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Report No: PAD3877

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED INTERNATIONAL DEVELOPMENT ASSOCIATION CREDIT
IN THE AMOUNT OF SDR 36.7 MILLION
(US\$ 50 MILLION EQUIVALENT)
IN CRISIS RESPONSE WINDOW RESOURCES

TO

REPUBLIC OF THE UNION OF MYANMAR

FOR

MYANMAR COVID-19 EMERGENCY RESPONSE PROJECT

UNDER THE
COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PROGRAM (SPRP)

USING THE MULTIPHASE PROGRAMMATIC APPROACH (MPA)
WITH A FINANCING ENVELOPE OF
UP TO US\$ 6 BILLION

APPROVED BY THE BOARD ON APRIL 2, 2020

Health, Nutrition, and Population Global Practice
East Asia And Pacific Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective {Mar 31, 2020})

Currency Unit = Myanmar Kyat (MMK)

US\$ 1 = MMK 1,392.51

US\$ 1 = SDR 0.7327

FISCAL YEAR

October 1 – September 30

Regional Vice President: Victoria Kwakwa

Country Director: Mariam J. Sherman

Regional Director: Daniel Dulitzky

Practice Manager: Daniel Dulitzky

Task Team Leader(s): Nang Mo Kham, Hnin Hnin Pyne



ABBREVIATIONS AND ACRONYMS

ACCESS	Access to Health Fund
ADB	Asian Development Bank
AF	Additional Financing
BFP	Bank Facilitated Procurement
CBO	Community Based Organization
CPF	Country Partnership Framework
CSO	Civil Society Organization
DA	Designated Account
DMS	Department of Medical Services
EAO	Ethnic Armed Organization
EHP	Ethnic Health Providers
EHSAP	Essential Health Services Access Project
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standards
FM	Financial Management
FTCF	Fast Track COVID-19 Facility
FY	Fiscal Year
GAVI	The Vaccine Alliance
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOM	Government of Myanmar
GRM	Grievance Redress Mechanism
HCI	Human Capital Index
HCWM	Health Care Waste Management
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDA	International Development Association
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
IHR	International Health Regulations
IPC	Infection Prevention and Control
JEE	Joint External Evaluation
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MOHS	Ministry of Health and Sports
MSWRR	Ministry of Social Welfare, Relief, and Resettlement
MPA	Multiphase Programmatic Approach
NAPHS	National Action Plan on Health Security



NGO	Non-Government Organization
NHL	National Health Laboratory
OA	Other Account
OP	Operational Policies
PAD	Project Appraisal Document
PDO	Project Development Objective
PMT	Project Management Team
POM	Project Operations Manual
PPE	Personal Protective Equipment
PPSD	Project Procurement Strategy for Development
R/S	Region/State
SARS	Severe Acute Respiratory Syndrome
SDG	Sustainable Development Goal
SDR	Special Drawing Rights
SOE	Statement of Expenditure
SPRP	Strategic Preparedness and Response Program
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children’s Fund
US-CDC	United States Center for Disease Control
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization



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DATASHEET

BASIC INFORMATION		
Country(ies)	Project Name	
Myanmar	Myanmar COVID-19 Emergency Response Project	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P173902	Investment Project Financing	Substantial
Financing & Implementation Modalities		
<input checked="" type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input type="checkbox"/> Contingent Emergency Response Component (CERC)	
<input type="checkbox"/> Series of Projects (SOP)	<input type="checkbox"/> Fragile State(s)	
<input type="checkbox"/> Disbursement-linked Indicators (DLIs)	<input type="checkbox"/> Small State(s)	
<input type="checkbox"/> Financial Intermediaries (FI)	<input type="checkbox"/> Fragile within a non-fragile Country	
<input type="checkbox"/> Project-Based Guarantee	<input type="checkbox"/> Conflict	
<input type="checkbox"/> Deferred Drawdown	<input checked="" type="checkbox"/> Responding to Natural or Man-made Disaster	
<input type="checkbox"/> Alternate Procurement Arrangements (APA)		
Expected Project Approval Date	Expected Project Closing Date	Expected Program Closing Date
23-Apr-2020	31-Mar-2022	31-Mar-2025
Bank/IFC Collaboration		
No		
MPA Program Development Objective		
The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness		
MPA Financing Data (US\$, Millions)		



MPA Program Financing Envelope	3,965.05
with an additional request to IBRD	80.00
with an additional request to IDA	95.00

Proposed Project Development Objective(s)

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

Components

Component Name	Cost (US\$, millions)
Hospital Preparedness to Respond to COVID-19	48.50
Capacity Building and Community Engagement	1.00
Project Management and Monitoring & Evaluation	0.50

Organizations

Borrower: Ministry of Planning, Finance, and Industry
 Implementing Agency: Ministry of Health and Sports

MPA FINANCING DETAILS (US\$, Millions)

Board Approved MPA Financing Envelope:	3,790.05
MPA Program Financing Envelope:	3,965.05
of which Bank Financing (IBRD):	2,496.30
of which Bank Financing (IDA):	1,468.75
of which other financing sources:	0.00

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	50.00
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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
IDA Credit	50.00

IDA Resources (in US\$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Myanmar	50.00	0.00	0.00	50.00
Crisis Response Window (CRW)	50.00	0.00	0.00	50.00
Total	50.00	0.00	0.00	50.00

Expected Disbursements (in US\$, Millions)

WB Fiscal Year	2020	2021	2022
Annual	10.00	35.00	5.00
Cumulative	10.00	45.00	50.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has not been screened for short and long-term climate change and disaster risks

Explanation

Emergency response to pandemic



SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	● Substantial
2. Macroeconomic	● Substantial
3. Sector Strategies and Policies	● Moderate
4. Technical Design of Project or Program	● Substantial
5. Institutional Capacity for Implementation and Sustainability	● Substantial
6. Fiduciary	● Substantial
7. Environment and Social	● Substantial
8. Stakeholders	● Moderate
9. Other	
10. Overall	● Substantial
Overall MPA Program Risk	● High

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

Yes No

Does the project require any waivers of Bank policies?

Yes No

Have these been approved by Bank management?

Yes No

Is approval for any policy waiver sought from the Board?

Yes No



Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank’s due diligence assessment of the Project’s potential environmental and social risks and impacts, please refer to the Project’s Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description

Section I. A. Schedule 2 to the Financing Agreement

1. For the purposes of overall policy and strategic advice, the Recipient shall maintain throughout the implementation of the Project, the Project Oversight Committee with the composition, responsibilities and terms of reference satisfactory to the Association.
2. The Recipient shall vest responsibility for the overall implementation of the Project in MOHS. To this end the Recipient through MOHS shall, not later than one month after the Effective Date, establish within MOHS and thereafter maintain throughout the implementation of the Project, the Project Management Team for the purposes of day-to-day Project management and implementation, including financial management, procurement, and social and environmental risk management issues, with the composition, responsibilities and terms of reference at all



times satisfactory to the Association.

Sections and Description

Section I. B. Schedule 2 to the Financing Agreement:

By not later than one (1) month after the Effective Date (or such other date that the Association shall otherwise agree), the Recipient shall prepare and adopt a Project Operations Manual acceptable to the Association, which shall set forth, inter alia, the following detailed arrangements and procedures for the implementation of the Project: (i) institutional arrangements for the day-to-day execution of the Project; (ii) implementation arrangements for the Environmental and Social Commitment Plan (“ESCP”) and the environmental and social management instruments; (iii) budgeting, disbursement, auditing and financial management arrangements; (iv) Project monitoring, reporting, evaluation and communication arrangements; (v) Personal Data collection and processing; and (vi) any other administrative, financial, technical and organizational arrangements and procedures as shall be necessary for the implementation of the Project and the achievement of its development objective.

Sections and Description

Section I. C. Schedule 2 to the Financing Agreement:

1. The Recipient shall through MOHS furnish to the Association, for review and approval not later than October 31 of each year during the implementation of the Project (or such later date as the Association may agree), an annual work plan and budget (“AWPB”) for the Project containing relevant Project activities and expenditures proposed to be included in the Project in the subsequent year.
2. The Recipient shall through MOHS ensure that the Project is implemented in accordance with the AWPB accepted by the Association for the respective year; provided, however, that in the event of any conflict between the AWPB and the provisions of this Agreement, the provisions of this Agreement shall prevail.

Sections and Description

Section I. D of Schedule 2 to the Financing Agreement:

1. The Recipient shall through MOH ensure that the Project is carried out in accordance with the Environmental and Social Standards, in a manner acceptable to the Association.
2. The Recipient shall ensure that the Project is implemented in accordance with the Environmental and Social Commitment Plan (“ESCP”), in a manner acceptable to the Association.



Conditions



I. PROGRAM CONTEXT

A. MPA Program Context

1. This Project Appraisal Document (PAD) describes the emergency response to Myanmar under the COVID-19 Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA), approved by the World Bank's Board of Executive Directors on April 2, 2020 (PCBASIC0219761) with an overall Program financing envelope of up to US\$6.00 billion.
2. **An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China.** Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. As of March 29, 2020, the outbreak has resulted in 723,540 confirmed cases and 33,998 deaths in more than 200 countries and territories.
3. **COVID-19 is one of several emerging infectious disease outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts.** The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavioral risk factors such as tobacco use¹ and pre-existing chronic health problems that make viral respiratory infections particularly dangerous². With COVID-19, scientists are still trying to understand the full picture of the disease symptoms and severity. Reported symptoms in patients have varied from mild to severe, and can include fever, cough and shortness of breath. In general, studies of hospitalized patients have found that about 83 percent to 98 percent of patients develop a fever, 76 percent to 82 percent develop a dry cough and 11 percent to 44 percent develop fatigue or muscle aches³. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. While 3.7 percent of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe that as a mortality rate or death rate. This is because in an unfolding epidemic it can be misleading to look simply at the estimate of deaths divided by cases so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to COVID-19 across all IDA/IBRD countries to minimize the global risk and impact posed by this disease.
4. This proposed project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FTCF).

¹ Marquez, PV. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (Covid-19) Severity? The Case of China." <http://www.pvmarquez.com/Covid-19>

² Fauci, AS, Lane, C, and Redfield, RR. 2020. "Covid-19 — Navigating the Uncharted." *New Eng J of Medicine*, DOI: 10.1056/NEJMe2002387

³ Del Rio, C. and Malani, PN. 2020. "COVID-19—New Insights on a Rapidly Changing Epidemic." *JAMA*, doi:10.1001/jama.2020.3072



B. Updated MPA Program Framework

Table. 1 provides an updated MPA Program framework.

Table 1. MPA Program Framework

Phase #	Project ID	Sequential or Simultaneous	Phase’s Proposed DO*	IPF, DPF or PforR	Estimated IBRD Amount (\$ million)	Estimated IDA Amount (\$ million)	Estimated Other Amount (\$ million)	Estimated Approval Date	Estimated Environmental & Social Risk Rating
2	P173902	Sequential		IPF		50		April 23, 2020	Substantial
Total						50			

5. All projects under SPRP are assessed for Environmental and Social Framework (ESF) risk classification following the Bank procedures and the flexibility provided for COVID-19 operations.

C. Learning Agenda

6. The proposed project would employ adaptive learning throughout implementation in support of the COVID-19 SPRP learning agenda. There will be close collaboration with international organizations, such as World Health Organization (WHO), Asian Development Bank (ADB), the United States Center for Disease Control (US-CDC), Public Health England, and others. It would contribute to expanding the evidence-base in Myanmar and globally in the following key areas: modeling the progression of the pandemic, both in terms of new cases and deaths, as well as the economic impact of disease outbreaks; cost and effectiveness of prevention and preparedness activities; and options for distribution of medicines and medical supplies, with a specific focus on health facilities in hard-to-reach areas.

II. CONTEXT AND RELEVANCE

A. Country Context

7. 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.

8. **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.

9. **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.⁴ 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.

10. **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.

11. 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.

12. 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

⁴ 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.



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,⁵ 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.⁶ Furthermore, due to women's frontline interactions as caregivers and healthcare providers, they face a higher risk of exposure to COVID-19.⁷

13. **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.

B. Sectoral and Institutional Context

14. **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.

15. **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

⁵ Fraser, E. 2020. Impact of COVID-19 Pandemic on Violence Against Women and Girls. VAWG Helpdesk Research Report No. 284. 16 March, UKAID.

⁶ Care. 2020. Gender Implications of Covid-19 Outbreaks in Development and Humanitarian Settings.

⁷ UNFPA. 2020. Covid-19: A Gender Lens. March, UNFPA, p. 2.



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.

16. **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.

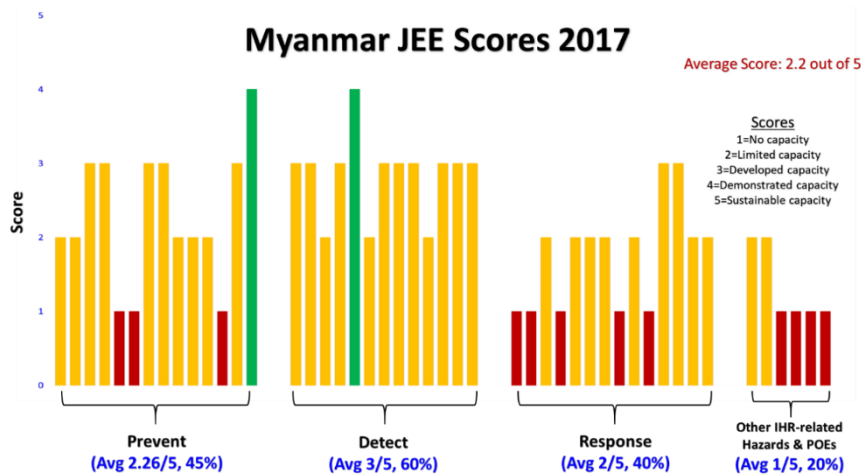
17. **Health spending in Myanmar, in local currency terms, has increased steadily** in the past five years in support of the government's goal of UHC. The government health budget has climbed to roughly one percent of GDP (from an average of 0.2 percent prior to 2012). MOHS also has steadily expanded 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.

18. **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.



19. **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).⁸ Italy had 12.5 ICU beds per



100,000 and Germany 29.2.⁹

20. 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.

21. **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.

⁸ 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]

⁹ 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]



22. 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.

23. **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 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.

24. **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. Annex 3 summarizes the technical areas of the Contingency Plan.

25. **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 ministries¹⁰, 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.

26. 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

¹⁰ 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.



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. Relevance to Higher Level Objectives

27. **The proposed project's objective and interventions are well aligned with goals of the existing Country Partnership Framework (CPF) 2015-2017 (Report No. 95183-MM), which calls for investing in people and effective institutions, and with that of the upcoming CPF 2020 - 2023, which will be presented to the WB Board approval in May 2020.** The latter calls for the need to boost human capital in Myanmar, by expanding access to basic health services for everyone in the country, strengthening health systems for resilience and preparedness for emergencies, sustainable financing, and inclusive service delivery. The proposed project is viewed as a part of the package that would support Myanmar in the emergency response to the COVID-19 pandemic as well as in addressing the impact of the pandemic on the country's economy, businesses, and households.

28. The project is aligned with WBG strategic priorities, particularly its mission to end extreme poverty and boost shared prosperity. The Program is focused on preparedness which is also critical to achieving UHC. It is also aligned with the World Bank's support for national plans and global commitments to strengthen pandemic preparedness through three key actions under Preparedness: (i) improving national preparedness plans including organizational structure of the government; promoting adherence to the International Health Regulations (IHR); and utilizing international framework for monitoring and evaluation (M&E) of IHR. The economic rationale for investing in the MPA interventions is strong, given that success can reduce the economic burden suffered both by individuals and countries. The project complements both WBG and development partner investments in health systems strengthening, disease control and surveillance, attention to changing individual and institutional behavior, and citizen engagement. Further, as part of the proposed IDA19 commitments, the World Bank is committed to "support at least 25 IDA countries to implement pandemic preparedness plans through interventions (including strengthening institutional capacity, technical assistance, lending and investment)." The project contributes to the implementation of the international standards set by IHR (2005), Integrated Disease Surveillance and Response (IDSR), and the World Organization for Animal Health, the Global Health Security Agenda, the Paris Climate Agreement, the attainment of UHC and of the SDGs and the promotion of a One Health approach.

29. **The WBG remains committed to providing a fast and flexible response to the COVID-19 pandemic,** utilizing all WBG operational and policy instruments and working in close partnership with government and other agencies. Grounded in One-Health, which provides for an integrated approach across sectors and disciplines, the proposed WBG response to COVID-19 will include emergency financing, policy advice, and technical assistance, building on existing instruments to support IDA/IBRD-eligible countries in addressing the health sector and broader development impacts of COVID-19. The WBG COVID-19 response will be anchored in the WHO's COVID-19 global Strategic Preparedness and Response Plan outlining the public health measures for all countries to prepare for and respond to COVID-9 and sustain their efforts to prevent future outbreaks of emerging infectious diseases.

III. PROJECT DESCRIPTION

30. **The proposed project seeks FTCF financing because Myanmar faces an elevated risk of a serious COVID-19 outbreak and a potentially devastating impact on the economy and households.** The project scope and design are fully aligned with the SPRP, namely the standard components and results framework. The project would finance



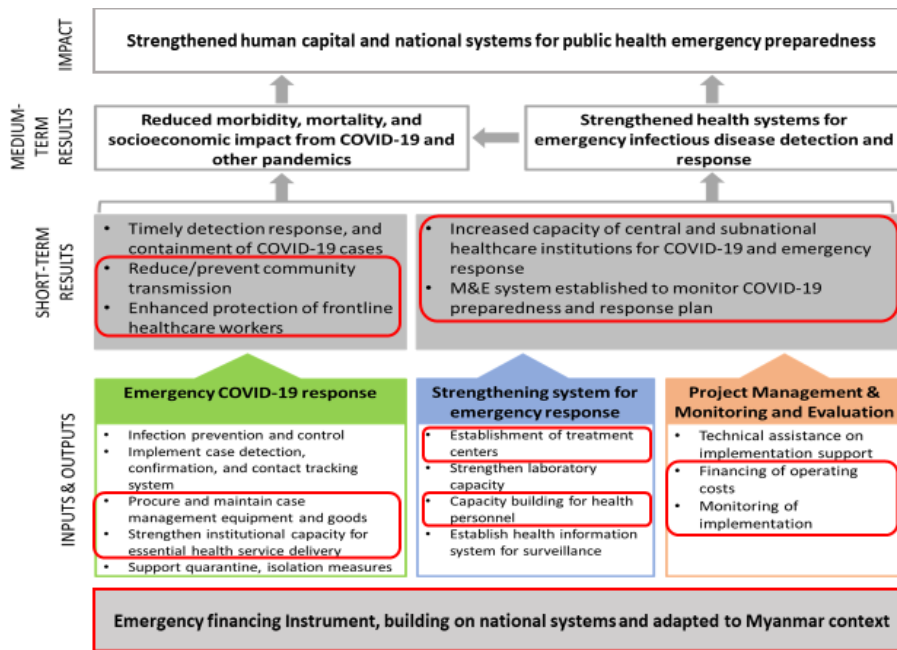
interventions that address immediate needs in the COVID-19 response, as well as those that lay the foundation for the health systems preparedness for public health emergencies. It would complement the other IDA-financed health operation in Myanmar, namely the Essential Health Services Access Project (EHSAP) and the proposed Additional Financing (AF) that are focused on medium to longer term health systems outcomes. EHSAP AF, which has been recently approved by the Parliament of Myanmar and will be presented to the World Bank Board for approval in May 2020, will help to sustain and institutionalize systems building efforts initiated under the emergency project. In addition to improving readiness of the primary health care facilities to deliver the essential package of health services, the AF would help to further cement infection prevention and control (IPC) and health care waste management (HCWM) practices, institutionalize mechanisms that facilitate better coordination and collaboration between government and NGOs, Ethnic Health Providers (EHPs), and Civil Society Organizations, expand supply chain logistics management system, strengthen community engagement and outreach through health volunteers and scale up use of Information and Community Technology (ICT).

A. Development Objectives

31. The Project objectives are aligned to the results chain of the COVID-19 SPRP, as demonstrated in Figure 1 below.
32. **Project DO statement:** To respond to the COVID-19 outbreak and strengthen national systems for public health emergency preparedness in Myanmar.
33. 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



Figure 1. Results Chain



B. Project Components

34. 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 (see Annex 3). 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 mapping shows that the majority of the development assistance has been mobilized for case detection, risk communication, and national laboratory. 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.

35. 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. Annex 5 discusses more in-depth how the project components address inclusion and gender issues.

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

36. 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.

37. 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 distribution of ICU beds to be supported will be approximately proportionate to the size of the population, their vulnerabilities or risks specific to COVID-19, catchment area of the hospital, gaps identified according to the hospital preparedness assessment, etc.

38. 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 as well as people affected by displacement, who are unlikely to access central level facilities. This access will be enabled by improved referral pathways which will be supported under Component 2.

39. 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 locations.¹¹ Infection prevention and control practices instituted within the facilities will take into consideration protection of accompanying family members and care-givers of patients, who are often women, to ensure appropriate hygiene and physical distancing between all present within the hospital premises. This will help to reduce risk of transmission by those who are potentially infected with COVID19 but are asymptomatic. 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.

40. 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

¹¹ 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.



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. List of central and region/state level hospitals to be financed by the project is described in Annex 4.

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

41. 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, 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.

42. 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 EHPs and MOHS healthcare providers would 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. MOHS will also be supported in its collaboration with Ministry of Social Welfare, Relief and Resettlement (MSWRR) on implementation of MSWRR's recently developed "Action Plan for the Control of COVID-19 Outbreak at IDP camps", which aims to promote risk communication, conduct surveillance, improve preparedness for quarantine facilities and protective supplies, provide immediate care and establish referral arrangements. Together the improvement of ICU capacity, referral guidelines and collaboration across healthcare providers in all states and with MSWRR for IDP camp settings or temporary shelters, along with complementary support to emergency referral from ACCESS, will increase access to treatment for people residing in rural, remote and conflict-affected areas and IDPs in temporary shelters.

43. 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.



44. 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.

45. 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. Other uses of ICT will include communicating, where appropriate, any relevant accommodation or support available to care-seekers, such as protocol for safe transport of patients across conflict lines, translation assistance at the hospital and emergency referrals support for the cost of transport. The guidelines on data privacy will be duly followed.

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

46. **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. Annex 2 provides a chart summarizing the project management arrangement.

47. **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. This communication will be made available in languages most relevant to local areas, particularly in diverse and conflict-affected areas of the country, where proficiency in Burmese language is not common.

48. **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.

C. Project Beneficiaries

49. The expected project beneficiaries will be people who are infected by COVID-19 and their families; people who are at higher risk of getting ill, hospitalized, and dying from COVID-19, such as the elderly and people with chronic health conditions; medical and emergency personnel; and health care facilities. The beneficiaries also include those living in conflict affected areas and IDPs in temporary shelters, as access to appropriate clinical care will be facilitated by referral pathways that are developed specifically to be suited to the local context, in discussion with local authorities and existing health providers, such as NGOs and EHPs. The proposed project will cover 8 Central level hospitals and 43 region/state level hospitals, across all 17 Regions and States, with implementation rolled out in a phased manner, starting with most at risk areas, such as densely populated areas and areas with frequent travel and migration.

IV. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

50. 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.

51. 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.

52. 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.

53. 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.

54. 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.

B. Results Monitoring and Evaluation Arrangements

55. **M&E Responsibility.** DMS, with the support of the PMT, will be responsible for the overall M&E of the project. It will undertake the following activities: (i) collect and compile data related to project indicators; (ii) provide regular update to the Project Oversight Committee; and (iii) share the progress and results of the activities to the WB on a quarterly basis.

56. **Project Supervision and implementation support:** Given the nature of outbreak and public health measures put in place, in terms of travel restrictions, the implementation support of the project is expected to face some challenges. The WB Myanmar office, however, has an extensive team of technical, operational, and fiduciary specialists--staff and consultants--who will be able to provide attention and problem-solving support daily. Also given a long-standing collaborative relationship with development partners, WB will continue to coordinate with respect to providing implementation support jointly with the UN partners and others also heavily engaged in COVID-19 response in Myanmar. In addition, the project will follow the supervision arrangements as outlined in the Global MPA.

C. Sustainability

57. The proposed project will strengthen public health system through enhancing hospital preparedness to respond to the COVID-19 emergency. The improvement in physical and human capacity in the clinical management will also lead to greater capacity for the MOHS to combat any future disease outbreaks. In addition, the improvement in infection prevention and control measures will be beneficial to MOHS' overall quality of healthcare services, not just for outbreaks. To ensure sustainability of the capital investments under Component 1, the MOHS is already anticipating and will be reflecting the operational or running costs of the ICU facilities within the hospitals – e.g.,



utilities, maintenance, staffing, etc. under its own Ministry budget through the annual budget appropriations. The investments under the project are in complementarity to the other investments under ongoing EHSAP and the proposed EHSAP AF, where the focus is on health systems strengthening and capacity building for fully functional health service delivery infrastructure at the primary health care level.

58. The COVID-19 pandemic has also captured attention at the highest level of the Government through the State Counsellor chairing the National level Central Committee on Prevention, Control and Treatment of COVID-19 and mobilization of the whole-of-government and whole-of-society approach. COVID-19 has raised awareness among the government as well as the public about the importance of pandemic preparedness and the critical need to strengthen the public health system, especially the preparedness of the hospitals for public health emergencies. This agenda will be receiving continued attention and support in the coming years and it is expected that more public financing would be directed towards pandemic preparedness.

V. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

59. Although there are very significant gaps in knowledge of the scope and features of the COVID-19 pandemic, it is apparent that one main set of economic effects will derive from increased sickness and death among humans and the impact this will have on the potential output of the global economy. In the Spanish Influenza pandemic (1918-19) 50 million people died - about 2.5 percent of the then global population of 1.8 billion. The most direct impact would be through the impact of increased illness and mortality on the size and productivity of the world labor force. The loss of productivity as a result of illness which, even in normal influenza episodes is estimated to be ten times as large as all other costs combined will be quite significant.

60. Another significant set of economic impacts will result from the uncoordinated efforts of private individuals to avoid becoming infected or to survive the results of infection. The Severe Acute Respiratory Syndrome (SARS) outbreak of 2003 provides a good example. The number of deaths due to SARS was estimated at “only” 800 deaths and it resulted in economic losses of about 0.5 percent of annual GDP for the entire East Asia region, concentrated in the second quarter. The measures that people took resulted in a severe demand shock for services sectors, such as tourism, mass transportation, retail sales, and increased business costs due to workplace absenteeism, disruption of production processes and shifts to more costly procedures. Prompt and transparent public information policy can reduce economic losses.

61. Myanmar, like most countries facing COVID-19 cases, faces difficult short-term tradeoffs in terms of public health measures and economic activity. Curbing the spread of the disease will limit health costs; however, social distancing and public containment measures may have significant macroeconomic costs. Nevertheless, early action to stop the virus’ spread can limit the duration of the economic slowdown.

B. Fiduciary

(i) Financial Management

62. The project will be implemented by DMS with fiduciary support from the PMT. Staff from the Finance Section of DMS have an extensive experience working with the ongoing IDA-financed EHSAP (P149960). In terms of staffing



for financial management (FM) function of the project, designated finance staff from this Finance Section have been assigned as part of the PMT to carry out FM function, i.e., a Deputy Director and two Staff Officers will be responsible for the project FM and the Director of Finance will be in charge of the overall project FM matters and take oversight FM function of the project.

63. **Fund Flow and disbursement arrangement.** A segregated Designated Account (DA) in USD will be opened at the Myanmar Economic Bank to receive IDA funds. The PMT at Union level will manage the DA and subsequent channeling of the funds from DA to the Project Operation Account (i.e., Other Account/OA) in MMK. The disbursement will be based on the statement of expenditures (SOE). The ceiling of the DA is variable which is based on the project needs and to be approved by the Association. Funds from the OA will flow into MD account of DMS and later transfer to the MD accounts of the respective hospitals at Central, States and Regions based on their requests of funds. Frequency of reporting from DA is semi-annual. The Minimum value of application for Direct payment, Reimbursement and Special Commitment is US\$50,000 equivalent. No minimum threshold will be applicable to Mandatory Direct Payment contracts. If the MOHS contracts an UN agency to implement the Component 1, the payment to UN agency will follow the payment schedule in the “Agreement for Delivery of Outputs” between the Government and the UN agency.

64. **Financial Reporting and External Audit.** PMT will be responsible for overall FM and financial reporting. PMT will prepare Interim Unaudited Financial Reports – according to the simple templates that are being used for inputs-based operation under ongoing EHSAP - every six months and submit these reports to the WBG within 60 days of the end of each six-month period (semester). The project annual financial statements – which cover all three Components - will be prepared and submitted to the Office of the Auditor General of the Union of Myanmar within three months after the fiscal year ends. If UN agencies are contracted to provide goods and works under Component 1, UN’s FM procedures will be applied. Therefore, UN agencies will arrange audit and then, their audited financial reports will be shared with the MOHS and the World Bank. The audited financial statements and the management letters of the whole project will be submitted to the WBG within nine months after the end of each fiscal year.

65. **Retroactive Financing.** A clause on retroactive financing has been included in the Loan Agreement as governed by Bank Policy, Investment Project Financing, October 1, 2018. The Project will utilize retroactive financing, if needed, up to US\$ 20 million equivalent (SDR 14.68 million) for the expenses incurred under all three Components for payments made by the Borrower on or after January 31, 2020, but in no case more than 12 months prior to the Signing of the Loan Agreement. Procurement of eligible expenditures have to be conducted in compliance with the World Bank’s Procurement Regulations for IPF Borrowers for Goods, Works, Non-Consulting and Consulting Services, dated July 1, 2016 (revised in November 2017 and August 2018). For contracts already signed but that did not include the application of the ACG and the Bank’s Sanction framework, it will be sufficient for each supplier/contractor/consultant to sign a Letter of Acceptance of the World Bank’s Anti-Corruption Guidelines and Sanctions Framework.

66. **Key identified risks and proposed mitigation measures.** The project FM residual risk after mitigation is Substantial. The following three key risks are identified: (1) Assets Procurement: if Direct Contracting is used in procuring assets by the project, then there may be risks that (a) the purchases are overpriced, and (b) the contract management (including monitoring of contract performance, payments, etc.) may not be effectively done; (2) Assets management: (a) demands of ICU equipment and other support equipment and tools (Goods) may not be properly identified, (b) The procured goods may not be delivered to the needy hospital and medical institutes timely, (c) The goods delivered may not be properly used due to potential inadequate training for end-users, and (d) They may not be properly maintained and monitored; and (3) the current budgeting process of the government pose challenges to rapid/advanced procurement and payments. The mitigation measures proposed are: (1) if Direct Contracting is



conducted, close support from the Bank procurement team to the MOHS in contract negotiation, close monitoring of contract performance, and a thorough procurement post review will be done to ascertain value for money and compliance to the Bank procedures; (2) the Government Medical Assets Management in particular for the goods will be developed and issued by 30 April 2020; (3) identification of lists of medical equipment and goods for acute care /ICU facility is done in accordance with the national and international standards; (4) agreement with UN agencies and other vendors, whenever possible, will include the delivery of the goods to the location of intended facilities; (5) health staff and technicians at these hospitals will be trained in the proper use and management of equipment by MOHS using its own resources even before this project and as part of project component 2, and monitoring plan under component 3 will include this aspect; (6) DMS will ensure hospitals include sufficient maintenance budget in the annual budget appropriations; and (7) The amendment/ addition of budget allocation will be made for the FY2019-2020 and FY2020-2021 to allow for the project procurement and payment.

(ii) Procurement

67. Procurement for the project will be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers for Goods, Works, Non-Consulting and Consulting Services, dated July 1, 2016 (revised in November 2017 and August 2018). The Project will be subject to the World Bank's Anti-Corruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. The Project will use the Systematic tracking of Exchanges in Procurement (STEP) to plan, record and track procurement transactions.

68. The major planned procurement includes medical and laboratory equipment, minor works to retrofit or refurbish existing wing or room within the existing hospital infrastructure and footprint, capacity building and training, community outreach, and support to the project implementation and monitoring. No new structures or construction are anticipated. Finalization of the streamlined Project Procurement Strategy for Development (PPSD) has been deferred to implementation. An initial procurement plan for the first six months has been agreed with the Borrower and will be updated during implementation.

69. The proposed procurement approach prioritizes fast track emergency procurement for the required goods, works and services. Key measures to fast track procurement include (i) use of simple and fast procurement and selection methods fit for an emergency situation including direct contracting, as appropriate, (ii) streamlined competitive procedures with shorter bidding time, (iii) use of framework agreements including existing ones, (iv) procurement from UN Agencies enabled and expedited by Bank procedures and templates, (v) use of procurement agents, (vi) force account, as needed, and (vii) increased thresholds for Requests For Quotations and national procurement among others, as well as minimal or no prior review for emergency procurement. As requested by the borrower, the Bank will provide procurement hands-on expanded implementation support to help expedite all stages of procurement – from help with supplier identification, to support for bidding/selection and/or negotiations to contract signing and monitoring of implementation

70. The project may be significantly constrained in purchasing critically needed supplies and materials due to significant disruption in the supply chain, especially for PPE. The supply problems that have initially impacted PPE are emerging for other medical products (e.g. reagents and possibly oxygen) and more complex equipment (e.g. ventilators) where manufacturing capacity is being fully allocated by rapid orders from other countries.

71. Upon the Borrower's request, in addition to the above procurement approach options, the Bank has agreed to provide Bank Facilitated Procurement (BFP) to proactively assist the implementing agency(ies) in accessing existing supply chains for the agreed list of critical medical consumables and equipment needed under the project. Once the



suppliers are identified, the Bank will proactively support borrowers with negotiating prices and other contract conditions. The Borrowers will remain fully responsible for signing and entering into contracts and implementation, including assuring relevant logistics with suppliers such as arranging the necessary freight/shipment of the goods to their destination, receiving and inspecting the goods and paying the suppliers, with the direct payment by the Bank disbursement option available to them. If needed, the Bank may also provide hands-on support to the implementing agency in contracting to outsource logistics.

72. BFP to access available supplies may include aggregating demand across participating countries, whenever possible, extensive market engagement to identify suppliers from the private sector and UN Agencies. The Bank is coordinating closely with the WHO and other UN agencies (specifically WHO and UNICEF) that have established systems for procuring medical supplies and charge a fee which varies across agencies and type of service and can be negotiated (around 5% on average.) In addition, the Bank may help borrowers access governments' available stock.

73. In providing BFP the Bank will remain within its operational boundaries and mandate which already include expanded hands-on implementation support to help borrowers achieve the project's development objectives. Procurement for goods/works and services outside this list will follow the Bank's standard procurement arrangements with the Borrower responsible for all procurement steps (or with normal Hands-on Implementation support, as applicable).

74. Procurement under the project will be carried out by DMS, a key implementing department for the project in MOHS. Streamlined procedures for approval of emergency procurement to expedite decision making and approvals by the Borrower have been agreed.

75. The procurement risk rating for the project is substantial. The major risks to procurement are: (1) fragile operating environment with limited institutional structures and inadequate procurement policies demonstrated through the absence of unified and comprehensive procurement regulations to guide procurement implementation; (2) weak accountability structures for procurement decisions; (3) overly heavy bureaucracy in Government in processing procurement contracts; (4) absence of institutional structures and procedures for handling complaints; (5) delayed delivery of goods due to disruption of the supply chains impacted by the COVID-19 pandemic resulting in rapid and unplanned orders globally by affected countries; and (6) inadequate procurement skills for urgent emergency response.

76. To mitigate the risks, the Borrower proposes to (1) use a mix of measures outlined above for fast track emergency procurement of medical equipment and retrofitting of ICU facilities - e.g., UN agencies, BFP, streamlined national procurement; (2) designate a PMT lead by a Project Director (Deputy Director General level) at the Department of Medical Services. The team will include operational level staff with designated responsibility for Procurement and Distribution; and (3) hire additional short term external human resources for procurement and logistics to coordinate with contracted suppliers including UN agency, the WB and MOHS and to ensure timely implementation. If Direct Contracting is used by the MOHS, the Bank procurement team would provide close support to the MOHS to negotiate contract at reasonable prices, quality and delivery times. The task team would also closely monitor the performance of the contracts to ensure that there are minimal cost and time overruns and overall effective contract management. Given that all procurements are categorized as post review due to the emergency nature of this operation, a thorough procurement post review would be conducted on the project during and after the project implementation to ascertain value for money and compliance to the Bank procedures. More details on procurement approach, risk rating and mitigation measures will be elaborated in the PPSD.



C. Legal Operational Policies

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

D. Environmental and Social Standards

77. Consistent with the ESF policy, Environmental and Social activities will be timed and sequenced to fit the needs and risks of the project, with a particular focus 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 Environmental and Social Management Framework (ESMF), and standardized and streamlined Environment and Social documentation as much as feasible, such as development of a HCWM 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, a basic stakeholder engagement plan has been prepared and will be updated prior to project effectiveness.

VI. GRIEVANCE REDRESS SERVICES

78. Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the Bank’s Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the Bank’s independent Inspection Panel which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the Bank’s corporate Grievance Redress Service (GRS), please visit: <http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service>. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.



VII. KEY RISKS

79. The **overall project risk rating is Substantial**. Key risks in the eight categories are assessed as follows. Risks related to sector strategies and policies and stakeholders are rated as **Moderate**, whereas risks related to macroeconomic, political and governance, institutional capacity, technical design, fiduciary, and environment and social as **Substantial**.

80. **Macro, Political and Governance Risks**. The proposed project will be operating in a country context marked by high poverty, limited public sector capacity and conflict. There is considerable degree of risks inherent in implementing an emergency project of this nature, and important mitigation measures have been integrated into its design. Project activities will strengthen the health system and enhance protection of individuals and families against the severe illness and death due to COVID-19, and therefore, may afford some mitigation for the size and productivity of labor force. The factors outlined in the technical, economic and financial analysis, however, leave the **macro-economic residual risk as substantial**. In addition, there are strong indications that the government at its highest level is committed to provide resources to core COVID-19 response measures and to delivering essential health service. For immediate term, assistance has also been mobilized in the form of grants and loans from development partners and donations from the private sector and individuals into the COVID-19 Emergency Fund, led by the State Counsellor. In addition, the chair of the Central Committee on Prevention, Control and Treatment of COVID-19 within a week of its formation was upgraded from the Ministers of International Cooperation and Health and Sports to the State Counsellor; this change further facilitate the whole-of-government approach in the response. National level working committee was also established immediately to address the economic consequences of the global pandemic on Myanmar. Although there is the highest political commitment to the COVID-19 response as reflected above, due to nascent accountability and feedback measures to ensure that resources required for COVID-19 response activities reach intended health care facilities and beneficiaries, the residual risk for **political and governance is rated as Substantial**. To further mitigate this risk, the project will support ICT-empowered information sharing and grievance redress mechanism platforms that are targeted for the public and private sector health providers/facilities across the country, the general public, the civil society organizations including EHPs, and populations living in areas not under government administration.

81. **Institutional risk, even after mitigation measures, also remains substantial**, as MOHS continue to face management and human resource challenges to effectively manage and coordinate intra- and inter-agency activities. As mitigation measures, clear institutional and implementation arrangements for the project have been defined within DMS, the key entity responsible for implementation. The project will also support technical assistance on project management, including clear plans for monitoring the implementation progress and results. R/S health departments will be given clear responsibility and delegated authority to manage and oversee the project activities in the hospitals under their control. For timely and clear communication and information sharing about the project at all levels of implementation, project-specific email distribution list will be used. Scaling up of ICU capacity in referral level hospitals is inherently a more complex undertaking compared to other elements of the COVID-19 response strategy. There are risks of not having adequate skilled human resources and sufficient quantity of drugs and other medical inputs needed to make the supported ICU facilities to be fully functional. Mitigation measures include close coordination on various contributions and efforts undertaken by all the development partners, private donors including Government's own resources to facilitate access to essential laboratory and medical supplies; protection, capacity building and operational support to health workers; coordinating and facilitating technical assistance from multilateral and bilateral agencies, such as WHO, US-CDC, Public Health England, and JICA; and modifications and redesign as needed, based on the detailed analysis of the referral hospital capacities and gaps.

82. **Key fiduciary risks** are related to the disruption of global supply chains as well as other factors that impede rapid procurement and payment--such as fragile operating environment, inadequate government procurement infrastructure,



policies and regulations, insufficient human resources, heavy bureaucracy in processing procurement contracts and budgeting. For mitigation, the project will use a mix of measures available under the fast track emergency procurement. In order to increase the chance of success at getting the necessary equipment and supplies from the global supply chain, the PMT will be put in place. It will be led by a Project Director (Deputy Director General level) at the DMS and will include operational level staff with designated responsibility for procurement and FM. Additional short term external human resources would also be recruited to coordinate with contracted supplier(s), the WB and MOHS and to ensure timely implementation. High demand for and insufficient supply of essential medical equipment for acute care services at the global level, however, justifies the residual risk as Substantial.

83. ***Environment and Social risks are Substantial.*** Key social risks include the possible exclusion of vulnerable groups including ethnic groups residing in remote areas where there is limited access to health services, others residing in locations that are affected by conflict (including internally displaced persons) or under the control of ethnic armed organizations, the elderly and those with underlying medical conditions, returning migrants, prisoners and rural residents with only limited access to primary care. Both project workers, and communities surrounding facilities supported by the project, may be exposed to the increased spread of coronavirus and resulting disease, due to poor implementation of protections for health care providers and increased volume of medical waste. Mitigation measures on environment focus on health care waste management; capacity to manage potential risks; and the contextual concerns over the severity of the potential outbreak and ability to manage the case load. Environment risk mitigation will be through application of and building on the recently developed HCWM guidelines, which were supported by the ongoing EHSAP. On Social risks, GOM provides testing and treatment for COVID-19 to everyone at no cost. Component 2 of the project will review referral services considering equity and severity of case risks, identify and develop protocols for the referral and physical transportation of COVID-19 patients across boundaries of control to reach an equipped referral hospital. It will also support the preparation of culturally appropriate and tailored risk communication and engagement material. Moreover, project will support and develop labor management procedures that includes occupational health and safety measures for project workers and measures to protect the broader community health and safety in the project ESMF.



VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Myanmar
Myanmar COVID-19 Emergency Response Project

Project Development Objective(s)

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

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
Increased capacity of health care facilities			
Acute healthcare facilities with isolation capacity (Number)		0.00	50.00
Acute healthcare facilities with triage capacity (Number)		0.00	50.00
Diagnosed cases treated in health facilities (Number)		0.00	200.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
Hospital Preparedness			
Facilities with access to safe water and basic sanitation services (Number)		0.00	50.00



Indicator Name	DLI	Baseline	End Target
Hospitals with refurbished and equipped ICU (Number)		0.00	50.00
Capacity Building and Community Engagement			
Staff trained in infection prevention and control and health care waste management (Number)		0.00	500.00
Hospitals with improved assets management (Number)		0.00	50.00
Region/States engaging communities about emergency services through use of ICT (Number)		0.00	14.00
Referral system to care for COVID-19 patients established and functional (Yes/No)		No	Yes
Project Management and M&E			
M&E system established to monitor COVID-19 preparedness and response plan (Contingency Plan) (Yes/No)		No	Yes

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Acute healthcare facilities with isolation capacity	Acute healthcare facilities--central and region/state levels--with isolation capacity	Monthly	Supervision Reports	Observation using checklist	Department of Medical Services
Acute healthcare facilities with triage capacity	Hospitals--central and region/state levels--using clear triage protocol and checklist (e.g. infection	Monthly	Supervision report	Observation using checklist	Department of Medical Services



	control measure) and designated area for triage				
Diagnosed cases treated in health facilities	Diagnosed cases treated in accordance with national protocol of in health facilities receiving support from the project. As advised, the end target is set conservatively to account for the challenge in estimating an accurate target	Monthly	Hospital information systems	Compilation of the data from hospital information system	Department of Medical Services

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Facilities with access to safe water and basic sanitation services	Hospitals have ease of access to hand washing station, safe water supply and sanitation (dis-aggregated by Central and Region/State)	Monthly	Supervision visits	Observation using check-list	Department of Medical Services
Hospitals with refurbished and equipped ICU	Number of hospitals with refurbished and equipped ICU (dis-aggregated by central and state/region levels)	Monthly	Project Progress Report	Site visits and documentation	Department of Medical Services
Staff trained in infection prevention and control and health care waste management	Hospital staff trained in infection prevention and control and health care	Quarterly	Training reports	Documentation from training sessions	Department of Medical Services



	waste management (dis-aggregated by gender and ethnicity)				
Hospitals with improved assets management	Hospitals are monitored for asset management using checklist based on MOHS guidelines (dis-aggregated by central and region/state)	Six months	Supervision checklist	Supervision visits using checklist	Department of Medical Services
Region/States engaging communities about emergency services through use of ICT	Region/State Health Departments engaging communities about emergency services using locally contextualized messages using social media, SMS and other ICT platforms.	Monthly	Region/State Health Department reports	Compilation of messages and ICT initiatives	Region/State Health Department
Referral system to care for COVID-19 patients established and functional	Referral guidelines adapted and utilized (number of referral cases following guidelines)	Monthly	Hospital Information System	Administrative data	Department of Medical Services
M&E system established to monitor COVID-19 preparedness and response plan (Contingency Plan)	Regular reporting from M&E system on hospital preparedness for public health emergencies	Quarterly	Progress Report	Compilation based standard template	Department of Medical Services





ANNEX 1: Project Costs

COUNTRY: Myanmar
Myanmar COVID-19 Emergency Response Project

COSTS AND FINANCING OF THE COUNTRY PROJECT

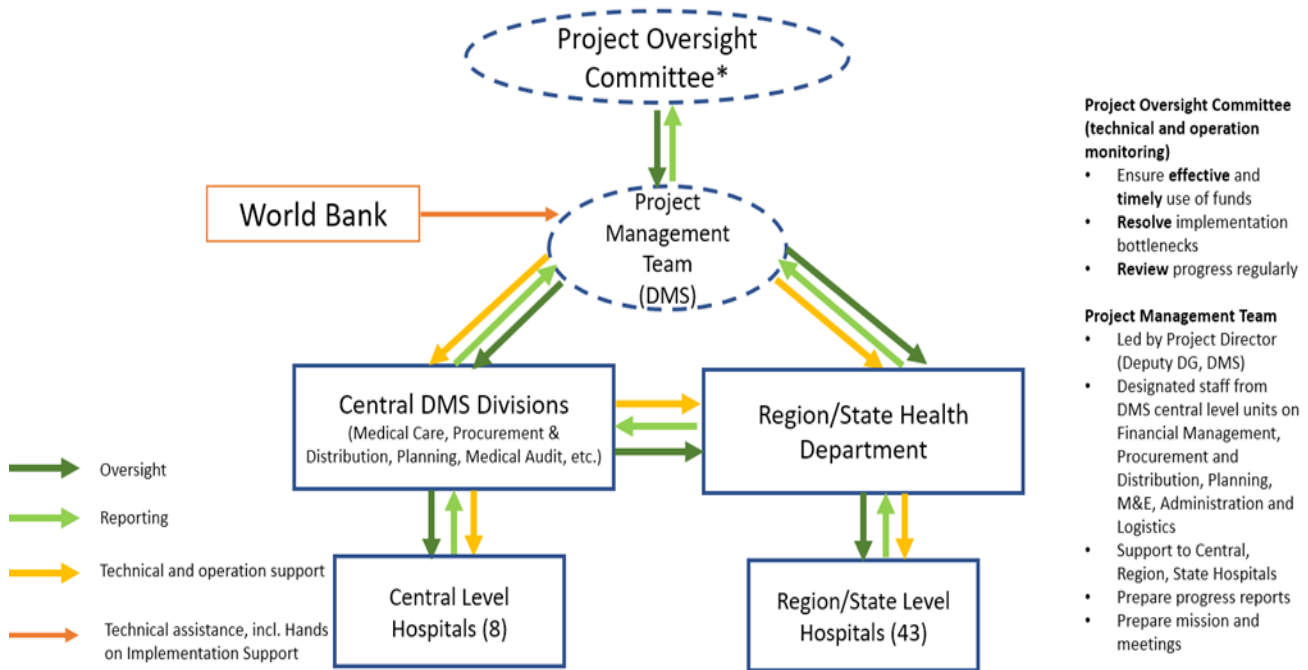
Program Components	Project Cost	IBRD or IDA Financing	Trust Funds	Counter part Funding
Component 1: Hospital Preparedness to respond to COVID-19	48.5	48.5		
Component 2: Capacity Building and Community Engagement	1.0	1.0		
Component 3: Project Management and M&E	0.5	0.5		
Total Costs	50	50		
	Total Costs	50		
	Front End Fees	0		
	Total Financing Required	50		



ANNEX 2: Implementation Arrangements and Support Plan

1. Implementation and project management arrangements are demonstrated in a chart below.

Implementation arrangements: Project Management



* Project Oversight Committee is the same structure established to provide integrated and coordinated oversight to all the operations financed by the IDA (EHSAP, AF, COVID)

2. **Implementation Support Strategy and Plan.** The project will require intensive implementation support and regular communication between with the client and Bank team. It will rely heavily on the country-based task team leader and technical staff and consultants, who are already known and trusted by the client. In addition to daily exchange, there will be formal missions to provide implementation support to ensure timely technical and operation support. Implementation support will include (a) a mission every three months--this is possible with a team based in-country; (b) interim technical discussions and field visits by the World Bank; (c) monitoring and reporting by the DMS on implementation progress and achievement of results; (e) annual financial audits and FM reporting; and (f) periodic procurement post review. Furthermore, implementation support would rely on ongoing collaboration and coordination with partners that are actively engaged in implementing emergency health activities in the country, such as UN agencies, NGOs, and CBOs. In the immediate and short term, there is a recognition that all stakeholders--government, development partners, and the Bank--will experience challenges in providing technical and operational support and monitoring progress, as everyone is faced with travel restrictions and social distancing measures. However, a strong existing in-country partnerships would help to overcome some of these challenges. Furthermore, WB's *Streamlined Fiduciary Implementation Support Measures for Active Bank-financed Operations given Travel Limitations due to COVID-19 Pandemic* (issued March 24, 2020) would facilitate implementation.



3. The following table details the skills required and the team membership to be considered for implementation support. There will be hands-on support on procurement, particularly on contract management skills, FM, and social and environmental safeguards.

Team Composition

Skills Needed	No. of Staff Weeks	Number of Missions	Comments
Task team leaders	15	Continuous mission	Country-based
Health Security consultant	25	Continuous mission	Country-based
Operations/project management consultant	25	Continuous mission	Country-based
Emergency care consultant	5	Twice a year	Based in the region
Procurement specialist	3	As needed	Country-based
Procurement consultant	6	Three times a year	Consultant in the region
FM specialist	3	Twice a year	Based in the region
Social safeguards specialist	5	Three times a year	Based in the region
Environmental safeguard specialist	5	Three times a year	Based in the region
Program Assistant	5	Once a year	Country-based



**ANNEX 3: Summary of the Contingency Plan and Proposed External Assistance
Working Document (Draft)**

Summary of Technical Areas and Activities Myanmar Health Sector Contingency Plan for COVID-19	COVID-19 SPRP Components	Estimated Cost (US\$)	EXTERNAL ASSISTANCE
<p>EPIDEMIOLOGICAL SURVEILLANCE & POINT OF ENTRY (POE)</p> <p>Temperature screening at POE, active case detection according to national suspected/case definition, contact tracing, quarantine of close contacts and isolation of suspected cases at a designated public healthcare facility, restricted non-essential travels to prevent, etc.</p> <p>Mobilization and capacity building of Surveillance Rapid Response Teams. Development and dissemination of guidelines and checklists.</p> <p>Social distancing to reduce the overall impact on the community/ delivery of essential healthcare services. Monitoring the geographical spread of the virus, transmission intensity, disease trends, virologic features and impact on health-care services.</p> <p>Epidemiological analysis to identify the factors related to spread of infection and contact tracing from the patients.</p> <p>Surge capacity for surveillance and response shall be strengthened by real time electronic surveillance system, expanded SARI sites, additional work forces such as GPs, volunteers and EHPs/CBOs to support functions of central epidemiology unit, SCU and RRTs.</p>	<p>Case detection, case confirmation, contact tracing, case recording, case reporting</p> <p>Social distancing measures</p>	<p align="center">17.5 M</p>	<p>USAID, UNICEF GAVI, GF/UNOPS ACCESS/UNOPS, WHO ICRC, ADB, and WB (EHSAP)</p>
<p>NATIONAL LABORATORY SYSTEM</p> <p>Sampling strategy - National Health Laboratory (NHL) distributed SOPs/guidelines for sample collection, packaging, and transportation, as well as developing laboratory request forms for hospitals.</p> <p>Staff training -NHL and all laboratory personnel from public hospitals on biosafety, sample collection and transportation, diagnosis and testing, IPC guidelines.</p> <p>Guidelines on biosafety, lab procedures, SOPs, protocols developed and disseminated.</p> <p>Surge Plan for increasing testing volume - Mobilizing for additional human resources from relevant health departments and lab staff from unaffected S/R.</p> <p>Equipping Public Health Laboratory in Mandalay, in addition to NHL.</p> <p>Testing equipment and supplies</p>	<p>Case detection, case confirmation, contact tracing, case recording, case reporting</p>	<p align="center">3.25 M</p>	<p>WHO, JICA, ADB, US-CDC, USAID, Mahidol, Oxford Tropical Med Research, ACCESS/UNOPS, GF/UNOPS</p>
<p>CLINICAL MANAGEMENT AND MEDICAL CARE SERVICES</p> <p>Referral pathway - Clear referral guidelines, including for referral from EHPs and areas not under government administration.</p> <p>Accelerate capacity building measures - Focal points at S/R HDs and at central hospitals to obtain information in a timely manner. Hotline number for timely communication and access of information to and from all hospitals. Guidelines and protocols development.</p> <p>Supply and distribution -Supply and distribution of ventilators to national/S/R hospitals with ICUs. Supply of equipment and supportive equipment (Personal Protective Equipment (PPE), VTM, Guidelines, posters, etc.)</p> <p>Managing Surge Capacities at Hospitals - Training /refresher training for health care providers. ICU staff in S/R hospitals. Upgrading the hospitals including isolation wards and ICU units. Awareness campaigns among health care providers and community.</p> <p>Procurement of PPE, hand hygiene materials and other IPC materials</p>	<p>Health systems strengthening</p>	<p align="center">97.0 M</p>	<p>GF/UNOPS, ACCESS/UNOPS, ADB, and WB (COVID-19 ERP)</p>



<p align="center">Summary of Technical Areas and Activities Myanmar Health Sector Contingency Plan for COVID-19</p>	<p align="center">COVID-19 SPRP Components</p>	<p align="center">Estimated Cost (US\$)</p>	<p align="center">EXTERNAL ASSISTANCE</p>
<p>INFECTION PREVENTION & CONTROL (IPC) Establishment of IPC structure; Training; Action Plan developed for the implementation of IPC activities. IEC materials on proper handwashing, hand hygiene posters, hospital infection control guidelines. IPC compliance through regular monitoring and supervision of IPC activities. Healthcare-Associated Infection surveillance. Triage/early recognition/ Source control - Management protocol for COVID-19 / standard operating procedure including IPC released. Implementing triage, early detection and infectious-source controls, administrative controls and engineering controls, health education to patients and family members about respiratory symptoms and respiratory etiquette.</p>	<p>Health systems strengthening</p>		<p>ACCESS/UNOPS GF/UNOPS, USAID, ADB, and WB (EHSAP AF)</p>
<p>NON-PHARMACEUTICAL PUBLIC HEALTH INTERVENTIONS Hand hygiene, respiratory etiquette/face masks, health advice for travelers, voluntary self-quarantine, surface/object cleaning, school closures, workplace closures and other measures</p>	<p>Risk Communication Preparedness</p>	<p align="center">37.3M</p>	<p>UNICEF GAVI WORLD BANK</p>
<p>RISK COMMUNICATION Health Literacy Promotion Framework against COVID-19 was developed in January 2020 with key messages to specific targeted audiences using simple, short and straight forward messages and IEC materials. Assessments of risk perception, KAP and preventive behaviors in communities, especially among the most vulnerable groups. Strengthen risk communication capacities at national and sub-nation level. Assign and train focal persons. Involve non-government stakeholders for risk communications</p>	<p>Community Engagement Risk Communication</p>	<p align="center">0.50 M</p>	<p>UNICEF ADB ICRC</p>
<p>OPERATIONAL SUPPORT AND LOGISTICS MANAGEMENT Procurement, supply chain and distribution system for fast-track processes for timely response for COVID-19. Establishing an emergency fast-track supply chain mechanism. Stockpiling, storage, security, transportation and distribution arrangements, as well as capacity assessment of suppliers to ensure availability of needed supplies. Exploring international supply chains and markets through regional and global supply chain mechanism (e.g. UNOPS, ICRC supply chain network)</p>	<p>Project management</p>	<p align="center">0.45M</p>	<p>WORLD BANK</p>
<p align="right">ESTIMATED TOTAL COST</p>		<p align="center">156 M</p>	



ANNEX 4: List of Hospitals to be Financed under the Proposed Project

SN	Central Level	Hospital Capacity (# of Beds)	ICU Beds to be supported by the Project
1	Yangon General Hospital	2000	10
2	Mandalay General Hospital	1500	10
3	North Okkala General Hospital	800	10
4	Naypyitaw General Hospital	1000	10
5	Yangon Specialist Hospital	500	10
6	Thingangyun General Hospital	500	10
7	Insein General Hospital	500	10
8	Magway Teaching Hospital	200	10
Sub-Total (Central level)			80
1	Myitkyina General Hospital, Kachin State	500	6
2	Bamaw General Hospital, Kachin State	200	6
3	Loikaw General Hospital, Kayah State	500	6
4	Hpa-an General Hospital, Kayin State	200	6
5	Pha-lan General Hospital, Chin State	200	6
6	Hakha General Hospital, Chin State	200	6
7	Monywa General Hospital, Sagaing Region	500	6
8	Kalay General Hospital, Sagaing Region	300	6
9	Sagaing General Hospital, Sagaing Region	200	6
10	Shwe Bo General Hospital, Sagaing Region	200	6
11	Dawei General Hospital, Tanintharyi Region	200	6
12	Myeik General Hospital, Tanintharyi Region	200	6
13	Bago General Hospital, Bago Region	500	6
14	Pyay General Hospital, Bago Region	500	6
15	Taung-U General Hospital, Bago Region	200	6
16	Magway General Hospital, Magway Region	200	6
17	Minnbu General Hospital, Magway Region	200	6
18	Pakkoku General Hospital, Magway Region	200	6
19	Pyinoolwin General Hospital, Mandalay Region	300	6
20	Kyaukse General Hospital, Mandalay Region	200	6
21	Nyaung-U General Hospital, Mandalay Region	200	6
22	Meithtila General Hospital, Mandalay Region	200	6
23	Mawlamyine General Hospital, Mon State	500	6
24	Mawlamyine Women and Children Hospital, Mon State	200	6
25	Sittwe General Hospital, Rakhine State	500	6
26	Kyaukphyu General Hospital, Rakhine State	200	6
27	Waibagi Specialist Hospital, Yangon Region	200	6
28	East General Hospital, Yangon Region	200	6
29	West General Hospital, Yangon Region	200	6
30	Hlaingtharyar General Hospital, Yangon Region	200	6
31	Thanlyin General Hospital, Yangon Region	200	6
32	Loilin General Hospital, Shan South State	200	6
33	Women and Children Hospital, Shan South State	200	6
34	Lashio General Hospital, Shan North State	500	6
35	Kengtong General Hospital, Shan East State	200	6
36	Pathein General Hospital, Ayeyarwady Region	500	6
37	Maubin General Hospital, Ayeyarwady Region	200	6
38	Myaungmya General Hospital, Ayeyarwady Region	200	6
39	Labutta General Hospital, Ayeyarwady Region	200	6
40	Phyarpon General Hospital, Ayeyarwady Region	200	6
41	Hinthada General Hospital, Ayeyarwady Region	200	6
42	Pyinmana General Hospital, Naypyitaw Council	200	6
43	300 bedded General Hospital, Naypyitaw Council	300	6
Sub-Total (Region/State level)			258
TOTAL NUMBER OF ICU BEDS			338



ANNEX 5: Addressing Inclusion and Gender

Country-Wide Diversity and Exclusion Issues

1. Evidence derived from the Demographic and Health Survey 2015/16, Census 2014, household surveys (IHLCA1 2005, IHLCA2 2010, MPLCS 2015, MLCS 2017) and social assessments undertaken for the EHSAP and a more recently developed social protection project to improve nutrition as well as other administrative information, all point to risks of exclusion based on the following:
2. **Geography.** Shan, Ayeyarwady, Kayin, Kachin and Rakhine have consistently lower access and poor outcomes, as shown by indicators related to basic health and nutrition services and non-monetary welfare. The infant mortality rate is 74 deaths per 1,000 live births in Shan, 66 in Ayeyarwady and Kayin, 50 in Kachin, and 47 in Rakhine compared with a national average of 40. Only 19.2 percent of live births in Rakhine, 27.6 percent in Shan, 29.5 percent in Kachin, 34 percent in Ayeyarwady, and 36.8 percent in Kayin take place in a health facility, compared with a national average of 37 percent. Among women aged 15-49, 23 percent reported distance to a health facility as a barrier in accessing health care. These geographical areas perform worse than the national average on MDI-1 (20.7):¹² 15.4 in Kachin, 24 in Shan, 27.3 in Kayin, 27.4 in Ayeyarwady, and 39.2 in Rakhine. Outcomes are lower in rural than urban areas.
3. **Conflict.** Around one-third of the 330 townships in Myanmar are affected by conflict in one shape or form. Socio-economic deprivation tends to overlap with conflict. Conflict-affected border areas face many forms of disadvantages, such as limited access to basic services and infrastructure, including clean water, education, health care, and electricity. The government's ability to access and directly provide services in some areas in Shan, Kachin, Kayin and Rakhine is limited, given the frequent occurrence of armed conflict or control by Ethnic Armed Organizations (EAOs). Rakhine State has also seen particularly high levels of violence over the last few years with violent events in August 2017 leading to the forced displacement of more than 730,000 Muslims, who self-identify as Rohingya, into Bangladesh and more recently due to fighting between the military and the Arakan Army. Due to the latter, access to townships in the central and northern part of Rakhine is tightly restricted at present. The almost one million people affected by humanitarian crisis and internal displacement in Rakhine, Chin, Kachin, Shan and Kayin States face many challenges that place them at higher risk for COVID-19. Overcrowding 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. Displaced population living in temporary shelters and camps usually have varying degree of access to basic health and education services through fixed and mobile clinics and temporary learning centers, and are also at risk of exclusion from access to quality services.
4. Ethno-religious identity, language, and citizenship/ID possession. Nationally, some ethnic minorities, non-Buddhists, non-Bamar speakers and non-citizens are found to be more at risk of exclusion from access to basic services and have poorer welfare outcomes (IHLCA2 and MPLCS). Social Assessments and past experience point to language as a ground that could lead to exclusion, unless communications materials are translated and adapted accordingly. Possession of citizenship/national ID has not ever been a prerequisite for access to public health services nor will it be a requirement for participation in the project. The project benefits are not limited to citizens¹³ and are designed in full

¹² This can be interpreted as an average person in Myanmar being disadvantaged in 20.7 percent of weighted indicators. Note that the MDI brings together 14 indicators across six domains. See MOLIP and World Bank 2018.

¹³ Non-citizens make up about 1.5 percent in Shan and 0.7 percent in Ayeyarwady, according to General Administration Department (GAD) 2017 data. This data does not include counting those people who belong to the official ethnic groups but who do not have a national registration card.



cognizance of the barriers to health service access faced by individuals without national ID.

5. **Gender.** Myanmar Demographic and Health Survey (DHS) 2015-16 noted that 31 percent of women aged 15-49 reported not wanting to go or travel alone to seek health care. The disparity of access to health services among girls and boys highlight the risks of exclusion and discrimination based on the gender of the child. In terms of gender gaps in basic health services for the children, DHS also shows that 64.8 percent of boys aged under five received advice or treatment for symptoms of acute respiratory infection, compared with 47.6 percent of girls in the same age category. Additionally, the DHS 2015-2016 indicated 21 percent of ever-married women have experienced spousal violence (15 percent physical; 14 percent emotional; 3 percent sexual). However, only 22 percent of women who have ever experienced physical or sexual violence sought help to stop the violence. A recent assessment of service provision for GBV survivors showed that there are very limited services available across the country to support survivors. Few survivors ever seek care from doctors or health clinics due to lack of healthcare access, stigma and shame.¹⁴ In the context of the outbreak, women may be even less likely to seek out GBV and health services due to fear of infection, severely limiting agency in reproductive and healthcare choices.¹⁵ Myanmar already has the second highest rates of maternal mortality in the region,¹⁶ and the COVID-19 outbreak may divert resources and skilled personnel from sexual and reproductive health to fight the pandemic.¹⁷ Due to women's frontline interactions as caregivers and healthcare providers, they also face a higher risk of exposure to COVID-19.¹⁸

6. **Poverty and Income.** A substantial portion of people do not seek care when they need it. On average, 21 percent of people who reported ill-health did not seek treatment.¹⁹ Cost is a major factor driving this decision. Not seeking care (or using inappropriate care) puts people at risk of their conditions worsening and suffering from complications or chronic ill-health. Both the DHS and the most recent Myanmar Micronutrients and Food Consumption Survey (2017-2018) indicate that nutrition outcomes and access to health services are lower among the lower income/wealth quintiles. Among the 15-49-year-old women surveyed, the leading reason for not accessing health care was stated as not having money for medical advice or treatment (34 percent). Poverty would represent a ground of exclusion when significant costs are encountered to access health care (such as the cost of transport to a health facility).

Gender Sensitivity and Inclusion Measures

7. The project is expected benefit all people in the country who are infected by COVID-19 and their families; people who are at higher risk of getting ill, hospitalized, and dying from COVID-19, such as the elderly and people with chronic health conditions; medical and emergency personnel and health providers; and health care facilities. The proposed project will cover 8 Central level hospitals and 43 region/state level hospitals, across all 17 Regions and States, with implementation rolled out in a phased manner, starting with most at risk areas, such as densely populated areas and areas with frequent travel and migration. The beneficiaries include those living in conflict affected areas and IDPs in temporary shelters, as access to appropriate care will be facilitated by referral pathways that are developed specifically to be suited to the local context, with local authorities and existing health providers, such as EHPs and NGOs. Details on inclusion approaches by project component are included below:

¹⁴ The Gender Equality Network (GEN). 2018. Service provision for Gender Based Violence Survivors in Myanmar.

¹⁵ Fraser, E. 2020. Impact of COVID-19 Pandemic on Violence Against Women and Girls. VAWG Helpdesk Research Report No. 284. 16 March, UKAID.

¹⁶ Department of Population. 2016. "Thematic Report on Maternal Mortality", 2014 Myanmar Population and Housing Census. Ministry of Immigration and Population.

¹⁷ UNFPA. 2020. Covid-19: A Gender Lens. March, UNFPA, p. 4.

¹⁸ UNFPA. 2020. Covid-19: A Gender Lens. March, UNFPA, p. 2.

¹⁹ Myanmar Household Poverty and Living Conditions Survey.



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

8. **Overview:** 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. Support key activities related to clinical management and health care services and infection prevention and control, identified and prioritized in the Health Sector Contingency Plan.

9. **Infection prevention and control to benefit all within hospital premises:** Inputs for hygiene and other protection measures 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, 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 the majority of these staff are women. Additionally, infection prevention and control practices instituted within the facilities will take into consideration protection of accompanying family members and care-givers of patients, who are often women, to ensure appropriate hygiene and physical distancing between all present within the hospital premises. This will help to reduce risk of transmission by those who are potentially infected with COVID19 but are asymptomatic.

10. **Inclusive access to treatment facilities:** The investments under the proposed project will improve proximity of treatment facilities by making an additional 338 ICU beds (including ventilators and other essential equipment) available across the country – i.e., 80 additional ICU beds at the central hospitals and 258 additional beds at region/state level hospital. More importantly, the project will increase the number of region/state level hospitals with fully functional ICU facility, therefore improving access to intensive clinical care services for all people across the country. The emphasis on supporting ICU facilities and beds at the state and region level gives priority to increasing access to people in **rural, remote and conflict-affected areas and people affected by displacement**, who are unlikely to access central level facilities. The distribution of ICU beds to be supported will be approximately proportionate to the size of the population, their vulnerabilities or risks specific to COVID-19, catchment area of the hospital, gaps identified according to the hospital preparedness assessment, etc.

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

11. **Overview:** Reinforce the clinical care capacity at the hospitals financed under the Component 1 by investing in guidelines on clinical treatment, infection prevention and control and health care waste management, and referral pathways. Capacity building of health staff at the hospitals in the use of relevant guidelines, equipment and machines in the ICU facility.

12. **Improving referral pathways to treatment facilities:** Support MOHS to review and adapt the national level referral guidelines for referral of patients and suspected cases from the areas not under government administration and from IDP camps and temporary shelters for displaced population, in consultation and collaboration with the relevant EHPs, CSOs, NGOs and UN agencies, so that people from these areas can get access to clinical care services at the public hospitals. Decades of conflict and contested control over territory mean that infrastructure for basic health, education and social services is very much underdeveloped in the conflict-affected areas and areas not under government control. 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 currently affected by conflict and internal displacement, the project will support the 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 and internally displaced persons. MOHS will also be supported in its collaboration with Ministry of Social Welfare, Relief and Resettlement (MSWRR) on implementation of MSWRR's recently developed "Action Plan for the Control of COVID-19 Outbreak at IDP camps", which aims to promote risk communication, conduct surveillance, improve preparedness for quarantine facilities and protective supplies, provide immediate care and establish referral arrangements. Together the improvement of ICU capacity, referral guidelines and collaboration across healthcare providers in all states and with MSWRR for IDP camp settings, along with complementary support to emergency referral from ACCESS, will increase access to treatment for people residing in **rural, remote and conflict-affected areas and IDP camps or temporary shelters.**

13. **Using ICT platforms to include all ethnic minorities:** 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 **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 of audio/audiovisual materials in ethnic languages** across the tablet platforms and mobiles used by healthcare workers (MOHS, EHOs and private providers) as well as community members themselves. Other uses of ICT include communicating, where appropriate, any relevant accommodation or support available to care-seekers, such as protocol for safe transport of patients across conflict lines, translation assistance at the hospital and emergency referral support for the cost of transport.

Component 3. Project Management and Monitoring & Evaluation (US\$0.5 million)

14. **Overview:** Support to the designated Project Management Team (PMT) within the Department of Medical Services (DMS) as the implementing department within the MOHS for project related management functions, including planning, budgeting, reporting and coordination across the various levels and units of DMS and other relevant MOHS departments, and development of national level M&E system for hospital preparedness.

15. **Expanding Grievance Redress Mechanisms (GRM) through ICT platforms:** Building on the lessons learned from the EHSAP and aligning with proposed GRM measures in the proposed EHSAP AF, the project GRM 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, general public and other stakeholders, such as EHPs, CSOs, and local authorities, etc. This communication will be made available in languages most relevant to local areas, particularly in diverse and conflict-affected areas of the country, where proficiency in Burmese language is not common.

Monitoring and Evaluation:

16. The project will support DMS and other MOHS departments with data collection and M&E activities related to COVID-19 response, and finance associated costs. Indicators relevant to services provided to patients and support provided to healthcare workers will be **disaggregated by gender, and ethnicity or language.** Indicators related to improvement in hospital facilities (e.g. refurbished and equipped ICUs; safe water and basic sanitation services) and capacities (i.e. triage and isolation) will be tracked and reported according to central, state or region location. This facility level disaggregation will ensure that progress is measured not only in terms of overall achievement of facility targets, but also in terms of the **distribution of benefits across central, region and state levels of the country.**