Report Number: ICRR0024569

1. Project Data

Project ID P149960	**Project Name** Essential Health Services Access Project
Country Myanmar	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-55420,IDA-66680	30-Jun-2019	74,673,756.35
Bank Approval Date	**Closing Date (Actual)**	
14-Oct-2014	30-Sep-2024	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	100,000,000.00	0.00
Revised Commitment	100,000,000.00	0.00
Actual	74,673,756.35	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

The project development objective (PDO) was “to increase the coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health” (Financing Agreement 2015, p. 4).

The objectives were revised in 2016: "to increase the coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health, and, in the event of an Eligible Crisis or

Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency" (Amendment to Financing Agreement 2016, p. 5).

This ICRR separately assesses achievement against the two core objectives of the PDO: increasing coverage and improving quality of essential health services, with a focus on maternal, newborn and child health.

Note: The addition of the Contingent Emergency Response (CERC) objective did not trigger a split rating, as it reflected an expansion in project scope and was never financed despite being activated. A split rating methodology is applied, however, because an August 2018 restructuring reduced key outcome targets.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

17-Aug-2018

c. Will a split evaluation be undertaken?

Yes

d. Components

Component 1. Strengthening Service Delivery at the Primary Health Care Level (Appraisal: US$84.0 million; Actual: US$86.76 million): The component aimed to enhance supply-side readiness by ensuring predictable and flexible operational funding to primary health care facilities across Myanmar. At design, the project envisioned three core areas of support for strengthening service delivery. First, health facility grants were to be provided to township hospitals, station hospitals, rural health centers, and maternal and child health clinics. Facilities located in hardship townships were to receive a 100 percent premium to account for additional logistical and service delivery challenges. Second, the component was to support State and Regional Health Departments to strengthen coordination, supervision, and communication functions. Each of the health departments was to receive a base annual allocation of US$200,000, with additional resources calibrated to the number of townships under their jurisdiction. Third, the project aimed to support activities to enhance communities' awareness of efforts to enhance service delivery and mobilization towards inclusive planning. Results were tracked annually through a set of disbursement-linked indicators (DLIs) to ensure implementation.

Component 2. Systems Strengthening, Capacity Building, and Project Management Support (Appraisal: US$16.0 million; Actual: US$10.59 million): The component aimed to build institutional foundations for universal health coverage and strengthen system-wide capacity for service delivery. At appraisal, the component was structured around two broad areas. First, system strengthening activities were to focus on defining and costing an Essential Package of Health Services, developing a national health financing strategy, preparing health care waste management guidelines, and introducing scorecards for quality monitoring and financial management tools. These efforts were to be led by the Ministry of Health and Sports (MOHS) using national expertise through consultation and technical working groups. Second, the component included a capacity building subcomponent to support midwives, financial managers, and

MOHS staff through training programs, courses, and exposure visits. The component also included funding for project management and early-stage implementation activities such as independent verification, technical assistance, and monitoring and evaluation (M&E) systems.

Component 3. Contingent Emergency Response (CERC) (Appraisal: US$0.0 million; Actual: US$0.0 million): This component was designed as a zero-dollar provisional window to enable rapid mobilization of resources in response to crises, in line with OP 10. It allowed for the reallocation of project funds in the event of a national emergency. In 2016, the CERC was formally activated following the 2015 floods and landslides, with US$3.43 million reallocated from Component 2 to support Myanmar's emergency response infrastructure and capacity. A corresponding intermediate results indicator was added. However, due to access challenges and implementation constraints, the planned activities under the CERC were not completed, and in 2018, the full amount was reallocated back to Component 2. As a result, no expenditures were incurred under this component.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

At appraisal, the total project cost was estimated at US$210 million, including US$200 million in International Development Association (IDA) financing and a US$10 million Global Financing Facility (GFF) grant administered by the World Bank. An Additional Financing (AF) package of US$100 million from IDA plus a US$10 million GFF grant was approved on June 22, 2020, to strengthen health systems and pandemic preparedness. Although the PDO remained unchanged, seven new DLIs and four new intermediate indicators were added. Key design changes included: (i) a new infrastructure-focused subcomponent to upgrade township hospitals and rural facilities; (ii) expansion of digital tools and information and communication technology-based training for frontline workers; (iii) institutional reforms in quality monitoring, community health worker programs, infection prevention and control, health care waste management, public financial management, and supply chain systems; and (iv) mechanisms for inclusive planning in conflict-affected areas involving non-governmental organizations, ethnic health providers, and community-based organizations.

However, these funds were never accessed before the military takeover in February 2021, when implementation ceased, and no disbursements were made under the AF. Actual disbursement under the original financing stood at US$74.67 million, slightly above the revised financing agreement of US$72.74 million due to exchange rate gains. The undisbursed balance was formally cancelled in July 2024, and the project closed on September 30, 2024. Following the February 2021 military coup in Myanmar, the Bank paused all disbursements and limited interaction with military authorities. Due to the volatile context, the OP7.30 assessment could not be completed. Rather than suspend operations, Bank management opted to let projects close on their original dates. The project remained open to preserve operational flexibility, enable continued oversight, and support ICR preparation. In 2024, senior management cancelled the remaining undisbursed funds as part of a portfolio-wide decision.

In addition, the project underwent five restructurings, each reflecting responses to exogenous shocks or evolving implementation needs:

May 12, 2015: This first restructuring changed disbursement and institutional arrangements due to a name change of the national ministry responsible for health almost immediately after project effectiveness

June 23, 2016: The second restructuring changed the PDO, added the CERC to address damage from 2015 floods and landslides, and added an indicator to monitor its implementation. US$3.43 million was reallocated from Component 2 to the CERC. However, no funds were ultimately disbursed under the CERC, and the allocation was returned in a subsequent restructuring.

Feb 20, 2017: The third restructuring introduced two key changes: (i) it replaced the private firm DLI verification mechanism with the Department of Medical Research and an oversight committee, due to capacity constraints to procure consultants; and (ii) it revised the disbursement calendar to enable two disbursements per fiscal year. An advance of 50 percent of total DLI value was to be provided on April 1, followed by a performance-adjusted second installment after verification. This addressed cash flow constraints caused by Myanmar's inability to operate on a reimbursement basis.

August 22, 2018: The fourth restructuring extended the project period by 21 months, to March 31, 2021, and significantly reduced the project's scope. The target for one PDO indicator, the number of townships where township hospitals and at least 60 percent of health facilities met a minimum readiness level (measured based on availability of trained staff, essential medicines, basic equipment, and infrastructure needed to provide services), was lowered from 300 to 180 due to delays in securing the planned AF. DLI targets for Years 3 and 4 were recalibrated accordingly. Additional changes included extending the Interim Unaudited Financial Report submission period to 60 days to accommodate manual data compilation. Finally, unused CERC financing was reallocated back to Component 2.

March 24, 2020: The fifth restructuring extended the audit submission deadline from six to nine months for all active Myanmar projects, starting with FY2020 audits, to align with prevailing country systems and capacity constraints.

3. Relevance of Objectives

Rationale

The project's objectives were highly relevant to Myanmar's development challenges and to World Bank strategies at both appraisal and closing. At preparation, Myanmar faced high poverty levels, internal conflict, and severe service delivery gaps. Between 2009 and 2010, poverty estimates ranged from 25.6 to 37.5 percent. Health indicators were similarly poor, with an infant mortality rate of 40 per 1,000 live births and limited access to maternal, newborn, and child health (MNCH) services, particularly in rural and conflict-affected areas.

The project directly supported the World Bank's Country Partnership Strategy (CPS) for FY15–17, specifically Outcome 2.2 under Pillar 2: Investing in People and Effective Institutions for Delivery (CPS, p. 30), which aimed to improve access to and quality of essential services in health, education, and nutrition. The project's emphasis on frontline facility readiness, midwife training, and township planning aimed to strengthen core systems needed for equitable delivery.

At project closing, the project remained highly aligned with the Myanmar Country Partnership Framework (CPF) for FY20–24. Focus Area 1: Building Human Capital and Fostering Peaceful Communities (CPF, pp. 22–23) prioritized inclusive service delivery across geographic areas, particularly in health, education, and

nutrition. The project's design supported this goal by improving service readiness and governance structures in underserved and conflict-affected regions, and by building health system resilience.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1
Objective
To increase coverage of essential health services, with a focus on maternal, newborn and child health (coverage)

Rationale
The project's theory of change postulated that increasing the coverage of essential health services, particularly for MNCH, would require addressing key operational barriers at the frontline level. Based on analytical evidence, the lack of predictable and flexible financing in health facilities and limited logistical capacity were identified as key constraints. To overcome these constraints, the project was to introduce Health Facility Grants, disbursed through township health departments to finance essential non-salary expenditures. Hardship townships were to receive additional support to account for elevated delivery costs. This operational financing was to be complemented by midwife training, supervision mechanisms, and inclusive township planning processes to include communities. These inputs were expected to improve the availability and continuity of MNCH services at the community level.

The theory of change was to be further reinforced through a results-based financing framework. DLIs tied to service readiness and coverage (e.g., antenatal care, postnatal visits, attended deliveries) were designed to incentivize progress and drive implementation focus.

The AF, approved in 2020, was to retain this logic and deepen it by addressing persistent infrastructure bottlenecks. It was to introduce a subcomponent to support the refurbishment of health facilities in selected regions and expand the use of digital tools to strengthen training and reporting. However, the AF was not implemented due to the military takeover, and no disbursements were made.

Outputs and Intermediate Outcomes

- 52,500 pregnancies were registered in health facilities, against a target of 60,000 pregnancies.
- 325 township hospitals received health facility grants, exceeding the original target of 300 and revised target of 180 hospitals.
- 80 percent of health facilities in 325 townships received health facility grants, exceeding the original target of 300 and revised target of 180 townships.

- 113 townships prepared integrated and inclusive Township Health Plans, falling short of the original target of 300 and revised target of 180 townships.
- Increased availability of MNCH medicines, such an oxytocin and magnesium sulfate, was reported in health facilities.
- Community health planning frameworks were introduced, engaging local communities in health-related decision making.
- Over 1,000 midwives were trained in maternal and neonatal care, with deployment focused on underserved areas.

Many of these outputs and intermediate outcomes were tied to DLIs, serving both as performance incentives and verification milestones for critical quality-related improvements.

Outcomes

The project made reasonable progress toward its coverage objective.

- 70 percent of deliveries were followed by adequate postnatal care within two days of birth, meeting the target of 69 percent (baseline: 65.8 percent).
- 10.9 million people received essential health, nutrition, and population (HNP) services, falling short of the target of 19.5 million people (baseline: 0) [added in 2018] .
- 90.2 percent of children were immunized for measles/rubella at age 9 months, falling short of the target of 91 percent (baseline: 87.8 percent) [added in 2018].

The selected indicators were appropriate for tracking progress toward the objective of increasing coverage of essential services for MNCH. However, some coverage indicators introduced during the 2018 restructuring were not reported in the ICR. These included the number of women and children provided with basic nutrition services (target: 2.9 million, increased to 4.6 million at the 2020 restructuring) and the number of attended deliveries (target: 2.8 million, increased to 7.0 million at the 2020 restructuring).

The reported indicators reflected service utilization patterns and were reinforced through DLIs that incentivized performance at the subnational level. Despite significant implementation constraints, including a difficult operating context and early closure of the project following the military takeover, the available results suggest reasonable progress toward the objective.

The ICR attributes this progress to a combination of community health worker outreach, health promotion activities, and improved facility readiness. While the definition of the postnatal care indicator was revised in 2019 to reflect a more stringent international standard measuring care within two days of delivery rather than within 42 days, this change strengthens the plausibility that the project contributed meaningfully to improved coverage. Despite the shift in methodology, the target was exceeded under a tighter standard.

The number of people who received essential HNP services did not meet its revised target. The ICR argues that the indicator was on track to be met and clarifies that this figure excludes data from 2019 and 2020 due to reporting delays, suggesting that actual performance may have been higher. However, no conclusive assessment can be made about the achievement of this target.

Given the adequacy of the indicators, reasonable progress against coverage targets up to the point of cancellation, but gaps in outcome reporting, this ICRR rates the achievement of this objective as borderline Substantial.

Rating
Substantial

OBJECTIVE 2
Objective
To increase coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health (quality) (original outcome targets)

Rationale
The project's theory of change for improving quality assumed that service delivery performance would improve if frontline health facilities were equipped to meet basic standards, and staff were supported through supervision and training. To support this, the project was to provide health facility grants to township hospitals, rural health centers, and sub-centers to cover operational costs. Additional support was to be directed to facilities in remote or underserved areas. Complementing this, the project was to introduce a supervision framework and deploy trained midwives to reinforce adherence to national guidelines for maternal and newborn care.

Quality-focused DLIs were used to incentivize achievement of these standards. DLI 1 tracked the number of townships in which the township hospital and at least 60 percent of other health facilities met the minimum readiness score, including infrastructure, staffing, supplies, and infection prevention. Achieving a minimum threshold on this scorecard was to be a core measure of quality.

The 2020 AF was to retain this structure but expand the quality agenda by introducing a new infrastructure subcomponent to address persistent bottlenecks in facility readiness. It was also to add new DLIs to institutionalize infection prevention and control, health care waste management, and supportive supervision. These enhancements reinforced the original logic, but implementation was halted following the suspension of World Bank operations in early 2021.

Outputs and Intermediate Outcomes

- A service readiness scorecard was introduced to assess township-level facility preparedness for delivering MNCH services.
- National guidelines and a policy framework for Health Care Waste Management were developed and implemented across participating facilities.
- Standards and checklists for supervision were developed to strengthen routine oversight by Township Health Departments.
- Over 1,000 midwives were trained.
- By project close, 193 townships had at least 60 percent of their midwives trained to deliver Basic Emergency Obstetric and Neonatal Care and Integrated Management of Childhood Illness, against a target of 300 townships.

- In 130 townships, at least 50 percent of health facilities were supervised twice annually using a standardized checklist, falling short of the target of 300 townships.

Many of these outputs and intermediate outcomes were tied to DLIs, serving both as performance incentives and verification milestones for critical quality-related improvements.

Outcomes

- 86 percent of births were conducted by skilled attendants, meeting the original target of 82 percent (baseline: 74 percent).
- 60 percent of health facilities met a minimum readiness level of 14 out of 20 to deliver essential MNCH services in 168 townships, falling short of the original target of 300 townships. The readiness score was based on a 20-point checklist covering staffing, essential drugs, equipment, and infrastructure required for MNCH services.
- 51 percent of children under 6 months were exclusively breastfed, exceeding the original target of 40 percent. However, this indicator was dropped between ISR 11 and 12 (August 2018) due to the lack of a planned follow-up household survey before project closure.

While the indicators and DLIs were logically structured to support quality improvements, achievement against original targets was uneven. Facility readiness and supervision fell significantly short of expectations, and capacity constraints at township and facility levels limited consistent application of standards. Given these implementation shortcomings and limited progress toward the health facility readiness target, the achievement of the quality objective under the original outcome targets is rated Modest.

Rating
Modest

OBJECTIVE 2 REVISION 1
Revised Objective
To increase coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health (quality) (revised outcome targets)

Revised Rationale
Note: See outputs reported above.

Outcomes

- **Skilled Birth Attendance**: 86 percent of births were attended by skilled health personnel, falling just short of the revised target of 87 percent (baseline: 74 percent).

- **Facility Readiness**: I60 percent of health facilities met a minimum readiness score of 14 out of 20 in 168 townships, just below the revised target of 180 townships. The readiness score was based on a

20-point checklist covering staffing, essential drugs, equipment, and infrastructure required for maternal, newborn, and child health services.

- **Exclusive Breastfeeding**: 51 percent of children under six months were exclusively breastfed, exceeding the original target of 24 percent. However, this indicator was dropped between ISR 11 and 12 (August 2018) due to the lack of a planned follow-up household survey before project closure.

Performance against the revised targets was generally strong. Two of the three PDO indicators either met or nearly met their revised targets. The township readiness target was 93 percent achieved (168 out of 180 townships), and skilled birth attendance was almost achieved against the upwardly revised target. While shortfalls were observed in facility supervision coverage and readiness and engagement with community-level stakeholders, and ethnic health organization was limited, taken together, the results indicate a substantial contribution to improving the quality of essential MNCH services in Myanmar.

Revised Rating
Substantial

OBJECTIVE 3
Objective
In the event of an eligible crisis or emergency, to provide immediate and effective response to said crisis or emergency

Rationale
The third objective was formally added to the PDO in 2016 with the activation of the CERC. In response to the 2015 floods and landslides, US$3.43 million was reallocated from Component 2 to support recovery activities in six affected regions. As part of this reallocation, procurement-related actions were added as an intermediate results indicator under the IDA Immediate Response Mechanism and documented in the Contingent Emergency Response Implementation Plan. However, due to access constraints, the reallocated funds were never used and were fully returned to Component 2 in 2018. As a result, the intended emergency response was not implemented under this project. Instead, recovery efforts were initiated under other World Bank–financed operations in Myanmar, but those disbursements were delayed by 18 months, limiting their usefulness for the initial emergency. Lessons from this experience are noted in the Completion and Learning Review of the Myanmar Country Partnership Framework FY15–19.

In 2020, COVID-19 constituted an eligible emergency under the CERC framework, but the project did not activate the instrument. Instead, the emergency response was supported through internal reallocations within Component 2. These reallocations enabled the deployment of resources, training of health workers in infection prevention and control, and the procurement of emergency medical supplies in selected townships. Although the CERC mechanism was not used effectively, the project's broader response to emerging public health challenges demonstrated adaptability and operational flexibility in crisis settings.

Rating

Not Rated/Not Applicable

OVERALL EFFICACY

Rationale

Efficacy is rated Modest prior to the August 2018 restructuring, in line with the ICR's rating. The project fell short of its original ambition to achieve service readiness across 300 townships. Performance on DLIs and intermediate results indicators lagged behind planned targets, reflecting challenges in implementation and design realism during the early phase. These shortcomings were compounded by external shocks, including the 2017 Rakhine crisis and conflict-related access constraints, which diverted government attention and affected project delivery. Although some results, such as skilled birth attendance, exceeded targets and indicate plausible progress, the causal chain for broader outcomes was not consistently realized at scale. On balance, while achievement of Objective 1 was borderline Substantial, key performance gaps and implementation delays justify a Modest rating for efficacy under the original outcome targets.

Overall Efficacy Rating

Modest

Primary Reason

Low achievement

OVERALL EFFICACY REVISION 1

Overall Efficacy Revision 1 Rationale

Efficacy is rated Substantial after the August 2018 restructuring. The revised target of 180 townships achieving set quality thresholds was more closely aligned with available financing and implementation capacity, and the project made strong progress toward achieving it. By 2020, 168 townships had met the readiness criteria, and postnatal care coverage exceeded its 69 percent target. Improvements across core PDO indicators and strengthened implementation support reflect substantial achievement under the revised results framework.

Overall Efficacy Revision 1 Rating

Substantial

5. Efficiency

The Project Appraisal Document (PAD) did not include an ex-ante rate of return analysis. The economic rationale for the project was grounded in improving allocative efficiency by increasing operational funding for under-resourced frontline health facilities and addressing chronic underinvestment in the public health system. At appraisal, the focus was on improving access and quality. The AF approved in 2020 further aimed to expand these efforts and strengthen efficiency. However, the funds were never disbursed following the February 2021 military coup. The ICR includes an ex-post economic analysis, estimating an internal rate of return of 14.81 percent over 10 years and 17.24 percent over 20 years. These estimates exceed the assumed opportunity cost

of capital of 5 percent. The analysis finds economic savings of roughly US$ 9 million annually, primarily through reduced emergency obstetric care, neonatal admissions, and postnatal complications. The reduction in township coverage from the planned 300 to 180 townships limited overall economic benefits, although the ICR notes that per-beneficiary returns remained high.

The project met its revised objectives without exceeding costs. Strengths during implementation included close supervision, adaptive support in response to contextual constraints, and sustained technical assistance. Notably, the Bank supported efforts to develop standard operating procedures, strengthen M&E tools, and roll out financial management reforms. However, the project also experienced significant shortcomings in implementation efficiency. There were multiple delays. Procurement and disbursement were slow, particularly for essential training materials and facility upgrades, and the township planning process experienced bottlenecks. Implementation efficiency was also affected by external and operational constraints. Health facility grants struggled to reach facilities in conflict-affected areas, and delivery of essential medicines and supplies was delayed in regions such as Rakhine, Kachin, and Shan due to poor infrastructure and ongoing conflict. Community engagement efforts varied widely in effectiveness, with inconsistent documentation and challenges in ensuring participation in ethnic minority regions due to language and cultural barriers. These factors limited geographically equitable service delivery and contributed to the failure to meet the original DLI 1 target of 300 townships. Moreover, implementation using MOHS staff, rather than external consultants, aligned with government preference but placed a dual burden on staff, affecting the pace of delivery. The project continued to incur supervision costs for 3.5 years after Bank operations were suspended in February 2021 following the military coup. Approximately US$110 million in undisbursed funds remained at closure, and while more than three years passed between the 2021 military takeover and formal project cancellation, this delay is not explained in the ICR.

Efficiency Rating

Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐ Not Applicable
ICR Estimate	✓	14.81	100.00 ☐ Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of project objectives is rated High throughout the project's duration, as the objectives remained aligned with Myanmar’s health priorities and the World Bank’s CPF for FY20–24. Efficiency is rated Modest due

to implementation inefficiency and procurement bottlenecks, despite gains in cost effectiveness and improved fund flows post-restructuring.

Efficacy is rated Modest against the original outcome targets, as the project made partial progress, with uneven DLI performance. Against the revised outcome targets, efficacy is rated Substantial, as the project met most revised targets, including service readiness in 168 of 180 townships and improved postnatal care coverage.

A disbursement-weighted rating yields a score of 3.26, which rounds to 3.0.

Rating Dimension	Ratings under the original outcome targets	Ratings under the revised outcome targets
Relevance	High	
Objective 1: To increase coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health (MNCH).	Substantial (borderline)	
Objective 2: To increase coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health (MNCH).	Modest	Substantial
Objective 3: Improve the coverage of ICDS nutrition services	NA	
Overall Efficacy	Modest	Substantial
Efficiency	Modest	
Outcome Rating	Moderately Unsatisfactory	Moderately Satisfactory
Numerical value of the outcome rating	3	4
Amount Disbursed (US$ million)	US $55.16 million	US $19.51 million
Disbursement (%)	73.9%	26.1%
Weight Value	2.217	1.04
Total weights	3.26	
Overall Outcome Rating	Moderately Unsatisfactory	

a. Outcome Rating
Moderately Unsatisfactory

7. Risk to Development Outcome

The risk to development outcome is high, reflecting the fragile political and institutional context following the 2021 military takeover, which significantly disrupted health service delivery and weakened governance structures. While the project contributed to improvements in MNCH by strengthening frontline service readiness, the sustainability of these gains remains uncertain. Government health spending has declined from 4.6 percent to 2.5 percent of total expenditure, and there has been a pronounced shift in care-seeking

behavior from public to private providers (rising from 34 percent to 59 percent), raising concerns around equitable access, particularly for poorer households. The ICR notes that although some elements, such as immunization coverage, facility readiness, and financial reporting systems, have shown resilience, others have deteriorated or stalled. Continued political instability, constrained fiscal space, and reliance on external financing underscore the uncertainty surrounding the durability of outcomes achieved under the project.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was aligned with the World Bank's CPS for FY15–17, which prioritized support to Myanmar's transition by strengthening institutions for service delivery. It was also closely aligned with the Government of Myanmar's National Health Plan (2011–2016) and its broader development objectives of improving MNCH. The project's focus on strengthening service delivery systems, enhancing frontline provider capacity, and expanding access in underserved areas was consistent with both strategic priorities.

The preparation process was informed by a broad consultation effort involving government counterparts, local health authorities, and development partners, including the United Nations Children's Fund (UNICEF). These consultations helped shape the design of township-level interventions and targeting strategies. The World Bank also drew on its ongoing advisory services and analytics work, which had identified key bottlenecks in the health system and informed the project's results-based financing approach. Lessons from the Bank's global portfolio were also incorporated, particularly the importance of maintaining focused project design and using country systems where feasible (PAD, Annex 6).

Despite these strengths, quality at entry suffered from an underestimation of institutional and contextual risks. The project was not fully ready for implementation at the time of approval. While the Government of Myanmar had experience working with other development partners, its familiarity with World Bank procedures, particularly the use of DLIs, was limited. Manual reporting systems persisted during the initial years, contributing to delays in financial reporting and audits. The project introduced a performance-based financing approach that required counterpart contributions and placed demands on township-level financial and procurement systems, many of which had limited implementation capacity. These constraints were not fully accounted for in project timelines. Additionally, the project did not adequately apply a fragility and conflict lens, and engagement with ethnic health organizations and community-level stakeholders was limited during preparation. These gaps later affected implementation in conflict-affected areas. Moreover, monitoring and evaluation systems were ambitious in scope but poorly adapted to fragile and conflict-affected (FCV) conditions. Heavy reliance on national household surveys limited the utility of data for midcourse correction, and contingencies for follow-up surveys were not planned.

Quality-at-Entry Rating

Moderately Unsatisfactory

b. Quality of supervision

The World Bank remained engaged throughout implementation, providing technical assistance and conducting regular supervision missions. Early on, the Bank supported the development and rollout of Standard Operating Procedures for financial management and reporting, in response to limited institutional capacity and delays in fund utilization. Additional financial management staff were hired and trained by 2018 to improve compliance and reporting, though challenges in disbursement and meeting DLI requirements persisted. The Bank also worked to address delays in the procurement of essential training materials and equipment, which had disrupted capacity-building efforts for midwives and affected maternal health service delivery. Procurement delays, most notably for life-saving medicines and training materials, disrupted essential maternal health services and delayed capacity-building for frontline providers.

Supervision efforts flagged gaps in township planning and reporting, but data quality and monitoring weaknesses remained unresolved in several areas. Community engagement processes were inconsistently documented, limiting the Bank's ability to assess their reach and representativeness. During preparation of the AF, the Bank incorporated lessons from earlier phases and introduced a more focused geographic strategy using a multidimensional disadvantage index. However, implementation was affected by the COVID-19 pandemic, and activities were fully paused after the February 2021 military takeover. Overall, Bank performance during implementation was adaptive and sustained, but limitations in procurement oversight, subnational capacity-building, design and supervision of monitoring and evaluation (See section 9) and documentation warrant a Moderately Satisfactory rating. Finally, though the World Bank paused disbursements to assess the situation following the military takeover in February 2021, the project was cancelled after 3.5 years in 2024. The ICR does not offer any explanation for this lengthy delay.

Quality of Supervision Rating

Moderately Satisfactory

Overall Bank Performance Rating

Moderately Unsatisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The project's M&E framework was comprehensive in scope, combining indicators to track essential health service coverage, quality of care, and institutional capacity-building. The use of DLIs tied to specific systems strengthening outputs under Component 2 provided a structured results chain for tracking progress. However, the design of monitoring and evaluation did not fully anticipate the implementation constraints associated with low capacity and conflict-affected settings. In particular, the use of linear annual targets for township facility readiness over the first four years proved overly optimistic, given the complexity of achieving minimum standards in underserved areas. The reliance on national household surveys (e.g., Multiple Indicator Cluster Surveys and the Demographic and Health Survey) for validating three of the four PDO indicators was also a design limitation, as these surveys are infrequent and ill-suited for real-time decision-making, particularly in FCV contexts. The PAD had included a provision to consider financing a

follow-up survey if it became clear at midterm that no national survey would be conducted, but this contingency was not operationalized.

b. M&E Implementation

M&E implementation was generally consistent in the early stages of the project. MOHS routinely submitted progress reports, and the World Bank provided technical support to improve data systems and strengthen indicator reporting. Early bottlenecks, such as delays in data submission from township health facilities with weaker administrative capacity, were gradually addressed through capacity-building support. However, the composite nature of the facility readiness indicator limited the timeliness and clarity of progress tracking, as data had to be aggregated across multiple dimensions before it could be interpreted. While implementation was rated Moderately Satisfactory (MS) in Implementation and Status Results (ISR) reporting during the first two years, these ratings appear optimistic in hindsight, especially as the 2018 restructuring reduced the target number of townships from 300 to 180, a 40 percent reduction. The planned follow-up surveys to validate project results were not conducted, largely due to COVID-19 and the political crisis of 2021. Although MOHS data were used to report on the PDO indicators, this gap underscores the importance of ensuring dedicated financing and planning for endline data collection, rather than relying on external survey schedules.

c. M&E Utilization

M&E data were used actively to inform project implementation, particularly in the earlier phases. Monitoring results helped identify persistent bottlenecks, such as midwife staffing and uneven progress in achieving facility readiness, prompting course corrections including additional training. As implementation progressed, political instability and data flow disruptions from certain regions limited the scope of evidence-informed adjustments. The M&E system remained central to the project's ability to track progress and adapt scope, e.g., in the decision to reduce geographic coverage and reallocate resources during restructuring.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project was classified as Category B due to moderate environmental and social risks. It triggered three safeguard policies: Environmental Assessment (OP/BP 4.01), Indigenous Peoples (OP/BP 4.10), and Emergency Response Operations (OP/BP 8.00). Safeguards compliance was rated as Moderately Satisfactory throughout the project cycle. These ratings are not stated in the ICR. To manage risks, the project developed and implemented a Health Care Waste Management (HCWM) Plan, an Indigenous Peoples Planning Framework, and a Community Engagement Framework. These instruments were integrated into project operations to ensure inclusive planning, safe medical waste disposal, and outreach to disadvantaged groups. Supervision reports and field visits indicated that most mitigation measures were

implemented, including the rollout of HCWM protocols and targeted engagement with tribal and minority communities. However, community engagement efforts were uneven across regions, particularly in areas affected by conflict and limited capacity. In some cases, participatory planning processes were delayed or did not fully reflect local priorities. Despite these challenges, the project remained compliant with safeguard requirements throughout implementation, with consistent oversight and corrective actions taken as needed.

b. Fiduciary Compliance

Procurement performance was a notable constraint. Fiduciary compliance was rated as Moderately Unsatisfactory prior to restructuring and remained Moderately Satisfactory for the rest of the project period. The issues and ratings related to fiduciary compliance were not clearly outlined in the fiduciary compliance section of the ICR. Delays in procuring training materials and medical equipment for midwives disrupted capacity-building activities, particularly under Component 2 (ICR, p.10). These delays slowed progress on increasing skilled birth attendance and impeded the timely rollout of critical interventions, including Basic Emergency Obstetric and Neonatal Care and Integrated Management of Childhood Illness training. Health facility grants were disbursed to most townships but were often underutilized due to slow delivery of necessary equipment. Prolonged stockouts of life-saving drugs such as oxytocin and magnesium sulfate further undermined service delivery, especially in rural and remote areas. These procurement-related inefficiencies contributed to delayed disbursements and uneven implementation of planned activities across the project's geographic scope.

c. Unintended impacts (Positive or Negative)

The project contributed to increased technology adoption by introducing tablet-based systems for health data collection and training, which may have had positive spillover effects on the digital literacy of health workers in rural areas. Following the 2021 military takeover, some of the personnel trained under the project transitioned to the non-public sector. While this reflected a loss of capacity within the public system, it may have inadvertently supported service continuity and diversification through private and non-profit providers.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Unsatisfactory	This ICR and ICR Review have the same component ratings, but the ICR made an error in the calculation per guidelines, which

			is reason for difference in outcome rating.
Bank Performance	Moderately Satisfactory	Moderately Unsatisfactory	Limited risk identification and mitigation.
Quality of M&E	Substantial	Modest	Incomplete data and weak real-time tracking.
Quality of ICR	---	Substantial	

12. Lessons

Results-based financing requires strong institutional readiness and simplified DLI design. The project used DLIs to incentivize service readiness and planning improvements. However, the government's limited familiarity with performance-based disbursement, combined with administrative complexity and delays in verification, impeded smooth implementation. The lesson is that in low-capacity or FCV settings, DLIs must be phased, realistically targeted, and aligned with local operational rhythms to maintain both momentum and disbursement flow.

Capacity development must extend across all levels of the system to be effective in fragile environments. Although the project invested in national-level planning and health worker training, procurement delays and implementation bottlenecks persisted at the township level. In several cases, gaps in local administrative capacity undermined service delivery despite upstream progress. This underscores that system strengthening in FCV contexts requires horizontal coordination and tailored support across all operational tiers, not just central ministries.

Government-only implementation models can leave gaps in fragile or contested areas. The project relied solely on government delivery systems, which limited its reach in areas not under government control. As a result, some conflict-affected communities remained underserved despite available funding. This experience shows that in FCV contexts, exclusive reliance on state systems may constrain access, and alternative delivery models may be needed where neutrality and access are compromised.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a generally candid narrative of the project's evolution and challenges, with a structure that supported a chronological understanding of implementation. It documented how DLIs supported progress toward project objectives and provided a clear account of contextual shocks that shaped project delivery. While the efficacy section did not unpack the compound nature of the PDO, this unpacking was provided in the annex and references in the report. The theory of change could have also been more clearly articulated to reflect revised objectives and targets. Although a split rating was presented in the annex, it was not incorporated into

the main efficacy discussion, and the efficiency rating was split contrary to OPCS guidelines. Nonetheless, the ICR presented a balanced and evidence-based assessment, and the overall quality of the ICR is rated Substantial.

a. Quality of ICR Rating
Substantial