Community Engagement Planning Framework

FOR MYANMAR MINISTRY OF HEALTH AND SPORTS PROGRAMS BENEFITING FROM WORLD BANK SUPPORT:
ESSENTIAL HEALTH SERVICES ACCESS PROJECT
&
ADDITIONAL FINANCING TO THE ESSENTIAL HEALTH SERVICES ACCESS PROJECT

MINISTRY OF HEALTH AND SPORTS

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1 INTRODUCTION AND OBJECTIVE

Since April 2015, the World Bank has been supporting the Ministry of Health and Sports (MOHS) in Myanmar through the Essential Health Services Access Project (EHSAP). The project aims to support the Government of Myanmar in increasing access to essential health services, in particular those related to improving maternal, newborn, and child health. The project has been providing support to strengthen MOHS in its efforts to meet its universal health coverage goals and provide funding to township levels and below for operational costs, medical consumables and minor maintenance. The project also aims to empower local communities to take a more active role in the health sector and demand services, provide feedback and community oversight.

To inform the EHSAP project design, a social assessment (SA) and consultation process was undertaken in 2014. The aim was to capture the key social issues in the health sector in order to identify project features and measures that can enhance the project outcomes and ensure equitable benefits for vulnerable social groups such as the poor, women, ethnic minorities and migrants. The SA was also undertaken to assess potential social impacts of proposed project activities as per World Bank's operational policy on environmental assessment (OP 4.01) and to assess particular issues and risks concerning ethnic minorities following the requirements of the World Bank's operational policy on indigenous peoples (OP 4.10). Consultations with key stakeholders, including government staff, civil society representatives were undertaken in parallel with, and as part of, the SA. Field visits were also made to a few local communities, but the emphasis on community consultations will be during project implementation. The findings of the SA and the consultations informed the design of the project and the present Community Engagement Planning framework (CEPF) to enhance community engagement and address particular issues concerning ethnic minorities.

In Fiscal Year 2019-2020, the World Bank will provide an additional IDA credit of US$100m and US$10m of grant financing from Global Financing Facility (GFF) to the Government of Myanmar to support EHSAP. The EHSAP Additional Financing (EHSAP AF) would help finance the costs associated with the scaling up of some of the systems strengthening activities under EHSAP and the increase in scope arising out of the implementation of the Myanmar's National Health Plan (NHP) 2017-2021. The NHP's goal is to extend access to a Basic Essential Package of Health Services to the entire population, while increasing financial protection. Furthermore, the proposed AF would support the country's priority to foster peace and inclusion while boosting human capital for sustained economic growth.

In summary, the changes proposed to the project are as follows: (1) Modify component 1 on strengthening service delivery at the Primary Health Care level to focus on development of rural infrastructure and on expansion of mobile health services to remote and vulnerable populations, such as internally displaced and migrant camps; (2) add grant financing assistance to sharpen the focus of primary health care service delivery on improving Reproductive, Maternal, Neonatal, Child and Adolescent Health outcomes; (3) improve implementation arrangements based on lessons learned thus far in EHSAP; (4) revise the results framework and disbursement linked indicators (DLIs) to reflect the scaling up of the program and new areas of support in line with the NHP; (5) extend the life of the project, by revising the Closing Date from March 31, 2021 to March 31, 2024.

To reflect lessoned learned during the implementation of the EHSAP and reflect the activities under EHSAP AF, the CEPF for EHSAP has been revised into the following document. The revised CEPF aims to provide

MOHS with the operational planning framework to avoid adverse social impacts and to provide equitable and culturally appropriate project benefits to local communities, particularly poor and vulnerable population groups such as ethnic minorities and internally displaced. The CEPF addresses social safeguards aspects of the World Bank operational policies on environmental assessment and indigenous peoples (or ethnic minorities in the context of Myanmar). Elements of an indigenous peoples planning framework (IPPF), as required by OP 4.10, are reflected in this CEPF. In addition, the revised CEPF reflects the government's recently issued *Community Engagement Approach: Manual for Basic Health Staff* (December 2018, MOHS) to build on the country systems and processes in Myanmar.

2 PROJECT COMPONENTS – BACKGROUND AND CHANGES

2.1 ESSENTIAL HEALTH SERVICES ACCESS PROJECT (EHSAP)

In alignment with the Country Partnership Framework 2015-2017, which has a focus on investing in people and effective institutions for people, by supporting Myanmar to achieve universal access to quality social services, the original Credit Amount of SDR 65.4 million (US dollars 100 million equivalent) was approved on October 14, 2014 and it became effective on April 8, 2015. The project, which supports Myanmar's aspiration for Universal Health Coverage by 2030, has a development objective of increasing coverage of essential health services of adequate quality, with a focus on maternal, newborn and child health. The original project design consisted of the following three components.

Component 1: Strengthening Service Delivery at the Primary Health Care Level focuses on channeling funds through central level MOHS to the States/Regions, Townships and below (in the form of health facility funds in the latter) for operational expenses or non-salary recurrent expenditures. The funds are to support the expansion of supervision and oversight, communication and community engagement activities by basic health staff and medical officers, as well as the operation, maintenance and repair of health facilities and equipment and the provision of amenities and consumables required for effective health care at the township and below. In addition, the component supports State/Regional Health Departments to improve supervision/ mentoring, and oversight, and to better engage communities and diverse stakeholders in health to enhance coordination and participation. The World Bank disburses Component 1 funds to MOHS against an eligible expenditure program using a results-based financing modality, upon the achievement of agreed disbursement linked indicator (DLI) targets, which are monitored annually and subject to independent verification.

Component 2: System Strengthening, Capacity-building and Program Support consists of the development of strategies, plans, standard operating procedures, checklists and guidelines, many of which are required preparatory steps to achieve the results of component 1. It finances capacity building (training, courses, workshops and seminars), communications and dissemination activities, consensus building meetings, the day to day management, coordination and monitoring and evaluation (M&E), including independent verification of DLI achievement. The World Bank disburses Component 2 funds

based on statements of expenditures incurred for the requisite inputs, as per agreed implementation plans.

Component 3: Contingent Emergency Response is a provisional zero amount component that allows for rapid reallocation of loan proceeds during an eligible emergency, disaster or catastrophic event under streamlined procurement and disbursement procedures.

To date, the project performance of the past three years has been moderately satisfactory. The project has been broadly on track to achieving its project development objectives. It has so far achieved majority of the DLIs and by the end of Year 4, all DLIs are expected to be met. The covenants were in partial to full compliance. The project has contributed to inclusive and participatory decision making on health investment prioritization at the township level through the Township Health Plans (THP). One of the project's DLIs is dependent on the inclusiveness of the process in formulating the THP. In addition, through supporting mobile clinics, the project has been able to support MOHS in expanding basic coverage to remote populations, with basic health staff adapting heath information into some of the local languages. In Rakhine, the project supported mobile clinics to reach out to populations that have mobility restrictions and expanded the coverage of birth registration to vulnerable and excluded communities. Lastly, EHSAP has also supported funding at state/regional level to convene multi-stakeholder discussions including ethnic health organizations and civil society organizations.

Four years of EHSAP implementation have provided many lessons, which were most often related to institutional and capacity issues. As the challenges emerge, actions were identified and taken to address them. They included: (i) Fund flow was delayed to township and below, awaiting verification of DLI achievement. To address this MOHS requested advance disbursement of 50% of the annual DLI value at the beginning of the fiscal year (without waiting for DLI report of the previous year); (ii) The financial management operational procedures were found to be too difficult to use at the facilities in lower levels. These were then revised and simplified; (iii) There were too many budget lines for lower level facilities to manage. To address this, MOHS has strategically selected fewer but critical budget lines to help the township levels in the management of the health facility grants; and (iv) There was inadequate financial management skills and tools at the township, state/region and at the central MOHS level. Nationwide capacity building of finance staff from all townships on accounting and reporting per government financial rules and regulations was conducted under the project. Modernizing of the financial information system was also initiated with introduction of e-budget submissions and monthly budget implementation reporting.

2.2 ESSENTIAL HEALTH SERVICES ACCESS PROJECT ADDITIONAL FINANCING (EHSAP AF)

The rationale for the additional financing request is a combination of: (i) scale-up of activities and introduction of new areas in support of the National Health Plan 2017-2021; (ii) strengthening the country's priority to foster peace and inclusion through development and service delivery; and (iii) alignment with the World Bank's Country Partnership Framework which seeks to support Myanmar's journey towards Universal Health Coverage with financing of US$200 million. EHSAP was financed with US$100 Million at first, and the second US$100 Million was envisaged to be processed subsequently to support additional reforms, especially in health financing and public financial management. This Additional Financing proposal would actualize the strategic approach, supporting the National Health

Plan, and ensuring the health needs of vulnerable populations, particularly in conflict-affected areas, are explicitly met in the path towards universal health care. The additional financing also provides an opportunity to welcome Myanmar into the Global Financing Facility (GFF), which would enhance the effectiveness of EHSAP, through its coordinated approach to development assistance aimed at improving reproductive, maternal, newborn, child and adolescent health outcomes and focus on financing sustainability.

The Project Development Objective (PDO) remains the same to increase coverage of basic essential package of health services of acceptable quality, with a focus on maternal, newborn and child health. Key changes to the original design and scope are as follows:

1. Modifying Component 1 to add another dimension of strengthening service delivery at primary health care level—fully functional health service delivery infrastructure and expansion of mobile health services to hard-to-reach and conflict-affected populations, such as internally displaced.
2. Addition of GFF Trust Fund support to Myanmar's efforts on making greater strides in improving reproductive, maternal, newborn, child and adolescent health outcomes, in particular reduction of maternal and neonatal mortality through increased institutional deliveries and improved newborn care;
3. Improvement of implementation arrangements based on lessons learnt thus far (such as establishing a management and operations support team at the central level, improving fund flow and recording and reporting at the state/region and township level);
4. Change of the financing of Component 1, with a focus on rural health infrastructure, to an inputs-based disbursement modality and Component 2 to a results-based financing, using of disbursement linked indicators—to better incentivize policy changes and implementation of key reforms;
5. Extension of the life of the project by revising the Closing Date from March 31, 2021 to March 31, 2023.

Component 1 will be re-structured to have two sub-components: (i) Fully Functional Health Service Delivery Infrastructure (FFHSDI) and (ii) Strengthening Mobile Health Services for Hard-to-Reach and Conflict-Affected Populations.

Sub-component 1.1: Fully Functional Health Service Delivery Infrastructure (FFHSDI). This sub-component aims to improve supply side readiness of health care services at fixed facilities as a critical pre-requisite for achieving Myanmar's aspiration to achieve Universal Health Coverage (UHC) by 2030. EHSAP has been supporting supply side readiness by helping to provide timely and flexible operational funds to the primary health care facilities, i.e., at Township level and below. Recognizing that the operational funds can be effective only if adequate infrastructure is available, AF proposes to respond to the Government request for infrastructure financing; it has been agreed that such infrastructure does not merely consist of buildings; rather they would include equipment, supplies of essential medical and non-medical consumables, water supply, electricity and such amenities, adequate operational & maintenance budget, and sufficient numbers of skilled personnel, i.e., fully functional health service delivery infrastructure (FFHSDI). The facility layout, amenities and other inputs mentioned afore should be commensurate with the prescribed standards for the respective type of health facility, and match the service needs of the basic Essential Package of Health Services (EPHS) in accordance with the National Health Plan (NHP).

Investing in physical structures, without other inputs necessary for service delivery, is ineffective and highly inefficient. The IDA funds would finance the capital investments in infrastructure (buildings, equipment & furniture), and the Government would ensure adequate financing from its own budget for the recurrent costs of human resources, operational expenses and essential medicines. In view of the significant amount of civil works and other hardware procurement, this sub-component would use input-based disbursements.

PRIORITIZATION OF TOWNSHIPS

based on disadvantage indicators

Considering the large financing needs across the country (National Health Plan estimates the total cost of building, operating and maintaining FFHSDI at about US$600 million), the AF of US$110 million (roughly $60 million of which is available for this sub-component) over 4 years would be able to finance only a fraction of such needs. Therefore, MOHS, in discussion with the World Bank, reviewed available evidence on needs, and capacity, to prioritize as many townships, as could be supported with the envelope of US$60 million available for this sub-component under EHSAP AF.

All 330 townships were first ranked according to a composite index of social need - measured by the multi-dimensional disadvantage index (MDI)[1], infrastructure need, and implementation capacity measured by sanctioned human resources capacity[2]. MDI quantifies the level of deprivation and disadvantage in terms of poverty, education, health, and livelihoods and is a powerful targeting tool that takes account of welfare and service delivery gaps due to terrain, conflict and exclusion. Townships with the highest MDI (most severe deprivation) and most significant gaps in infrastructure were prioritized. Health Inputs Status Index counts the number of sanctioned staff positions, and not actually present human resources; therefore, in the places chosen based on high levels of deprivation, with sanctioned but vacant posts, there would be the potential to fill the vacancies and ensure full functionality of the health service infrastructure. Staffing of basic health providers is a fundamental requirement for optimal use of infrastructure investments to deliver services. Building infrastructure in areas without even sanctioned HR would clearly not afford a decent chance of success.

From the list of townships ranked by the composite index, the MOHS team in consultation with the World Bank, selected 19 townships (the number that could be covered with the available envelope of US$60 million, based on the township-wise cost estimates from National Health Plan), by selecting the topmost townships but omitting those which were difficult to access due to security constraints or under active conflict, and those which constituted less than 3 in one state/region (to enhance operational feasibility, and ease of implementation and monitoring by ensuring that their distribution was not too scattered).

[1] MDI is devised by the Ministry of Labor, Immigration and Population with assistance from the World Bank Group, and measures deprivation using indicators of education, employment, health, water, housing and assets.

[2] Infrastructure need and human resources capacity were taken from the Health Inputs Status Index (HISI) developed for the purposes of the National Health Plan and the plan's Implementation Monitoring Unit.

PRIORITIZATION OF INVESTMENTS

based on free, prior and informed consultation to obtain broad community support

For each of the selected townships, a new needs assessment would be carried out, followed by a participatory exercise involving the central and state/region levels of government, the state/region and township level health departments, members of parliament and civil society organizations/ethnic health organizations wherever applicable, and with technical assistance from the project, to prepare a township level investment plan showing the gaps in infrastructure, human resources, equipment, supplies and other inputs required to ensure supply side readiness for the provision of basic essential package of health services.

This exercise will include the following steps and will be undertaken in line with the free, prior and informed consultation principles and processes in the CEPF to obtain broad community support.

1. Assessment of what exists on the ground in terms of health service infrastructure, human resources, equipment and supplies, using tools to be developed, building on the questionnaire / checklist already being used by MOHS. Simple ICT-based methods could be used to conduct such needs assessment, e.g., using mobile apps to collect the data on what exists, in comparison with what is needed (as per standards for each type of health facility).

2. Findings from the assessment will be presented at the state/region level, but include participation of officials from the central level units and township level stakeholders.

3. Findings from the assessment will also be presented at the township level with all relevant stakeholders, including the General Administration Department, ethnic health organizations, non-governmental organizations, civil society organizations, and members of parliament where relevant to prioritize the investments (e.g. geographical areas where infrastructure, including equipment/furniture, will be established or improved), to develop the township level investment plans, and obtain unit costs. This process will enable ethnic health organizations to indicate whether they support government investments in non-government-controlled areas. In cases where government investments are not feasible, a plan to link ethnic health organizations providers with government providers will be proposed to ensure that public service delivery complements ethnic health organization's services.

4. The township level investment plan, developed initially for the whole duration of the project with annual update/adjustment made after evaluations, will be presented at Union level and state/region level for endorsement and commitment.

5. Implementation Monitoring: Annual evaluation meetings will be held at the state/region level to review implementation progress and status through a multi-stakeholder meeting including civil society and ethnic health organizations as well as state/regional government and members of parliament. ICT based progress tracking will be contracted to third parties and civil society organizations.

Through such participatory exercises, the list of townships may need to be revisited, in consultation with all stakeholders at the three levels, MOHS, the concerned states/regions, the township health department and the civil society actors including ethnic health organizations where applicable. There may also be a need to review the list if the ground-level situation changes, for example in case new conflict breaks out

in any of the selected townships or if ethnic armed organizations do not agree to the establishment of the government-owned and operated primary health care facilities in their areas.

Sub-component 1.2: Mobile Health Services in under-served and conflict-affected areas. Given that NHP aims to improve access to basic essential package of health services for everyone in the country, this sub-component will support approaches to bring basic essential health services in an inclusive manner to populations whose access to fixed health facilities is inadequate, be it due to geographic remoteness, difficult terrain and transportation challenges (e.g., Naga region, migrant workers camps) or due to displacement or other consequences of conflict (e.g., Kachin, Shan North, Rakhine, Kayin,). So, this sub-component will support primary health care in areas beyond the states/regions selected for sub-component 1.1.

The sub-component has the dual objective of bridging geographic inaccessibility and also enhancing inclusion in a conflict-sensitive manner. Any population without reasonable reach to fixed facilities would be eligible to receive support under this sub-component. In these areas, this sub-component will support mobile clinics, ambulances, and teleconsultation as some alternatives to bring the health services closer to the community. Such approaches may also be the most viable option to provide project support in non-government-controlled areas, where the respective ethnic armed organization or health provider do not wish to accept government-operated fixed facilities. The choice of which specific areas and communities would be receiving essential health services thorugh the mobile clinics modality would be informed by an analysis of available data on ethnic and linguistic distribution of the population, access to the area and security situation, to understand current factors of exclusion. Geo-mapping of existing health facilities, run by government as well as civil society actors, including ethnic health organizations, would also be used to determine the location and distribution of mobile facilities. Teleconsultation services, taking advantage of the high penetration of smartphones in Myanmar, would complement the mobile clinics and rapid response teams – with the use of dedicated phone lines and a central control room manned by qualified medical professionals.

The sub-component will finance costs associated with delivering mobile health services such as - procurement of essential medicines, supplies, kits, equipment and if necessary vehicles for mobile clinics; operational costs (travel allowance and per diem) for deploying rapid response teams including local trained volunteers to the field; oversight, coordination and supervision by state/region departments including use of ICT tools to do timely monitoring and reporting on the activities; and other recurrent and maintenance costs. In addition, this sub-component will support the central level to develop a clear set of policies, guidelines, manuals and tools for planning, implementing, monitoring and reporting of mobile health service delivery for different contexts – e.g., conflict affected areas, geographically hard-to-reach areas, areas under-served for other reasons (language, culture, high migration, etc.), and areas needing rapid response due to disease outbreaks and natural or manmade disasters. Supporting regular coordination platforms at state/region level (such as state level health cluster meeting, regional level coordination meeting), capacity building of relevant MOHS teams at union and state/region level, and training and supervision of community volunteers at the local level will also be included under this sub-component.

Clear roles and responsibilities would be assigned at the central, and state/region level, including the fund flows, procurement, financial and implementation arrangements. Disaster Preparedness and Health Emergency Response Division (DPHERD) will act as a central level focal unit for coordinating the service delivery in conflict and emergency situations. In addition, there will be a designated central level focal unit

for coordinating the broader engagement with regional health departments and some state health departments which are responsible for delivering non-emergency, regular mobile services to geographically and socially hard-to-reach areas. A series of review and planning meetings and workshops will be conducted between MOHS, relevant state/region health departments and the World Bank team. Existing MOHS policies, guidelines and manuals for mobile or rapid response service delivery, including emergency referral system will be reviewed and revised as may be necessary.

Component 2.1: Systems Strengthening and Innovations. This component focuses on seven areas of systems strengthening: Supply Chain and Procurement; Public Financial Management; Information Systems; Human Resources; Health Care Waste Management; and Community Engagement.

Supply Chain and Procurement. The success in delivery of essential health services depends critically on the timely, uninterrupted, and adequate supply of medicines, vaccines, and other essential commodities at the various service delivery points. With thousands of rural health centers and sub-centers spread across the country, procuring the medical and non-medical consumables essential for minimum acceptable quality of health care, and distributing the appropriate quantities to all the health facilities, managing the stock inventory and ordering replenishments in a timely fashion and ensuring accountability to prevent misuse are all daunting tasks without a smoothly operating procurement and logistics system. Myanmar has a National Health Supply Chain Strategy for Medicines, Medical Supplies, and Equipment spanning 2015-2020.

Public Finance Management. Under ongoing EHSAP project, combined with technical assistance and analytics using grant funds over the last four years, significant investments are being made in laying the foundations for modernizing and strengthening the public finance management (PFM) system and skills in the MoHS, particularly at the union and township departments of public health and medical services. Under the sub-component 2.1, investments will continue primarily to (i) roll out and nurture the nascent system strengthening tools piloted and introduced earlier so that their application is nationwide, uniform and systemic across the whole ministry at all levels; (ii) develop and strengthen institutional capacity within union and state/region departments to address the financial management skills gap especially at subnational levels, and database management and analysis skills at union level; (iii) undertake initiatives and institute mechanisms for better information sharing, collaboration, harmonized planning and budgeting processes and timelines across various programs/units and finance unit at the departments of public health and medical services; and (iv) procure necessary equipment and software for financial management.

ICT-based Innovations. MOHS have demonstrated commitment to applying ICT to improve service delivery. Health staff and providers at the township and below are provided with tablets with sim card. This infrastructure provides an enormous opportunity to scale up innovations through use of smartphones, and other possible ICT, including telemedicine (see next paragraph). The mission explored various applications. For example, training of providers; tracking of progress on infrastructure development; collecting and reporting data from the field; and communicating messages to clients, both for behavior change (for adopting healthy lifestyles, and for better care-seeking behaviors) and for service reminders (e.g., to attend antenatal care sessions, or immunizations for children). The modernization of MOHS' health information system (HIS) – which includes various components such as the Health Management Information System (HMIS), the recently introduced DHIS2 platform, the HR information system, the Logistics Management Information System, etc.– could benefit significantly with the use of ICT.

3 LEGAL, SECTORAL AND INSTITUTIONAL CONTEXT

Myanmar gained independence from the British empire in 1948, but long-standing grievances from over a century of colonial rule[3] continue to impact contemporary dynamics. There is a widespread perception that the British colonial administration privileged certain groups over others. When negotiations for the formation of the independent state of Burma were held, efforts were made to bring all of the territory of British Burma, much of which had previously enjoyed considerable autonomy, into the independent state of Burma. While the compromise known as the Panglong Agreement was reached in 1947, following independence civil war broke out on multiple fronts between multiple political and ethnic armed organizations. In some areas of the country, with the exception of some ceasefire periods, armed conflict has continued for the past 70 years.

The ongoing armed conflict, coupled with international isolation and desire for continued autonomy in frontier areas, has led to large swathes of the country, particularly in Shan, Kachin, Karen and Mon states where Myanmar government services currently (or until very recently) do not reach. Ethnic health organizations provide basic health services in some of these areas where the government services are not able to operate.

Since EHSAP was originally approved in 2014, there were historic elections in 2015 in Myanmar, resulting in the formation of a new democratically elected Government coming into power in April 2016. The new Government, led by the National League for Democracy, has since reaffirmed its commitment to Sustainable Development Goals through the formulation and implementation of the Myanmar Sustainable Development Plan (MSDP). Universal healthcare coverage is embedded in the Myanmar Sustainable Development Plan and the National Health Plan, endorsed by the Government in 2017, as a critical first phase on the path to the universal healthcare coverage. The MSDP also reinforces the reforms towards a free-market system and efforts to advance peace from the long-standing ethnic conflicts and inclusion.

Despite noteworthy progress, the country's political and economic situation remains fragile however. Around one-third of townships are conflict-affected. Since 2011, some progress has occurred in agreeing ceasefires with ethnic armed organizations. A series of bilateral ceasefire agreements was followed by the signing of a Nationwide Ceasefire Agreement (NCA) in late 2015 by eight of the 20 main ethnic armed organizations, with a further two groups signing in early 2018. This has significantly lowered levels of violence in many areas, especially the Southeast. More recently, however, the nationwide peace process has stalled. At least ten ethnic armed organizations have not signed the NCA and these include some of the largest armed groups. Three Union Peace Meetings have been held as part of the political dialogue, but limited substance has been discussed and no significant agreements have yet been reached. Conflict continued or even intensified in some areas of the country, such as Shan and Kachin. In Shan State, there has been an upsurge in violence between different ethnic armed organizations. The escalation in conflict

[3] Myanmar was annexed to British India in stages, with Arakan and the Tenasserim conquered in the First Anglo-Burmese War 1824-1826, Pegu (including Yangon) in 1852, and Upper Burma in 1885.

also has resulted in greater numbers of internally displaced people.

Myanmar remains one of the poorest countries in Southeast Asia[4] and significant challenges remain around disparities, social inclusion, and conflict. People all over Myanmar, and particularly the poor, suffer from difficulties in accessing some basic services and infrastructure, including clean water, education and health services, and electricity. Disadvantages in accessing services also correlates with ethnicity, religion, citizenship status, and location.

Communal tensions and nationalist sentiment have recently grown spilling over into violence in Rakhine State, and elsewhere in the country, deepening social fracture and causing widespread internal and international forced displacement. Rakhine State suffers from a pernicious mix of underdevelopment, intercommunal conflict, and lingering grievances toward the Central Government.[5] Since August 2017, the country faced an upsurge in violence and forced displacement in Rakhine State, with a massive outflow of the Muslim[6] population into Bangladesh (estimated at more than 720,000 people, mostly from Buthidaung, Maungdaw, and Yathedaung [BMY] townships[7]) and an increasing number of internally displaced.[8] Rakhine also experiences a security crisis, in which all communities harbor deep-seated fears of the others, because of past violence and segregation. This includes tensions between the ethnic Rakhine population and the Myanmar state over a perceived lack of autonomy locally. In January 2018, the Arakan Army, a Rakhine ethnic armed group, attacked police and military posts in northern Rakhine and fighting has continued since then.

In response to the crisis in Rakhine State, MOHS has formulated a plan to implement the health-specific recommendations of the Rakhine Commission led by Kofi Annan and in support of the broader Socio Economic Development Plan (SEDP). This plan will enhance the Ministry's public health response to meet the humanitarian and development needs in Rakhine in the immediate, intermediate and long term.

3.1 Legal and Policy Framework

3.1.1 The 2008 Constitution

According to Chapter 1, clause 22 of the 2008 Constitution of Myanmar, the Union Government of Myanmar is committed to assisting in developing and improving the education, health, language, literature, arts, and culture of Myanmar's "national races." It is stated, that the "Union shall assist:

(a) To develop language, literature, fine arts and culture of the National races;
(b) To promote solidarity, mutual amity and respect and mutual assistance among the National races;

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[4] World Bank. 2014. *Myanmar—Ending Poverty and Boosting Shared Prosperity in a Time of Transition: A Systematic Country Diagnostic.* Washington, DC: World Bank.

[5] Advisory Commission on Rakhine State. 2017. *Towards a Peaceful, Fair, and Prosperous Future for the People of Rakhine* (final report).

[6] In line with the Kofi Annan Advisory Commission report on Rakhine State (2017), we neither use the term "Bengali" nor "Rohingya" but refer to this population as "Muslims" or "the Muslim community in Rakhine". This does not include the Kaman Muslims in Rakhine or other Muslim in the country.

[7] Inter Sector Coordination Group. 2018. *Situation Report Rohingya Refugee Crisis*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/iscg_situation_report_27_sept_2018.pdf.

[8] There were already approximately 120,000 people in camps for internally displaced persons (IDPs) from prior peaks in the intercommunal conflict (2016, 2012, and so on).

(c) To promote socio-economic development including education, health, economy, transport and communication, [and] so forth, of less-developed National races."

The constitution provides equal rights to the various ethnic groups included in the *national races* and a number of laws and regulations aim to preserve their cultures and traditions. This includes the establishment of the University for the Development of the National Races of the Union which was promulgated in 1991 to, among other things, preserve and understand the culture, customs and traditions of the national races of the Union, and strengthen the Union spirit in the national races of the Union while residing in a friendly atmosphere and pursuing education at the University/

Under the current government, free media is developing and ethnic parties and associations are politically active. Ethnic minority organizations may also play a stronger role going forward through the current Government's decentralization efforts which would afford States and Regions to play a more prominent role in decision-making and implementation of various policies and programs.

3.1.2 Laws on ethnic groups

According to the 2014 census, Myanmar has a population of 51.4 million. While ethnically disaggregated data from the census are not yet available, estimates suggest that the Bamar are the largest ethnic group, comprising around two-thirds of the population, with a large number of ethnic groups accounting for about one-third. The majority Bamar population mainly lives in the central and delta parts of the country (divided into seven administrative Regions) while the ethnic groups live mainly, though not exclusively, in the mountainous border areas (roughly corresponding to the country's seven States: Kayah, Kayin, Kachin, Chin, Mon, Rakhine, and Shan). Main minority groups include Shan, Kayin, Rakhine, Chin, Mon, Kachin, and Kayah. These eight "ethnic races," including the majority Bamar, are subdivided into 135 officially recognized ethnic groups and belong to five linguistic families (Tibeto-Burman, Mon-Khmer, Tai-Kadai, Hmong-Mien, and Malayo-Polynesian); there are no population figures for ethnic group.

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- To develop language, literature, fine arts and culture of the National races;
- To promote solidarity, mutual amity and respect and mutual assistance among the National races; and
- To promote socio-economic development including education, health, economy, transport and communication, [and] so forth, of less-developed National races."

The Ethnic Rights Protection Law (The Comprising of Pyi Thu Hluttaw and Amotha Hluttaw (Pyi daung su Hluttaw) Law No.8, 2015), 24th February 2015. This law provides definitions of ethnic groups, Ministry, Union minister, Ministry of State or Region, State or Region minister, roles and responsibilities of the Ministry of Ethnic Affairs in ethnic affairs which means to promote sustainable socio-economic development that is including language, literature, fine arts, culture, customs and traditions of the national races, religious, historical heritages, peace and the included opportunities in 2008 Constitution of Myanmar. The constitution provides equal rights to the various ethnic groups included in the national races and a number of laws and regulations aim to preserve their cultures and traditions. This includes

the establishment of the University for the Development of the National Races of the Union which was promulgated in 1991 to, among other things, preserve and understand the culture, customs and traditions of the national races of the Union, and strengthen the Union spirit in the national races of the Union while residing in a friendly atmosphere and pursuing education at the University. However, the list of recognized ethnic groups has not been updated since 1982.

Since independence, there have been recurring conflicts between the Government and a number of ethnic armed groups over a range of issues, including relating to greater autonomy, recognition of cultural rights, and governance of natural resources. The Government's peace initiative, launched in 2011, has seen the conclusion or renewal of a number of ceasefire agreements with some ethnic armed groups, although conflict continues in several areas, including in Kachin State, northern Shan State, and Rakhine State. Following a number of bilateral ceasefire agreements between the Government and ethnic armed groups, some ethnic groups have been granted authority over political and economic affairs in their areas, which in some cases are sizeable. Social and other public services were developed by ethnic authorities, often with support from NGOs, and are still operating in several areas. Under the current government, a free media is developing, and ethnic parties and associations are politically active. Civil society organizations also play an active role.

3.2 Health Sector Legal and Institutional Framework

The National Health Policy of 1993 provides the overall legal framework for the health sector. Among other things it aims to raise the level of health of the country and promote physical and mental wellbeing of the people with the objective of achieving "health for all" using a primary health care approach, and to expand the health services not only to rural areas but also to border areas to meet the health needs across the country.

Supporting the progress towards universal health coverage, the Government has recently introduced a few policies that would improve service delivery, expand utilization and reduce out-of-pocket spending in health. Policies include provision of free essential drugs at primary health care facilities and township hospitals. In addition, health care services would be free at the point of delivery for children under 5, pregnant mothers, and patients needing emergency surgery (all services including medicines on the first day of emergency hospital admission and free essential medicines throughout the hospitalization).

MOHS completed the formulation of the National Health Plan through an inclusive and transparent process. It is the first of three phases to achieving universal healthcare coverage by 2030. The National Health Plan 2017-2021 sets a promising and strategic direction by seeking to ensure universal access to a basic package of essential primary health care services. Furthermore, the foundations and principles of EHSAP are reinforced and further concretized and institutionalized in the National Health Plan. They include:

- A focus on the frontlines of service delivery, providing essential health services, and supply side readiness (EHSAP's health facility grants aim to provide more financing to the primary health care level);
- A move from implicit to explicit package of health services—defined as the basic essential package

- Greater inclusiveness and integration of health planning at the township level (EHSAP has an explicit DLI related to this and the CEPF this)
- Systems strengthening to complement and enable supply side readiness in the public sector primary health care—such as public financial management (budget planning, formulation, execution and reporting), supply chain, human resources, and information systems.
- Recognition of ethnic health organizations, private providers and non-governmental organizations in service provision and their role in reaching universal healthcare coverage

Ensuring effective implementation of these policies to improve outcomes is a top priority for the country moving forward.

MOHS is the major provider of health care. Myanmar has a pluralistic mix of public and private system both in the financing and provision. Health care is organized and provided by public and private providers. The Ministry of Health and Sports is responsible for providing promotive, preventive, curative and rehabilitative services to raise the health status of the population. MOHS has seven departments of which the Department of Medical Services and Department of Public Health are the most important ones in the context of the proposed project. These two departments play a major role in providing comprehensive clinical and public health care throughout the country including remote and hard to reach border areas. There are 17 State and Regional Health Departments, 73 District Health Departments and a township hospital in every township. Under the township hospital there are station hospitals managed by station medical officers and rural health centers staffed by health assistants, lady health visitors, midwives and public health supervisors. Under the rural health centers, there are sub- centers staffed by midwives and public health supervisors, and supported by volunteer networks of auxiliary midwives and community health workers. At each level, oversight is provided through a system of health committees represented by local government, health staff and the community.

Some ministries are also providing health care for their employees and their families. They include Ministries of Defense, Railways, Mines, Industry, Energy, Home Affairs and Transport. Social Security Board under Ministry of Agriculture, Labor and Immigration has its own networks of hospitals, clinics and private providers to render services to those entitled under the social security scheme. Ministry of Industry is running a Myanmar Pharmaceutical Factory and producing medicines and therapeutic agents to meet the domestic needs. The private, for profit, sector is mainly providing ambulatory care though private institutional care has developed rapidly in Yangon, Mandalay and some large cities in recent years. They are regulated in conformity with the provisions of the law relating to Private Health Care Services. MOHS is currently strengthening the regulation of the health care provision in the private sector. The Myanmar Medical Association and its branches also provide a link between them and their counterparts in public sector so that private practitioners can also participate in public health care activities.

Community based organizations, faith-based organizations and ethnic health organizations are providing selective health care services and ambulatory care, though some providing institutional care and social health protection has developed in some townships. There is a strong presence of international and local NGOs on the front-lines delivering services supported by development partners. Moreover, ethnic organizations provide health services in many conflict and post-conflict areas in the States. Recognizing the growing importance of the needs to involve all relevant sectors at all administrative levels and to mobilize the community more effectively in health activities, health committees had been established in various administrative levels down to the wards and village tracts. The level of functioning of these health committees, however, vary significantly and MOHS is in the process of revitalizing the health committees through a process called Township Health Working Group under NHP.

4 APPLICABLE WORLD BANK OPERATIONAL POLICIES

The World Bank's Operational Policy (OP) 4.10 on Indigenous Peoples (ethnic minorities) applies to the project because site-specific project activities will be implemented in areas where ethnic minorities that meet the eligibility criteria of OP 4.10 are present and because national level project activities (e.g. policy reforms, institutional strengthening and capacity building) may have implications for ethnic minorities. The OP 4.10 aims to achieve the following objectives: 1) that ethnic minorities do not suffer adverse effects, and 2) receive culturally compatible social and economic benefits from Bank-financed activities. The policy requires the screening for the presence of ethnic minorities in project areas; ethnic minorities that fall under the policy are considered as a distinct, vulnerable, social and cultural group possessing the following characteristics in varying degrees:

a) Self-identification as members of a distinct indigenous cultural group and recognition of this identity by others;

b) Collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories;

c) Customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and

d) An indigenous language, often different from the official language of the country.

In areas with ethnic minorities, the policy requires that the borrower (1) undertakes a social assessment to assess potential impacts and identify culturally appropriate benefits; (2) conducts free, prior and informed consultations with affected ethnic minorities leading to their broad community support for the relevant project activities; and (3) prepares a plan (normally an Ethnic Minorities Plan) to address particular issues concerning ethnic minorities, provide culturally appropriate benefits, and ensure the avoidance or mitigation of adverse impacts. This project will support use of existing instruments, such as the preparation of site-specific inclusive Township Investment Plans, to address these requirements as described in this CEPF.

In addition, OP 4.01 on Environmental Assessment is triggered to the project because it covers some social impacts that are likely to occur but which are not covered under OP 4.10, such as potential benefits, impacts and risks concerning other vulnerable social groups, such as internally displaced, migrants and women. A separate Environmental Management Plan (EMP) is prepared to address the environmental aspects of OP 4.01, as well as to ensure that no activities under the project trigger OP 4.12 on Involuntary Resettlement. The EMP includes: 1) specific Environmental Codes of Practices (ECoPs) to address impacts linked to planned minor refurbishment, major renovations and new civil works, 2) a simple Health Care Waste Management Plan that will address health care waste management impacts, and 3) a land screening form for all activities that will have a physical footprint.

5 ETHNIC MINORITIES, VULNERABLE GROUPS, OTHER UNDERSERVED COMMUNITIES

The social assessment and consultation process for EHSAP identified potential vulnerable and underserved communities that may require targeted efforts and additional measures to provide them with quality health services. These include ethnic minorities, internally displaced populations groups, and migrants. As elsewhere, women and children may also be vulnerable and present with particular health needs and concerns. The project and this CEPF include design features and measures to reach these population groups with improved quality health care services.

Ethnic Minorities. According to the 2014 census, the population of Myanmar reached is around 51.5 million in 2010. The Bamar are the largest ethnic group, comprising around two-thirds of the population, and various ethnic minorities accounting for about one third. The majority Bamar population mainly lives in the central and delta regions (divided into seven Regions) while the ethnic minorities live mainly, however not exclusively, in the seven states (Kayah, Kayin, Kachin, Chin, Mon, Rakhine, and Shan) along the borders. The main ethnic minority groups are: Shan, Kayin/Karen, Rakhine, Chin, Mon, Kachin and Kayah. The eight "ethnic races," including the majority Bamar, are subdivided into 135 officially recognized ethnic groups and belong to five linguistic families (Tibeto-Burman, Mon-Khmer, Tai-Kadai, Hmong-Mien, and Malayo-Polynesian).

Economic development, infrastructure and social services in ethnic minorities' areas need more improvement and these areas also have lower achievement in health and education statistics. All of the main ethnic minority groups' areas have experienced various levels of conflict since 1962. Some of the armed groups have currently signed ceasefire agreements with the Government. However, fighting between the military and ethnic armed groups remains in a few areas of Kachin, Shan and Rakhine States. In relation to previous ceasefire agreements, ethnic minority groups were granted authority over political and economic affairs in their areas, covering large areas of the States. Social services were developed by ethnic authorities, often with support from NGOs, and are still operating in many areas. However, the health services in ethnic authorities' areas are under-developed with inadequate health infrastructure and human resources.

In remote ethnic minority areas covered by government provided health services, the services are sometimes inadequate due to geographic and economic constraints. In addition, language and cultural barriers are key factors preventing people from accessing public health care facilities, often combined with poor understanding of the benefits of health care.

Internally displaced groups. Due to military and civil conflicts there are internally displaced populations in some areas of the country, for example in Kachin, Rakhine, and Shan states. They are among the poorest and most vulnerable population groups and have limited access to quality health services, and combined with language and cultural barriers for many of them, they are highly vulnerable in terms of health services. They may not be identified in local population statistics and therefore local health plans may not be able to deliver in time the quality services that accommodate the particular circumstances and needs of internally displaced groups.

Migrants and post-disaster groups. Migrants and post-disaster groups have also been identified as highly vulnerable groups. This includes post-disaster communities in the Delta region, and seasonal migrant

workers in Mon State who come from central Myanmar to work in rubber plantations; migrants in Mon State may account for up to 20% of the population. In addition, there are returnees from Thailand who fled previous conflicts in the border areas but who in many cases have not been able to return to their original villages. In Kachin, migrants working in the mining sector also constitute a significant portion. Often these populations are not in a position to purchase health care, and they may not have established health or social networks for assistance when needed. They are also likely not to be identified in local poverty assessments and health plans.

Women and children. The main target group of the project – women and young children – is also the group at most risk with regards to the health sector because of the risks associated with birth and early childhood. About one third of births in Myanmar are not attended by a skilled birth attendant (2009 MICS). A number of factors have been identified: limited availability of health facilities and trained birth attendants in remote areas, affordability, and cultural factors.

6 Potential Issues and Impacts for Ethnic Minorities and Other Vulnerable Groups

Free, prior and informed consultations with ethnic minorities. A key requirement of OP 4.10 is to obtain broad community support from ethnic minorities, as identified under the policy, for project activities affecting them (whether adversely or positively). As described in this CEPF, free, prior and informed consultations will be undertaken during project implementation through the inclusive Township Investment Planning process.

Project Benefits. The project is expected to benefit directly the people living in the selected priority townships for fully functional heath service delivery infrastructure investment and people living in the townships affected by conflicts and hard to reach populations (approximately one third of all townships in the country. Indirect beneficiaries are other members of the communities, basic health staff and medical doctors. The project is likely to provide benefits to all population groups through an increase in health care financing and improved health systems through policy development, institutional strengthening and capacity building. This may particularly be the case for the poor and other persons currently choosing not to use the public health system for economic reasons. By improving the quality of health services, enhancing participatory approaches and increasing accountability, it is expected that more people will access health services.

While universal health care typically involves the continuum of health care through all three tiers, the priority for Myanmar is to strengthen primary health care, which is the first point of access to the system, and is often the only point of access for the most under-served population groups who live in remote areas of Myanmar. Primary health care interventions have globally shown to be among the most cost-effective and pro-poor interventions in the health sector.

Project Impacts. The provision of health services supported by the project is not expected to have adverse impacts on ethnic minorities or other vulnerable groups as such. However, the project presents issues related to equity in access to services and quality of services in areas with ethnic minorities as well as other vulnerable population groups. It may pose some risks in areas where ethnic health

organizations are operating, either solely (along with NGOs) or in addition to government services, as the proposed project activities may affect their own services or be perceived to affect them. Alternative health systems, particular those managed by ethnic health organizations, may have concern about sustainability of their health services in the changing context. Health providers, such as NGOs and ethnic health organizations, are operating in addition to the national government's health system. The government, particularly at field level (township, village), recognizes the NGOs contribution to reach some hard to reach populations. NGOs and other health care providers have health staff that are trained and experienced, but cannot work in the public health system yet due to accreditation issues; in addition, significant numbers of health staff of ethnic minority organization and NGOs may not meet MOHS Burmese language requirements. In some States (e.g., Kayin and Kayah), however, there have been some attempts to coordinate the efforts after ceasefire agreements have been made between the Government and ethnic armed groups.

Constraints to Accessing Health Services. A number of constraints or barriers have been identified that prevents people from accessing public health services and prevents a more equitable participation of ethnic minorities and vulnerable groups:

Affordability: Patients are required to pay for some medicines (not included in the essential medicines list) and some investigative services. "Out of pocket expenditure" for health service access is estimated to account for up to 74% in 2017 in Myanmar. In the past, communities contributed to build and maintain basic health infrastructure and contribute to operational costs at the primary care level. However, with significant increase in government health spending, infrastructure investment is now financed fully by MOHS. Many poorest households cannot afford to access health services. Others may do so, but is highly exposed to risk of catastrophic health spending that will put them in poverty. Some measures to address this situation were or are being implemented, such as village health funds, trust funds for the poor, maternal voucher scheme, free essential drugs, and drug revolving funds, but these measures would need to be expanded and communicated well among the community for better coverage and utilization. MOHS is also developing a health financing strategy that looks into various option for financial risk protection.

Geography: Myanmar is a vast country with rugged or mountainous terrain in the border areas and flood-prone areas in the Delta region. Physical infrastructure, such as roads, remains a challenge and remote and isolated areas are poorly covered by health facilities and staff. Health staff may face many challenges when posted in remote and hard-to-reach villages or they may be unable to do regular visits.

Language and culture: Language and cultural barriers, including cultural beliefs and practices, may prevent ethnic minorities from visiting public health providers. Ethnic minorities often have a different view of health, illness, and diseases, seeing health as directly related to their emotional health and social relations, and they may feel that traditional health practitioners are better equipped to guide them on health matters. Many people may also be more comfortable with village-based care, particularly for maternal health, that allows them to be near their family and social network rather than going to the nearest health clinic or hospital. Some may feel discriminated against by health practitioners who look down upon their culture and health practices. Finally, the language and culture barriers may result in limited trust between patient and health care practitioner.

Conflict and post-conflict areas: All of the States have experienced armed conflicts between various military governments and ethnic armed groups. Though Nationwide Ceasefire Agreement (NCA) in late 2015 with 8 EAOs and 2 more in 2018 has helped lowered the level of violence, around one-third of townships are still conflict-affected. The Government services do not have full access to active conflict areas and health services are provided by ethnic health organizations and NGOs. Given the past history of mistrust that is likely to linger for many years, expanding the Government's services will be difficult and may not be welcome in some areas. Recurrent civil conflicts in Rakhine State also affect the health services for people living in these areas. In terms of existing planning and implementation systems, Township, Village Tract and Village health committees were in principle set up in all areas controlled by the government though they are not active in many places especially in remote areas. Village health committee, when they do exist, may often be inactive and with poor participation of women and vulnerable groups.

7 EXISTING GOVERNMENT MECHANISMS FOR COMMUNITY ENGAGEMENT IN HEALTH PLANNING AND MONITORING

Community engagement aims to empower local communities to take a more active role in the health sector and demand services, provide feedback and community oversight for local health events. To identify measures that can enhance the health outcomes and ensure equitable benefits of public health services for the vulnerable social groups such as the poor, women and children, ethnic minorities and migrant populations, the state/region level and township level health planning processes need to be more inclusive and explore the risks concerning the vulnerable groups in getting equitable and quality health services. Currently, under the National Health Plan for 2017 – 2020, the MOHS is utilizing several different mechanisms, as mentioned in the table below, to get community voices in the health planning, implementation, and monitoring of service delivery.

The most important of the participatory processes for health service delivery is **Inclusive Township Investment Planning**, allowing basic health staff to conduct **community assessments and village mapping**, which aim to identify vulnerable social groups in the community (age, gender, ethnicity, socio-economic status including livelihoods), assess their health status (health seeking behaviours, common diseases per season, etc.), and identify barriers to access health services, and situation of health infrastructure. Basic health staff hold consultations with villagers to be able to conduct the community assessments and village mapping. This feedback from this community assessments and village mapping are recorded and relayed to the township level, to contribute to township level selection and prioritization of investment. The inclusive Township Investment Planning process provides clear guideline and templates for the townships to consult and incorporate better the community voices and expand the consultation process to civil society organizations and ethnic health organizations.

The community engagement at the village tract level by basic health care staff is guided by the MOHS's ***Community Engagement Approach: Manual for Basic Health Care Staff***. This manual provides detailed guidelines for basic health staff for community engagement. The manual:

- Describes principles, approaches and processes for community participation in decision making
- Provides tools and methods for planning community engagement
- Provides guidance on ensuring community engagement is inclusive and conflict sensitive
- Describes needed facilitation skills for basic health staff
- Provides guidance and formats for integrating community engagement results into Township Health Plans

The CEPF for World Bank support closely follows the MOHS Community Engagement Approach Manual, as well as the community assessment and village mapping at village tract level for the inclusive Township Investment Planning process.

Table 1. Existing Mechanisms for Community Engagement in Health Planning & Monitoring

	Mechanisms	Achievements	Areas for Improvement
1	**Inclusive Township Health Planning** Community consultation meetings are organized at village tract levels in each township with participation of community representatives (villagers or ward dwellers, village or township elders, village tract or township health committee members), basic health staff, local general administration department (heads of village/ward/ township), other related government and non-government stakeholders (e.g., Ministry of Education, NGOs, community-based organizations, ethnic health providers). Records and feedback from village tract level consultations feed into township level consultations with township stakeholders for a participatory process of selecting and prioritizing township health spending.	• Simple guidelines for community engagement within the township health planning process including a systematic checklist on how to plan, organize and record community consultation meetings have been developed. Townships have been trained and utilizing the guidelines and checklist. • Community assessment and Village Mapping covers critical information relating to identification of vulnerable social groups in the community (age, gender, ethnicity, socio-economic status including livelihoods), assessment of health status (health seeking behaviours, common diseases per season, etc.), identification of barriers to access health services, and situation of health infrastructure. • A mix of approaches are used depending on the context to solicit voices and inputs from the community; Community Meeting; Focus Group	* Due to ongoing armed conflicts and security concerns, especially in townships with ethnic controlled areas, some community consultation activities may be curtailed. * Efforts in identifying and inviting broader representatives to the community consultations are needed in some areas to include informal health providers and ethnic health organizations.

		Discussion; Individual Consultation with Key Informants.	
2	**Annual Evaluation of the Community Health Program**	• This is an established annual process whereby MOHS reviews internally the status, achievements and challenges of its community health programs. • The bottom-up approach is used in this type of evaluation. Townships begin their self-evaluation of previous year in late January or early Feb, using the data collected over the year from the lowest level of health facilities (Sub RHC, RHC, UHC, MCH clinics, School Health team, etc.). A workshop is usually organized at the township level, with participation of all Basic Health Staff who conduct community assessments and village mapping. • Township evaluation is then submitted and fed into the state/region wide evaluation led by the state/region health departments. • At union level, annual central evaluation workshop brings together all the states/regions for a comprehensive evaluation.	• Integrating community perspectives into the annual evaluation process can be strengthened. • For example, inviting community or CSOs to be part of the evaluation workshop/meeting at the township and state/region level; organizing community feedback session/meeting before the internal evaluation workshop at the township level.
3	**Suggestion Box** For patients (service users) and family members to have access to an anonymous feedback provision mechanism, MOHS has instructed all hospitals from township level and above to keep suggestion box at the hospital.	• All hospitals from township level hospital and above have established suggestion boxes for patients and family members to provide feedbacks on the health services and service providers anonymously.	• There is no clear guideline or procedures established for the most effective use of this tool. E.g., where to set up the box, how often to open and collect the feedback, who (a team including community/township/CSO representative in order to promote transparency) will review the feedbacks and how the response will be given or action will be taken, etc. • The actual application (and thus usefulness) of the box in the field varies with initiative and motivation of the township officers.

			• Applicability of using suggestion boxes in Health Facilities below the township level (e.g., Station Hospital and Rural health center) and providing multiple avenues for community feedback will need to be explored.
4	**State/Regional Level Health Assembly or Forum** Platform for bringing together the people and stakeholders together with the public service administrators and providers	• Under the leadership of the new Minister starting in April 2016, health assembly or forum has been organized at state/region level with diverse stakeholders and citizens in order for the public health service administrators and providers to listen to the people's voices vis-à-vis their health needs/priorities, perceived quality of health services including the clinical and interpersonal skills of service providers, feedbacks on the impacts of the health policies on the people and providers on the ground, etc.	• Establish clarity and guidance on whether the state/region level assembly will not be an ad-hoc but regular (how often?) event, what would be the guideline or procedures to conduct it most effectively and inclusively, how the information received will be compiled, relayed and utilized in health policy making, planning and service delivery, etc.
5	**Supervision and Monitoring Visits to States/Regions and Townships by Central Level**	• The supervision visits utilize a checklist to monitor and observe the progress of the service delivery at the primary health care level. As part of the visit, central level officers also have opportunities to meet with patients, family members, community leaders and community members to get feedback on their health needs and satisfaction with the service provision.	• The meeting/interview with the service users (patients and family members) and community during the central level supervision visits to be further strengthened and systematized (e.g., through a set of semi-structured questionnaires) in order to better solicit the feedbacks in confidentiality.
6	**Central level Collective Voice Workshop** A Platform for civil society organizations (including ethnic health providers) who are working with the community or who represent the various community groups to meet the policy makers and various program managers at the central level and provide feedbacks and suggestions from the ground	• Created a platform at central level for non-government organizations implementing community-based services to dialogue directly with the policy makers and program managers	• Need to make sure that this effort continues regularly.

8 IMPLEMENTATION & INSTITUTIONAL ARRANGEMENTS

Implementation of the CEPF is organized at the village / village tract, township, state/region and union level. As noted in the previous section, the CEPF builds on MOHS's Community Engagement Approach, community assessment and village mapping process, and the Inclusive Township Investment Plan process. The roles and responsibilities of the different levels are summarized below.

Village / village tract level. At this level, basic health care staff will carry our community assessments and village mapping, which aim to identify vulnerable social groups in the community (age, gender, ethnicity, socio-economic status including livelihoods), assess their health status (health seeking behaviours, common diseases per season, etc.), and identify barriers to access health services, and situation of health infrastructure.

More specifically, the community assessment and mapping will be used to:

1) Identify vulnerable and under-served population groups, such as ethnic minorities, internally displaced, migrants and women, in the village / village tract,
2) Assess particular health issues and risks in the village / village tract, with distinctions between social groups as appropriate,
3) Identify and assess constraints in accessing health care services of different households and social groups (gender, ethnic minorities, internally displaced, hard to reach communities etc.),
4) Identify and assess other health care providers and their services (e.g. NGOs, ethnic minority organizations, private sector).

All of this will be done following the guidelines outlined in MOHS's *Community Engagement Approach* and in line with consultation principles outlined in OP 4.10, in order to ensure:

- Free, prior and informed consultation with and participation of the affected peoples,
- Broad community support from ethnic minorities, and
- Integration of these consultation principles into existing processes of the MOHS system, which will be enhanced and modified through support from the project.

Communities at the village level would be informed of the MOHS support to the primary care service delivery units as well as the objectives and elements of the CEPF through various communications channels—print, local radio, village meetings, as well as through the township and village health committees, community volunteers, CSOs and NGOs. In addition, community members would be informed of their opportunity to participate in the Township investment planning and budgeting process and to voice their concerns and perspectives of the state and progress of primary health care services to basic health care staff.

Township level. At the township level, MOHS will conduct further stakeholder engagement and consultations, taking into account and discussing feedback and records of the community assessments and village mapping. At the Township level, the Township Medical Officer will be responsible for the participatory planning and formulation of inclusive Township Investment Plans, with technical support

from, and monitoring by, the State/Region and District Health Department and central level MOHS, and facilitation support from NGOs and CSOs in their locality wherever relevant.

Township level consultation meetings will be organized with participation of community representatives (villagers or ward dwellers, village or township elders, village tract or township health committee members), basic health staff, local general administration department (heads of village/ward/ township), other related government and non-government stakeholders (e.g., Ministry of Education, NGOs, community-based organizations, ethnic health providers). This process will inform the preparation of the inclusive Township Investment Plans by identifying the views and priorities of various communities and population groups concerning the quality and constraints of the health services through a participatory consultation process.

The process will involve the following elements:

1) Consultation with other health services providers and stakeholders in the township as applicable. This includes organizations representing vulnerable and underserved population groups when they exist (e.g. ethnic minority organizations), NGOs, faith-based organizations, and other private providers. In areas with ethnic minority organizations providing health services, consultations may need to involve the ethnic health providers in addition to representatives from the ethnic minority organizations.
2) Consultations with community members and leaders. The consultations should be inclusive and include representatives from the different population groups present in the township.
3) Consultations should be done in a manner that allows community members to voice their concerns and priorities following OP 4.10 principles for free, prior and informed consultations (this may involve conducting consultations in local languages and using facilitators, NGOs or ethnic minority organizations).

Records and feedback from village tract level consultations and township level consultations will feed into selecting and prioritizing of township health spending and service provision, and the formulation of the inclusive Township Investment Plan.

Broad community support to inclusive Township Investment Plans will be achieved through the participatory planning process and the involvement of township and communities in the preparation. Women participation in township planning process will be encouraged through their participation in the village tract and township level.

The inclusive Township Investment Plans will include, but not limited to, the following elements:

1) Brief description of the findings from the community assessment and village mapping
2) Brief overview of the township population characteristics, including vulnerable and underserved population groups, such as ethnic minorities when they are present in the township
3) Brief description of other health care providers and the services they provide
4) Measures to enhance health services in the township, strengthen the inclusion of vulnerable and underserved population groups;
5) Measures to inform and empower local communities (e.g. information and education campaigns, which need to consider language and cultural barriers when they exist for successful delivery);
6) Measures to address grievances and measures to enhance community feedback through participatory monitoring tools.

The inclusive Township Investment Plan will be made publicly available to interested township stakeholders and communities, and will be available in a summary form at health facilities in the Township.

State / region. State and regional level MOHS will be responsible for overseeing implementation of programs, including this CEPF, in their townships. They will also help facilitate the selection of townships and the identification of investment priorities in these townships for the targeted programs through inclusive consultations of stakeholders in their state/region. In addition, state/region level will lead the townships to consult with relevant stakeholders in preparing the annual work plan and budget for the mobile and emergency health services.

Union. Implementation and compliance with the CEPF ultimately lay with union level MOHS which is responsible for implementation of the supported programs. Union level MOHS will also be responsible for regularly reviewing implementation progress, as reported by the subnational departments or observed through monitoring visits, to identify issues of non-compliance or potential negative impacts of programs requiring actions to be remediated, minimized or mitigated. MOHS will officially report on the status of the implementation of and compliance with the CEPF to the World Bank annually as part of their reporting on program implementation. They will also immediately notify the World Bank on any evidence of possible non-compliance with this CEPF and negative impact of the programs as well as on actions taken in every such case.

9 MONITORING ARRANGEMENTS

Throughout the implementation of World Bank-supported MOHS programs, several mechanisms will be used to monitor and evaluate processes and outcomes including compliance with this CEPF, as well as any negative impacts that may arise.

Monitoring objective will be to 1) ensure effective and timely implementation according to plan and apply mid-course corrections where needed, 2) measure the achievement of results envisaged in its objectives and learn lessons for future operations; and 3) provide a robust basis for the disbursement of IDA funds, which would depend on the achievement of the project's DLIs. DLIs would be a subset of the fuller list of indicators included in the monitoring system. In addition, the implementation of the CEPF will be monitored on a regular basis.

As an integral part of implementation arrangements, MOHS will lead the following monitoring activities:

Inspection, monitoring and quality assurance. As part of their regular inspection/monitoring visits to all health centers, Township Medical Officers, will confirm compliance with key elements of this CEPF. Union and State/Region level staff also undertake monitoring visits to townships and health centers. On these occasions, to the extent possible, the visit aim will include assessing and reporting on compliance with this CEPF.

Joint monitoring visits. Periodically, MOHS will organize and lead monitoring visits in a sample of health centers from a team made up of representatives from MOHS, World Bank, and donor partners. The visit will assess achievement and challenges in project implementation, including compliance with this CEPF, as well as investigate selected questions meant to gather a deeper understanding of issues coming out of other monitoring activities.

To complement MOHS's work (and carry-out its role as supervision entity), the World Bank will lead the following monitoring activities:

ICT / Phone-based beneficiary engagement survey. To complement the rest of the activities, beneficiary engagement surveys will be carried-out through phone calls and text messages. Through this mean, different Stakeholders and health service users will be reached and asked, among other things, "satisfaction"-type of questions. This method will allow to expand the reach of external monitoring activities to communities and health centers country-wide and particularly in remote and conflict areas that are more difficult to cover through in-person visit.

Beyond assessing efficiency and compliance with processes and protocol, the above monitoring activities will include an important focus on social inclusion and equity and explore issues such as access to health services by different populations, and composition of participants to consultations/meetings on programs.

10 GRIEVANCE MECHANISM

10.1 CURRENT PRACTICES

For patients (service users) and family members to have access to an anonymous feedback provision mechanism, MOHS has instructed all hospitals from township level and above to keep suggestion box at the hospital. All hospitals from township level hospital and above have established suggestion boxes for patients and family members to provide feedbacks on the health services and service providers anonymously.

However, there is no clear guideline or procedures established for the most effective use of this tool. For example, where to set up the box, how often to open and collect the feedback, who (a team including community/township/CSO representative in order to promote transparency) will review the feedbacks and how the response will be given or action will be taken, etc. The actual application (and thus usefulness) of the box in the field varies with initiative and motivation of the township officers. Suggestions cannot be provided at health facilities below the township level (e.g., Station Hospital and Rural health center) at the moment. Users do not have multiple channels to provide suggestions and grievances.

The current system is working to some degree but reporting and access could be improved.

10.2 IMPROVED GRIEVANCE REDRESS MECHANISM

10.2.1 Principles

MOHS is committed to strengthening the grievance redress mechanism (GRM). Complaints and grievances will be dealt with using the MOHS grievance redress mechanism (GRM) to ensure that programs are implemented transparently and accountably, that voices of poor and marginalized groups are heard, and that issues and grievances raised are resolved effectively and expeditiously. Any stakeholders including patients, other community members, contractors, MOHS staff, authorities, and other involved parties may file a grievance if they consider that their right to information is interfered, inappropriate intervention by an outside party is found, fraud and corruption have taken place, the rights and entitlements granted in this CEPF are violated, or that any of the WB supported programs' principles and procedures have been violated.

Improvements to the GRM will focus on:

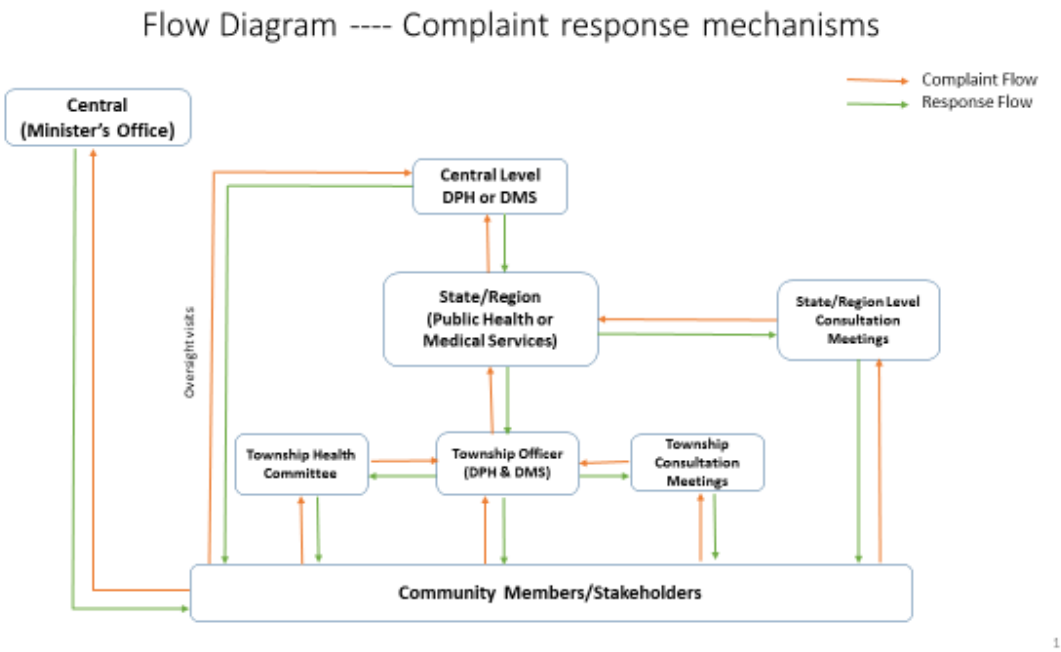
Wider dissemination. Information on the GRM will be hung in all health centers and pamphlets will be distributed during village level and townships level consultations meetings (including consultations relevant to the implementation of this CEPF), and on MOHS's website and facebook page.

Increased number of channels or ways to submit feedback and complaints. It will be possible to submit feedback and complaints in-person at different levels (townships, state and regions, union), individually or in the context of consultation meetings, in writing through letter/suggestion boxes place in health centers /communities or letters/emails sent to key addresses at the state/region or union level, and by phone using a hotline number.

More systematic recording and handling of complaints; Detailed processes for reviewing, recording, escalating, resolving, and reporting grievances/feedback will be developed, as well as training materials for all health staff. At the Union level, a focal point will be assigned to systematically compile the information received, as per guidelines, from the different levels and produce a bi-yearly report on grievances received and actions taken. Key issues will be made public on MOHS website and facebook page.

10.2.2 Procedures

Complaints concerning project financed activities may be submitted through the following channels either verbally or in written form: (i) directly to the MOHS at central level; (ii) at state/region and township level consultation meetings with relevant authorities; (iii) to the Township Medical/Public Health Officers; (iv) to the Township Health Committee/Township Health Working Group, and (v) to central level officials during their oversight or monitoring visits to the townships. See diagram below.



To the extent possible, complaints will be resolved at the township level. Local community members, or other interested stakeholders, may raise their concern with the Township Medical and/or Public Health Officers.

Local community members or other interested stakeholders may also raise their grievance with the Township Health Committee/Township Health Working Group, who will facilitate a resolution between the complainant and the Township Medical/Public Health Officer.

Complaints may be made in writing or orally, and anonymously.

The Township Medical or Public Health Officer will respond promptly (within 10 days of receiving complaint) and will document the complaint and the response given and actions taken.

If the complainant is not satisfied with the response or action, the complaint can be submitted to the State and Region Medical Services or Public Health Department (or) directly to the Ministry of Health and Sports at central level.

The MOHS central level, when receiving the complaint directly, will respond promptly (within 20 days of receiving the complaint) and will document the complaint and response given/actions taken.

The Terms of Reference of the Township and Village Tract Health Committees and/or Township Health Working Group will include the principles and procedures for managing grievances.

The inclusive Township Investment Plans will include details on the grievance redress mechanism, including contact information (name, telephone, address) for the Township Medical/Public Health Officers, Township Health Committee/Township Health Working Group and the MOHS central level.

The focal persons will be:

- At Township Level: Township Medical Officer and/or Township Public Health Officer
- At State/Region Level: A designated focal person from S/R Health Department
- At Central DPH & DMS Level: Designated focal point in the Project Management and Operations Support Team (MOST)

The focal person will 1) receive and record the complaints, 2) refer/inform and coordinate with respective sections or teams directly relevant to the complaint (e.g., program team and/or finance and admin team depending on the nature of the complaint) so that a response is prepared and a corresponding action can be taken, 3) inform the complaint regarding what action has been taken or will be taken, and record the response and action taken.

11 BUDGET

The implementation of the CEPF is integrated into the development of inclusive Township Investment Plan for component 1.1 and annual work plan of State/Region for component 1.2. In addition, costs of supporting the implementation of the CEFP, such as capacity building, workshops, assessments, is included in the capacity building and program management component.

12 CONSULTATIONS

The original CEPF for EHSAP was shared and discussed with a range of stakeholders through three public consultation meetings on July 7-8, 2014 in Yangon and Mawlamyine. Myanmar and English copies of the CEPF were provided to the invited stakeholders two weeks (June 23, 2014) before. Stakeholders consulted included representatives from national and international NGOs, civil society organizations, professional associations, and ethnic minority organizations involved in health and ethnic minority issues.

The key suggestions at the time from the consultations included: (i) ensure better alignment, coordination and collaboration between government and ethnic authorities' health services; (ii) integration of health plans of ethnic organizations in the township health plans; (iii) participation of private sector, communities, and civil society in the project process, activities and mechanisms especially in the health committees; (iv) that the project data would be disaggregated by ethnicity; (v) that capacity building mechanisms will include staff from ethnic health organizations; and (vi) that the monitoring and evaluation put in place can measure results and impacts of the project.

The CEPF integrated inputs from the consultation especially the inclusion of the vulnerable groups including disabled, migrants, women and ethnic minority organizations in the township health planning process, as well as the participation of civil society organizations, private sector and local communities in the project including monitoring and providing feedback.

For the revised CEPF, a series of public consultations in Ayeyarwady, Shan, Naypyitaw and Yangon have been organized by MOHS in May 2019.

The key concerns and comments from different stakeholders have been summarized as below.

TO BE COMPLETED AFTER CONSULTATIONS/