPC and HCWM at the primary health care level facilities across the country.

Given the rapidly evolving situation of COVID-19 in Myanmar, there is an urgent need to equip and refurbish ICU facilities as quickly as possible while maintaining the good quality standards. Based on these criteria, MOHS will utilize the flexibility provided by the Bank's Procurement Framework for fast track emergency procurement, which includes (1) use of simple and fast procurement and selection methods fit for an emergency situation including direct contracting, as appropriate; (2) streamlined competitive procedures with shorter bidding time; (3) use of framework agreements including existing ones, if any; (4) procurement from UN Agencies enabled and expedited by Bank procedures and templates; and (5) increased thresholds for Requests For Quotations and national procurement, among others. In addition, MOHS will make use of the Bank Facilitated Procurement (BFP) to access global supply chains if other suppliers cannot procure some items on the agreed list of critical medical consumables and equipment needed under the project.

Component 2. Capacity Building and Community Engagement (US\$1 million)

Component 2 would reinforce the clinical care capacity at the hospitals financed under Component 1, by investing in guidelines on clinical treatment, infection prevention and control and health care waste management, and referral pathways, and capacity building of health staff at the hospitals on these established guidelines and use of the equipment and machines in the ICU facility. DMS has been delivering training to clinical staff at the major referral hospitals on clinical case management and ventilator use. The project will support expansion of these capacity building efforts. Infection prevention and control will target not only medical staff (e.g., doctors, nurses) but also for other support staff at the hospitals (e.g., nurse aids, ambulance drivers,

⁸ Overall, MOHS is trying to mobilize additional human resources by utilizing retired medical professionals and expediting fresh graduates or those who are getting close to graduation into the workforce quickly.



cleaners, clinic-social workers, pharmacists, etc.) who will be working in close proximity to the patients and their contacts. This inclusive approach will contribute to gender equity in protection measures as majority of them are women. Given that one-third of the townships in Myanmar is affected by conflict and some areas are not under government administration, the project will emphasize supporting MOHS to review and adapt the national level referral guidelines for referral of patients and suspected cases from the areas not under government administration, in consultation and collaboration with the relevant EHPs and civil society organizations (CSOs), so that people from these areas can get access to clinical care services at the public hospitals. Most EHPs do not have the infrastructure or human resource capacity to provide ICU services, so it will be essential that individuals with the most severe symptoms of COVID-19 have referral treatment options. Improved collaboration and agreement of referral guidelines across EHP and MOHS healthcare providers can enable this type of critical referral. Additionally, as close to one million people are current affected by conflict and internal displacement, the project will support MoHS to coordinate and collaborate with humanitarian actors to ensure these populations have access to effective referral for treatment services. Currently, ACCESS is expanding emergency referral support to include suspected cases of COVID-19, which will help patients and their families cover transport and other costs of seeking care at available treatment facilities with a focus on those living in conflict affected areas, as well as IDPs. Together the improvement of ICU capacity, referral guidelines and collaboration across healthcare providers in all states, along with complementary support to emergency referral from ACCESS, will increase access to treatment for people in remote and conflict-affected areas

Component 2 would also complement activities being carried out with support from other development partners (such as GFATM, USAID, WHO, Gavi, and JICA) related to joint training of health workers from the MOHS, private sector and EHPs, with regards to clinical management, IPC and HCWM and referral guidelines. Component 2 support on IPC training will complement the personal protective supplies (masks, personal protective equipment, etc.) for health workers being financed by these development partners. Contact tracing of the confirmed COVID-19 cases admitted to the designated referral hospitals is being carried out by the Department of Public Health, with support from the above-mentioned development partners, including the ongoing EHSAP.

In addition, the Component would support better and timely 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, including EHPs and CSOs, through supporting regular coordination meetings at union and region/state level. This support would build on the region/state level multi-stakeholder coordination platforms, which would be institutionalized under the proposed EHSAP AF. The coordination would not only focus on COVID-19 response but also to ensure that essential health services (e.g., sexual and reproductive health, newborn and child health, immunization, HIV/AIDS, TB, malaria) are maintained for the community. MOHS is already working with development partners such as GAVI, GFATM, WHO, United Nations Children's Fund (UNICEF) and other implementing partners to adjust and modify service delivery to prevent and mitigate interruption of essential services.

Component 2 would also leverage the existing high penetration of mobile phone infrastructure in Myanmar and the tablets platform introduced by the MOHS to the basic health staff to disseminate information to the public and private health providers and the general public about the ICU facilities and hospital preparedness, and provide clear information on how to notify and refer suspected cases to the designated hospitals in their areas. It is essential that health messages are made available in the languages of all communities, especially in areas where ethnic languages are primarily spoken. MOHS has already produced information, education and



communication (IEC) materials in 20 major ethnic languages in text, audio and audiovisual formats. To make this information available to even wider audiences, particularly those with limited literacy, the project will support dissemination, using multiple channels such as text messaging, robo calls, Viber, Facebook, agent calls, etc., of audio/audiovisual materials in ethnic languages across the tablet platforms and mobiles used by healthcare workers (MOHS, EHPs and private providers) as well as community members themselves. The data cost of the tablet/smartphone usage for official purposes will be supported. The guidelines on data privacy will be duly followed.

Component 3. Project Management and M&E (US\$0.5 million)

Project Management. Component 3 would support project related management functions, including planning, budgeting, reporting and coordination across the various levels and units of DMS – the implementing department within MOHS--and between DMS and other relevant MOHS departments. The component would finance operational costs of the designated project management team (PMT) within DMS, led by the Deputy Director General of the Medical Care and includes designated staff from relevant units, such as procurement and distribution, construction, medical care, and finance. The PMT will be primarily responsible for day-to-day management, including procurement and contract management, work planning and budgeting, and overseeing capacity building initiatives. It will also be responsible for preparing regular progress reports. In addition, it will also oversee the grievance redress mechanism and respond to the feedbacks and grievances directed at the project.

M&E: The proposed project would finance establishment of M&E system to monitor the Contingency Plan. It will support DMS and other MOHS departments with data collection and disaggregation by gender, location, and ethnicity, disease surveillance, and M&E activities related to COVID-19 response, and finance associated costs. They include collecting and analyzing the data from the central and region/state level hospitals, which would receive the proposed project's investment for surge capacity; monitoring the progress of implementation based on the results framework indicators; carrying out virtual and in-person supervision and oversight visits, quality checks for the compliance with the clinical guidelines and infection prevention and control and health care waste management procedures; and conducting baseline assessment and regular assessment of hospital readiness using standard checklists. ICT platform – i.e., videoconferencing/ teleconferencing facility, tablets and mobile phones – will also be utilized to enhance data collection and monitoring efforts. A grievance redress mechanism (GRM), building on the lessons learned from the EHSAP and aligning with proposed GRM measures in the AF EHSAP, will use an ICT platform (hotline, text messaging) and dedicated staff within the project management team will be assigned for handling GRM. Information about the GRM will be disseminated together with project information to the public and private health providers, public and other stakeholders such as ethnic health organizations, civil society organizations, local authorities, etc.

Personal data collection and processing. Large volumes of personal data, personally identifiable information and sensitive data are likely to be collected and used in connection with the management of the COVID-19 outbreak under circumstances where measures to ensure the legitimate, appropriate and proportionate use and processing of that data may not feature in national law or data governance regulations or be routinely collected and managed in health information systems. To the extent feasible, the Project will incorporate good international practice for dealing with such data in such circumstances. Such measures may include, by way of example, data minimization (collecting only data that is necessary for the purpose), data accuracy (correct or erase data that are not necessary or are inaccurate), use limitations (data are only used for legitimate and related purposes), data retention (retain data only for as long as they are necessary), informing data subjects of



use and processing of data, and allowing data subjects the opportunity to correct information about them, etc.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

Project carries substantial environmental and social risks based on potential concerns relating to occupational health and safety; capacity to manage health care waste; accessibility to project benefits and social inclusion, and contextual concerns over the severity of the potential outbreak and ability to manage case-loads.

E. Implementation

Institutional and Implementation Arrangements

5. MOHS will be the implementing agency for the proposed project. The institutional arrangements are based on experience and lessons learned from ongoing IDA-financed EHSAP and in alignment with the arrangements under the proposed EHSAP AF.

6. The Department of Medical Services (DMS) of MOHS will be the key implementing department, as it is responsible for the clinical and hospital-based services. Since 2015 DMS has been implementing EHSAP and therefore, has experience and familiarity with IDA-financed operations. MOHS will designate a PMT, headed by a Project Director (Deputy Director General level) and a Project Manager (Director or Deputy Director level) before effectiveness. PMT will include designated staff responsible for finance, procurement and distribution, planning, monitoring, IPC and HCWM, and GRM. Additional short-term external human resources for logistics, capacity building and monitoring may be recruited to ensure timely implementation.

7. The Project Director will assume the overall management responsibility and ensure coordination of various divisions in DMS, such as Planning, Medical Care, Procurement and Distribution, Medical Audit, and Finance. S/he will also provide regular reporting to the Project Oversight Committee. The Project Manager will be responsible for day to day project management including technical and operational support, timely coordination and communication, monitoring and reporting on implementation progress across various implementing units or hospitals at the union, central and R/S levels.

8. The project oversight and guidance will be the responsibility of the Project Oversight Committee, which is the executive umbrella structure established by the MOHS to oversee IDA-financed operations, such as the ongoing EHSAP and proposed EHSAP AF. At the Union level, Medical Care Division will coordinate activities at the Central level hospitals, meanwhile R/S Health Directors will be responsible for the R/S level hospitals



supported under the project. Project coordination within MOHS and across various stakeholders will be carried out using the existing platforms, such as MOHS Central Containment Committee for COVID-19 response at the union level and Multi-Sectoral Coordination Committee at the R/S level.

Project implementation will be guided by Project Operations Manual (POM), which will reference heavily on the updated POM developed for the AF EHSAP project, given the similarity in institutional, fiduciary and implementation arrangements. Further relevant updates to the POM to reflect specific needs of this emergency COVID-19 response project vis-à-vis safeguards, procurement and M&E arrangements will be made.

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