Proposed World Bank-Financed Project

Myanmar Essential Health Services Access Project

Community Engagement Planning Framework

Ministry of Health

Republic of the Union of Myanmar

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1. Introduction

The proposed World Bank-financed Myanmar Essential Health Services Access Project (Myanmar EHSAP) Project aims to support the Government of the Republic of the Union of Myanmar in increasing access to essential health services, in particular those related to improving maternal, newborn, child health. The project will provide support to strengthen the Ministry of Health (MOH) 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 project design a preliminary social assessment (SA) and consultation process was undertaken during project preparation. 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 to date have 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.

This CEPF aims to provide the Ministry of Health 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 is developed to address *social* safeguards aspects of the World Bank operational policies on environmental assessment and indigenous peoples (or ethnic minorities in the context of Myanmar).[1] Elements of an indigenous peoples planning framework (IPPF), as required by OP 4.10, are reflected in this CEPF. It is developed based on the findings of the preliminary social assessment and preliminary free, prior and informed consultations with ethnic minority organizations and consultations with a broad range of other stakeholders including NGOs, professional associations and government staff and representatives.

[11] A separate Environmental Management Plan has been prepared to address *environmental* safeguards aspects of OP 4.01.

2. Proposed Project Objectives and Design

Project Description

The first phase of WBG group support focuses on bringing immediate relief from a critical constraint faced at the Primary Health Care (PHC) level, namely lack of flexible, timely and sufficient resources to meet the operational costs of providing better and more health services. Furthermore, it supports the enabling environment for the resources to be used effectively—enhancing capacity of staff, increased supervision and timely implementation support at all levels, improving planning, and mobilizing communities to voice their views and engage with providers of health care services at the various levels.

The proposed operation would use investment project financing with disbursement linked indicators (DLI), whereby funds are disbursed based on attainment of targets. The progress in achievement of DLI targets will be reviewed annually and will be subject to independent verification.

Project Components

Component 1: Strengthening Primary Health Care Delivery and Utilization:

Resources to the PHC levels: The central approach of this component would be to channel funds through the Ministry of Health to the States/Regions and to Townships and below for operational expenses. About 90% of the USD 92 million allocated to component 1 is expected to flow to townships and below. The funds will be used to (i) assist basic health staff and medical officers to expand outreach, supervision, communications, and engagement with communities; (ii) keep facilities, vehicles, furniture and equipment functioning and maintained; and (iii) allow users of facilities have basic needs met, such as clean water, appropriate foods and emergency travel costs. Funds will be provided to Township Medical Officers (TMOs), for use at the township hospitals and onward disbursement to station hospitals, Rural Health Centers (RHC), and Maternal and Child Health (MCH) centers, based on Standard Operating Procedures (SOP).

The allocation of resources across facilities will be determined by a simple formula which results in a payment. The formula is designed with the following principles in mind: simplicity, transparency (formula is easy to understand and based on data that are easily available and beyond dispute), equity (with larger allocation to facilities in hardship townships) and predictability (in terms of the facility amounts and their timing). The formula may evolve over time as more data become available. The increased funds for operational costs would complement inputs already being provided, by MOH and development partners, at the primary health care units. These inputs include ensuring adequate supply of essential drugs, supply chain management, well-maintained equipment, and skilled workforce.

Resources to the State/Regional Health Departments. Resources will also be provided to the state/regional Health Departments for operational expenses, such as for supervision, coordination, convening, and communication activities. It will also support functions and capacities needed to effectively implement project activities (e.g. development of convergence strategy by state authorities together with ethnic minority organizations, and hiring basic health staff or financial officer on contractual basis).

Community empowerment: Through existing mechanisms, such as health committees at village and township levels, network of grassroots volunteers and women's groups, communities would be informed of efforts to improve service delivery, empowered to demand services, and mobilized to participate in planning processes. Their role in providing feedback and oversight would be enhanced.

Component 2: System Development, Capacity-building and Program Support

Component 2 would focus on strengthening of systems and institutions that are needed for effective service delivery at the primary health care level. It would also help prepare for the Phase II support. The support to this component would be provided in two separate sub-components, the first of which would adopt the DLI approach similar to the Component 1, while the second sub-component would disburse based on expenditures incurred:

System Strengthening: Specifically, this sub-component would assist in the development of strategies, plans, guidelines, operational manual (e.g., health financing strategy, definition of essential package of health services, health care waste management guidelines), and related analytical / policy work. These activities are critical to the long-term system-building for the health sector in Myanmar, especially in the context of the country's aspiration for universal health coverage (UHC). Though, in the interest of selectivity, three specific areas have been prioritized through the DLIs for this sub-component, other related system-strengthening initiatives, such as human resource development, supply chain management and the modernization of health information system are equally important and are being supported by several other development partners, with whom the WBG would build partnerships to provide coordinated support to the Government and people of Myanmar.

Capacity-building and program support: This sub-component would finance ***monitoring and evaluation, including independent verification mechanism***, as well as management support, coordination both within MOH, with non-health ministries and with external development partners and internal non-state actors, technical support through consultancy services, research, training, workshops, and South-South exchanges. These activities would be financed based on a capacity-building plan, including a simplified procurement plan in line with IDA Guidelines for procurement.

In addition, the project will support the testing of RBF approaches to address bottlenecks in the system including efficiency gains by supporting conceptualization, piloting and learning from RBF approaches. The proposed project will: (i) test the effectiveness of results based management tools through programmatic financing linked to inter-governmental transfers made to townships and below; (ii) addressing demand side barriers for maternal care through the use of vouchers. These pilot innovations will be carefully evaluated using rigorous methodologies and implemented at a sustainable level of expenditure. Financing for this development, testing and learning from RBF pilots will be sought from the Health Results Innovations Trust Fund (HRITF). Lessons learned from these pilots will provide the basis for scaling up successful interventions through subsequent IDA and other donor supported projects.

3. Applicable World Bank Safeguard 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: (i) that ethnic minorities do not suffer adverse effects, and (ii) 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 (i) undertakes a social assessment to assess potential impacts and identify culturally appropriate benefits; (ii) conducts free, prior and informed consultations with affected ethnic minorities leading to their broad community support for the relevant project activities; and (iii) 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 Township Health 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). The EMP includes: (i) specific Environmental Codes of Practices (ECoPs) to address impacts linked to planned minor refurbishment works (e.g., wall painting, window repairs) and (ii) a simple Health Care Waste Management Plan that will address health care waste management impacts.

4. Legal and Institutional Framework

Legal framework concerning ethnic minorities:

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;
(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.[2]

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.

Legal framework for the health sector:

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 well-being 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).

[2] http://www.burmalibrary.org/docs15/1991-SLORC_Law1991-09-University_for_the_Development_of_the_National_Races_Law-en.pdf

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

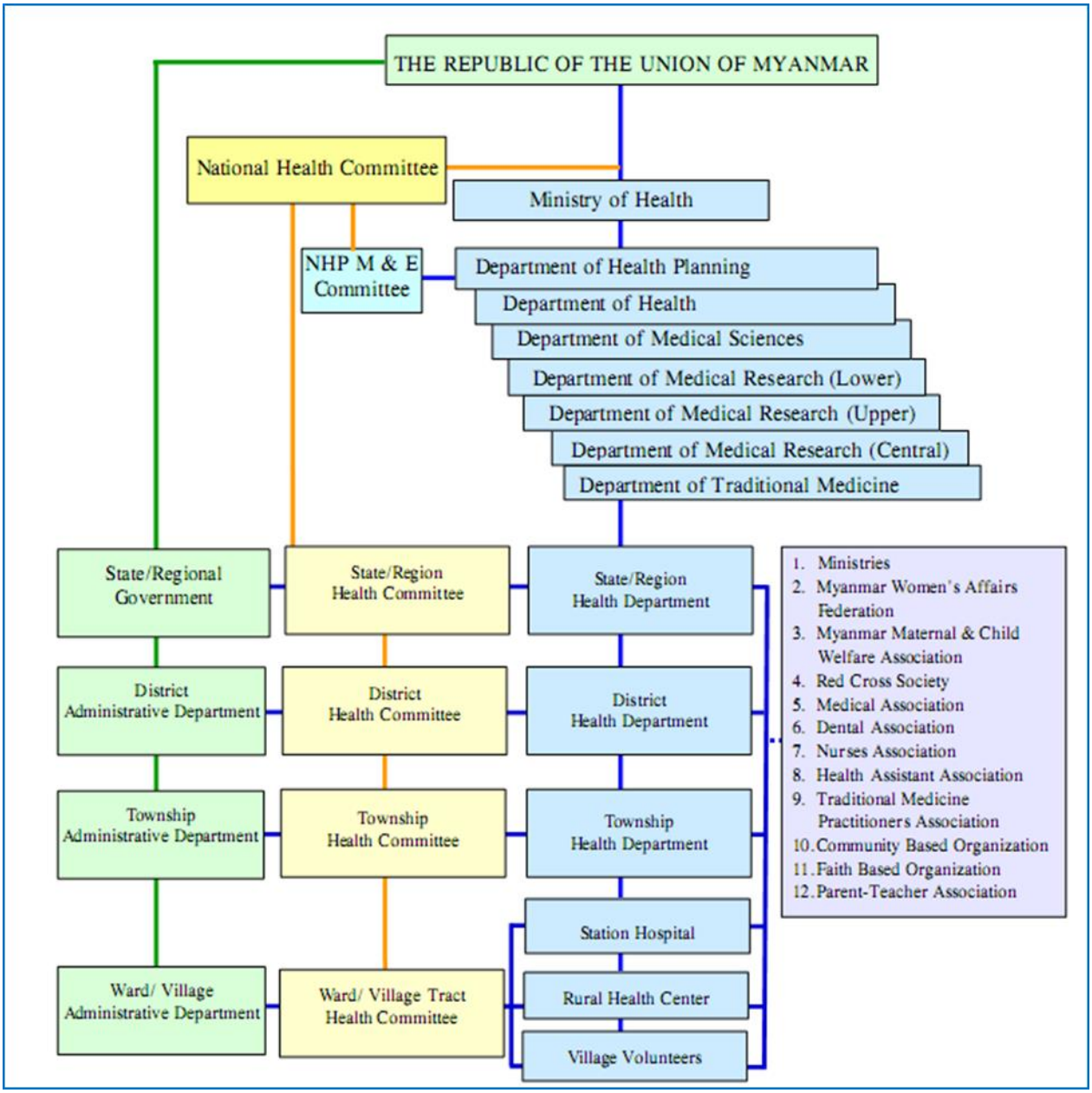
Institutional Framework for the health sector:

The Ministry of Health 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. In implementing the social objective laid down by the State, and the National Health Policy, the Ministry of Health is taking the responsibility of providing promotive, preventive, curative and rehabilitative services to raise the health status of the population. The Ministry of Health (MOH) has seven departments of which the Department of Health and Department of Health Planning are the most important ones in the context of the proposed project. Department of Health plays a major role in providing comprehensive health care throughout the country including remote and hard to reach border areas. There are 14 State and Regional Health Departments, 73 District Health Departments and a township hospital in every township. Under the township hospital there are station hospitals and rural health centers (RHC) staffed by health assistants, midwives and public health supervisors. Under the (RHCs) there are sub- centers staffed by midwives and (volunteer) auxiliary midwives, supported by networks of community health workers/volunteers. At each level, oversight is provided through a system of health committees represented by local government, health staff and the community. At the national level the National Health Committee is a high level policy-making body that provides guidance to the MOH.

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. Ministry of Labour has set up three general hospitals, two in Yangon and the other in Mandalay 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 some providing institutional care has developed 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. Ministry of Health 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.

The private, for non-profit, run by Community Based Organizations (CBOs) and Faith based Organizations are also providing ambulatory care though some providing institutional care and social health protection has developed in large cities and some townships. There is a strong presence of international and local NGOs on the front-lines delivering services supported by development partners. Moreover, ethnic minority 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.



5. Ethnic Minorities and Other Vulnerable and Under-Served Population Groups

The preliminary social assessment and consultation process for the proposed project identified potential vulnerable and under-served population groups 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 offer 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 official estimates, the population of Myanmar reached almost 60 million in 2010. The Bamar is 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 official population estimates of the main ethnic minority groups are roughly: Shan (9%), Kayin/Karen (7%), Rakhine (4.5%), Chin (2%), Mon (2%), Kachin (1.4%), Kayah (1%). 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); there are no population figures for ethnic minority sub-groups.[3]

There is freedom of religion in Myanmar. Some estimates list the proportion of Buddhists at 90%, while other sources estimate that they make up 80% of the population.[4] Other major religions as estimated by Pew Research Center are: 7.8% Christians, 5.8% folk religions, 4% Muslims, and 1.8% Hindus.

Table 1. Population by States and Regions, 2007-2008

State/Region	Population in ('000)			Density (Per sq km)	Percentage of total population
	Total	Males	Females		
Total Union	**57,504**	**28,586**	**28,918**	**85**	**100**
Kachin State	1,511	747	764	16	2.62
Kayah State	336	170	166	28	0.58
Kayin State	1,740	861	879	58	3.02
Chin State	533	260	273	14	0.92
Mon State	2,997	1,506	1,492	244	5.21
Rakhine State	3,183	1,586	1,592	87	5.53
Shan State	5,464	2,738	2,726	35	9.50
Total States	**15,764**	**7,868**	**7,892**		**27.41**
Sagaing Region	6,274	3,084	3,190	67	10.91
Tanintharyi Region	1,632	814	818	37	2.83
Bago Region	5,793	2,912	2,881	146	10.07
Magway Region	5,392	2,653	2,739	120	9.37
Mandalay Region	8,062	3,984	4,078	172	14.01
Yangon Region	6,724	3,338	3,386	661	11.69

[3] The government with support from the United Nations Population Fund (UNFPA) undertook a census in April 2014 using the official list of 135 ethnic groups; numbers are still to be released.
[4] Pew Research Center's Religion & Public Life Project: Burma. Pew Research Center. 2010.

Ayeyarwady Region	7,863	3,934	3,929	224	13.67
Total Regions	**41,740**	**20,719**	**21,021**		**72.58**

Source: Statistical Yearbook, 2008, CSO. Nay Pyi Taw, Myanmar, 2009.

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. Most 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 and Shan 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.[5]

[5] WHO and Ministry of Health. *Health Financing Review Myanmar*. February 23, 2012.

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 in 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 Relating to Ethnic Minorities and Other Vulnerable Groups

The findings from the preliminary social assessment (SA) and consultations are summarized in this section. The SA was undertaken to assess potential risks and social impacts of proposed project activities as per the Bank's operational policy on environmental assessment (OP 4.01) and to identify and assess particular issues and risks concerning ethnic minorities following the requirements of the Bank's operational policy on indigenous peoples (OP 4.10). As specific project areas have not been identified, the SA did not involve field work and is considered a preliminary assessment of project benefits and impacts. Additional social analysis will be integrated into project implementation as described in this CEPF.

The SA methodologies included: (i) review of existing literature; (ii) in-depth interviews and consultations with various stakeholders from government and civil society; and (iii) field visits to townships, including discussions with local community members. Consultations with key stakeholders, including government staff, civil society representatives and local communities have been undertaken in parallel with, and as part of, the SA. Consultations included government staff at the MOH, health personnel at township and rural health facilities. Consultations were undertaken with ethnic minority organizations as well as with professional associations, local and international non-governmental organizations. Finally, discussions were held with local communities in two townships, including with ethnic minorities in five villages and one urban ward.

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). However, since specific Townships have not been identified yet, it is premature to obtain such broad community support. As described in this CEPF, free, prior and informed consultations will be undertaken during project implementation. Similarly, the required site-specific plans to address particular issues pertaining to ethnic minorities will be prepared during implementation for each participating Township in areas with ethnic minorities. Both will be

integrated into existing processes of the national health system, which will be enhanced and modified through support from the project.

Consultations with ethnic minority organizations during project preparation have not revealed any opposition to the proposed project and improved health services are in demand in ethnic States as well as in the seven Regions of Myanmar. NGOs and ethnic minority organizations do not deliver health services that are any different from government delivered services, although the institutional and operational aspects differ. Some risks and concerns were, however, raised, including language and cultural barriers and concerns related to current health service providers organized by ethnic minority organizations in the context of reaching the country's universal health coverage goals. These issues are discussed below and will be addressed during project implementation.

Project Benefits:

Over the four-year implementation period, the project is expected to benefit approximately six million pregnant women and their young children across Myanmar's all 330 townships in 17 states and regions. 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 UHC 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 minority 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 minority organizations, may have concern about sustainability of their health services in the changing context. Health providers, such as NGOs and ethnic minority 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 MOH Burmese language requirements. In some States, 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 80% in 2010 in Myanmar. However with significant increase in government health spending and free essential medicines initiatives, the out of pocket spending is reducing (Public Expenditure Review -report not yet released). Communities contribute to build and maintain basic health infrastructure and contribute to operational costs at the primary care level. Many poorest household 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 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.
- **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, is lacking 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 seven States have experienced armed conflicts between various military governments and ethnic armed groups. However, under the current Government several ceasefire agreements have been made and coordinated negotiations are

undergoing. There are, however, still a few areas under armed conflict. The Government services do not have full access to active conflict areas and health services are provided by ethnic minority 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.

Existing planning and implementation systems in place: Township, Village Tract and Village health committees are in place in many places, although not in many remote areas. In Paletwa Township visited during project preparation, for instance, there are village health committees only in around 70 villages out of 384 villages. Moreover, when they do exist, they are often inactive and with poor participation of women and vulnerable groups. In Ye Township it was reported that the village committees were not very active and its structure inadequate. It was felt, however, that the committees could be strengthened to play a stronger role in engaging community members and improving health services.

The social assessment and field visits also found that there is room to improve the township planning system. Particularly its analytical aspects could be improved to provide a better understanding of the local health situation and provide basis for targeted services that meet the particular circumstances of the population, including vulnerable groups such as ethnic minorities and internally displaced.

It is important to note that constraints to a participatory approach may not just originate from a centralized political system. Traditional culture and local hierarchical systems may also discourage people from expressing their views and actively participate in local decision-making and planning processes.

7. Implementation Arrangements for Community Engagement and Issues Concerning Ethnic Minorities and Other Vulnerable Groups

The project's positive impacts will depend upon the degree to which it is successful in increasing the inclusion of vulnerable groups such as ethnic minorities and internally displaced. This requires a more participatory approach in the health care system and ways to address barriers of economic and geographical character as well as language and cultural barriers. Linkages to other health care services, such as those provided by ethnic minority organizations in States, NGOs and the private sector should also be considered in efforts to improve the health situation for poor communities. The CEPF includes measures to deal with project support to individual townships as well as national level activities. Component 1 concerns local level planning at township level and beyond, while Component 2 concerns national level activities aiming to strengthen the national health system. Both have implications for vulnerable and under-served population groups and other key stakeholders (e.g. various health care providers). The project's Operational Manual will provide additional details on the implementation arrangements for the CEPF.

A key principle of the CEPF is to build on, and improve existing mechanisms, including MOH processes for local planning, establishment of health committees and preparation of Township Health Plans.

7.1 Component 1: Strengthening Primary Health Care Delivery and Utilization

The component will help strengthen participatory planning for Townships. Townships are required to prepare Township Health Plans building on health plans from lower levels. These plans are of various quality and existing donor programs, such as GAVI and 3MDG, have introduced new planning templates and processes. With World Bank financing, MOH will be supported to enhance coordination between development partners working at Township level, and take measures to unify the various processes and templates into one improved planning process and documentation requirements for the Township Health Plan. The unified health planning process will involve a simple consultation and social analysis process with the objectives of enhancing the delivery of township health services, which would be more equitable and more inclusive. The social analysis will identify and examine any particular issues concerning vulnerable and under-served populations groups, including ethnic minorities where they are present in the Township. This is currently not explicit or emphasized in the current planning processes and templates. The existing health planning process and health plans, including the make-up and role of health committees, will be slightly modified to improve the process and outcomes, and integrate World Bank requirements under OP 4.10 with those of MOH and other programs financed by Global Fund (GFATM), GAVI and 3MDG.

MOH will work with its partners, and in consultation with relevant stakeholders, to streamline these procedures during project implementation. This exercise will be undertaken during early project implementation, through a series of workshop and consultation exercises with a broad range of stakeholders, with the aim to come up with a unified approach and format for the health planning process and the substance of the Township health plans.

Through the project's support to the participatory planning process, the project will help build capacity in participatory planning and analytical methods, strengthen the responsiveness of health services to the needs of local communities, increase consumer participation (including vulnerable and under-served population groups), and move towards greater social accountability at the local level. The following elements should be included in the preparation and implementation of Township level project support: [6]

1) Community engagement and social analysis:
    a) The social analysis will include the following elements:
        i) Identification of vulnerable and under-served population groups, such as ethnic minorities[7], internally displaced, migrants and women, in the Township;

[6] These elements aim to improve the health services by tailoring these to the local conditions and enhance community engagement; they also address the requirements of OP 4.10 for free, prior and informed consultations, social assessment and the preparation of an Ethnic Minorities Plan in areas with ethnic minorities.
[7] Ethnic screening should use, at minimum, the criteria provided in the OP 4.10 as eligibility criteria.

ii) Assessment of particular health issues and risks in the Township, with distinctions between villages, geographic areas, and social groups within the Township, as appropriate;
iii) Identification and assessment of constraints in accessing health care services of different local communities and social groups (gender, ethnic minorities, internally displaced, hard to reach communities etc.);
iv) Identification and assessment of other health care providers and their services (e.g. NGOs, ethnic minority organizations, private sector);
v) Assessment of capacity of township, village tract and village health committees and identification of measures to enhance their capacity and engagement.

b) The **community engagement** process aims to inform the preparation of the Township health 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:

i) Consultation with other health services providers and stakeholders in the Township. This includes organizations representing vulnerable and under-served 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 State health administration in addition to representatives from the Ethnic Minority Organizations;
ii) Consultations with community members and leaders. The consultations should be inclusive and include representatives from the different population groups present in the Township; the 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);

2) Preparation of a Township Health Plan: Based on the findings of the community engagement and social analysis process, the Township Health Plan (THP) will be prepared. Broad community support[8] to Township Health plans will be achieved through the participatory planning process and the involvement of township and village health committees in the preparation of the THP. Women participation in township health planning process will be encouraged through their participation in the village tract and township health committees. Health committees at various levels should have representation not only of the public sector but also of other key non-government stakeholders in the respective geographical areas.

The current content of THPs will be modified and should include the following elements:

a) Brief description of the findings from the community engagement and social analysis process;

[8] OP 4.10 requires that broad community support are obtained from affected, whether positively or adversely, ethnic minority communities. This requirement is achieved through the planning process for the THP as described in this CEPF.

b) Brief overview of the Township population characteristics, including vulnerable and under-served population groups, such as ethnic minorities when they are present in the Township;
c) Brief description of other health care providers and the services they provide;
d) Measures to enhance health services in the Township, strengthen the inclusion of vulnerable and under-served population groups;
e) 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);
f) Measures to strengthen and support Township, Village Tract and Village Health Committees and other participatory mechanism, including mechanisms to enhance the involvement of representatives of vulnerable and under-served population groups (e.g. ethnic minorities, internally displaced, women etc.). This should include mechanisms to address grievances and may include measures to enhance community feedback through participatory monitoring tools such as community scorecards, social audit, citizen report card and citizen satisfaction surveys.

3) Implementation and monitoring of the Township Health Plan: Implementation of the THP will include the following elements:

a) The THP will be made publicly available to interested Township stakeholders and communities; the THP should also be available at health facilities in the Township.[9] In areas with ethnic minorities or other language groups, the plan, or a summary of it, will be translated into key local languages and other materials may be prepared to widely disseminate the contents of the THP;
b) The Township Medical Officer (TMO) will have overall responsibility for the implementation of the THP by continuing current practice, and in doing so will coordinate with the Township, Village Tract and Village Health Committees;
c) State/Regional Health authorities will monitor the implementation of the THP on a regular basis; DOH will provide oversight and in doing so may use qualitative evaluation studies in sample Townships to assess the quality of the preparation process and outcomes of the preparation and implementation of the THP.

4) Involvement of Health Committees: The make-up and role of township and village health committees will be assessed in the process of defining a unified planning which aims to enhance the engagement of local communities in the health sector. Arrangements should be made to engage representatives of local communities, women's groups, civil society organizations, NGOs and INGOs, and ethnic health organizations where they exist. This may involve direct representation on the committee of these stakeholders or other formal structures for engaging them. The Village Health Committee should be responsible for providing health care information to villagers, organize consultations on health care needs and services at the village level as input to the township health plan, as well as for monitoring the implementation of the project especially to ensure that the poor

[9] This is consistent with the Bank's policy OP 4.10 as well as its Policy on Access to Information.

and underserved population groups in the village participate and receive benefit from the project. The VHC will also oversee the feedback mechanisms at the village level.

The project is using—and strengthening—existing systems for participatory planning at the township level. As per World Bank requirements concerning OP 4.10 when ethnic minorities are present in project areas, MOH has prepared this CEPF and will lay out in more detail in the Operations Manual (OM) how ethnic minorities will be involved and included in the township health planning process during project implementation. The OM will be reviewed and agreed upon by the World Bank.

During project implementation, WB will provide TA support to MOH to prepare the first batches of township health plans (10 - 15) until they have sufficient basic capacity to do so. The rest of the township health plans can be reviewed post randomly and/or during monitoring as plans will be participatory and include grievance redress mechanism. The implementation of THPs will be reported to MOH and the World Bank annually as part of MOH's annually reporting on program implementation.

Moreover, the Bank team will review the preparation and implementation of THPs during project implementation support missions. Through this process, revisions to the participatory process and the content of the THP may be made to enhance the process and outcomes. The CEPF may be revised accordingly in agreement between MOH and the Bank.

7.2 Component 2: System Strengthening, Capacity-building and Program Support:

This component would focus on strengthening of systems and institutions that are needed for effective service delivery at the primary health care level. To ensure that these activities take into account the circumstances of, and effects on, vulnerable and under-served population groups, such as ethnic minorities, the CEPF provides an engagement and assessment process at the national and State/Region levels.

Broad Stakeholder Consultations

The MOH will undertake broad stakeholder consultations during implementation of this component to seek input from stakeholders on systems strengthening and other elements supported by the project, such as development of health financing strategy and essential health package. The consultations will involve a broad section of stakeholders with the aim of including representatives of different social groups, including vulnerable and under-served population groups, such as ethnic minorities, women, internally displaced populations and migrants. Civil society organizations, such as NGOs and professional associations, will also be involved.

Additional consultations during project implementation would also help address concerns raised during the SA and discussions from ethnic minority organizations who are concerned that the project's support to the Government's UHC program may replace their health services.[10]

[10] See also similar concerns raised by ethnic minority organization in HCCG, 2014: *A Federal, Devolved Health System for Burma/Myanmar: A Policy Paper (draft)*. Health Convergence Core Group (HCCG).

The consultation process will aim to seek input into the Government's program to advance towards UHC. This would include assessments of policy reforms and how these might impact different population groups, particularly for vulnerable and under-served population groups. Given the separate, and in some places overlapping, health services provided by Government and ethnic minority organizations, policy reforms may affect the existing systems in place and consultations, and assessments when needed, would assess such effects and identify policies and programs that can enhance the health sector in Myanmar. Beyond the consultation process, the Project will also provide funds to support better alignment and collaboration between government and ethnic authorities.

Consultations may identify particular measures that could be taken to enhance the quality of health services for vulnerable and under-served populations groups such as ethnic minorities; such measures include:

- Sensitivity training for health managers and providers to raise their understanding of the circumstances of various population groups they serve, such as women, ethnic minorities, internally displaced and other communities with different health views and practices;
- Actively attempt to hire and train health practitioners (e.g. nurses and mid-wives from ethnic minorities), and considering waiving or lowering current language requirements;
- Development of oral and written materials in minority languages regarding the Government's universal health coverage program and general health education.

Improving Participatory Health Planning:

To support the participatory planning process undertaken for project financing to Townships and beyond, discussed above under Component 1, component 2 will help to strengthen these processes and capacities at MOH, States/Regions, District and Township levels, with the aim of developing a standard approach to participatory planning at different levels in the health system, particularly at the township level, that allows for a sound and inclusive process and that enhances the participation of vulnerable and under-served population groups, such as ethnic minorities and women. Training will be included in the capacity building plan.

8. Capacity Building of Key Stakeholders

As MOH has no previous experience implementing World Bank-financed projects with its specific requirements such as those under the Bank's policy on indigenous peoples as they are embedded within this CEPF, the Bank will provide capacity building and operational support to the implementation of the CEPF.

The MOH, with support from the World Bank, will provide training for TMOs and other relevant stakeholders on the elements of the CEPF, particularly with regard to the community engagement and social analysis process, preparation and implementation of the THP, including on strategies to enhance the participation of local communities and health committees, and broader consultations and engagement of stakeholders in regards to component 2. The MOH will also ensure that male and female staff of MOH and other health care providers including staff from the ethnic health organizations will have equal opportunities to receive training and support under component 2. This will be included in the capacity building plan.

9. Institutional Arrangements

Ministry of Health will be the implementing agency of the project and Technical Group led by Director General of Department of Health within MOH will assume overall responsibility for the implementation of this CEPF.

The National Health Committee (NHC), the highest health policy making body, would be informed and engaged regularly in the implementation of the CEPF as part of general reporting of project implementation. Within the Ministry of Health, the Executive Committee, consisting of the Minister, two Deputy Ministers, Directors-General and other senior officials, would have overall oversight responsibility of the proposed operation, including the CEPF, and would be informed regularly concerning overall implementation. Social analysis and CEPF will be implemented by the Planning Unit and Public Health Unit under Department of Health.

At the Township level, the Township Medical Officer will be responsible for the participatory planning and implementation of Township Health Plans as described in the CEPF, with support from, and monitoring by, the State/Region and District Health Department and central level. DOH will be responsible for engaging the Health Departments of the States/Regions and District, as appropriate, in the implementation of the CEPF, as part of the project's support to enhancing the role of the States /Regions and Districts in supervising Township level health services, and in engaging them in consultations concerning policy reforms, systems development and other activities under Component 2.

Communities at the village level would be informed of the Government's increased 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, members of NGOs, such as Maternal and Child Welfare Association, and other organizations. In addition, community members would be informed of their opportunity to participate in the Township planning and budgeting process and to voice their concerns and perspectives of the state and progress of primary health care services to the Village Health Committees. The state/region, district and township authorities would establish community feedback mechanisms—such as report cards, surveys—to gauge the effective provision of services.

10. Monitoring and Evaluation

The project would incorporate a strong system of Monitoring and Evaluation (M&E) to: (i) ensure effective and timely implementation according to plan and apply mid-course corrections where needed; (ii) measure the achievement of results envisaged in its objectives and learn lessons for future operations; and (iii) 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 M&E system. In addition, the implementation of the CEPF will be monitored on a regular basis.

To evaluate project effects on development objectives, population level data in the form of household surveys will be collected. Baseline data will be obtained from a 2014 Living Standards Measurement Study (LSMS) and a 2015 DHS survey, with follow-up data collection planned towards the end of the project life. Depending on the ability of the data collected to measure outcomes on vulnerable and under-served population groups, including ethnic minorities, additional surveys and/or qualitative assessments will be undertaken to assess impacts and outcomes for these population groups.

Monitoring exercises may also include other qualitative and quantitative studies to investigate social and other issues critical to enhancing the health services and outcomes for vulnerable and under-served population groups; for instance, participatory research to assess barriers to access, health seeking behavior, and factors that drive demand for public health services of the poor and other vulnerable groups.

To strengthen accountability and transparency, the monitoring system would involve consumer and civil society participation in monitoring of project and sector performance. Monitoring tools could include community scorecards, social audit, citizen report card and citizen satisfaction surveys. This would be included in the project's support to States and Regions to develop appropriate community feedback mechanisms to assess satisfaction with service delivery at the primary care level. Development of such mechanisms would be supported by the community engagement and social analysis carried out at the township level to inform the preparation of health plans.

Social accountability activities can strengthen the capacity of both local community members and civil society organizations to engage in government services and hold authorities accountable for better development results. They can also strengthen the capacity of the MOH, State/Region, District and Township authorities to become more transparent, participatory and accountable, and better respond to demands and needs of local communities that they serve.

11. Grievance Redress Mechanism

A grievance redress mechanism will be set up to address grievances concerning the implementation of the project and the CEPF. This mechanism will be built into the role of the health committees and the monitoring and evaluation arrangements discussed above.

In addition to these mechanism, complaints concerning project financed activities, e.g. the Township Health Plan, may be submitted through the following channels: (i) directly to the Ministry of Health; (ii) at consultation meetings with relevant authorities; (iii) to the Township Medical Officer; and (iv) to the Township Health Committee.

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 Officer. They may also raise their grievance with the Township Health Committee, who will facilitate a resolution between the complainant and the TMO. Complaints may be made in writing or orally. The TMO will respond promptly and within 10 days and will document the complaint.

If the complainant is not satisfied with the response, the complaint will be submitted to the State/Region and District Health Department or directly to the Ministry of Health. The MOH will respond promptly and within 20 days and will document the complaint.

The Township Health Plan will include details on the grievance redress mechanism, including contact information for the TMO, Township Health Committee and the MOH.

Complaints to the MOH can be made to the Technical Group led by the Director General of Department of Health. The Operations Manual will outline the steps required to meet the DLI on application of the CEPF into township health plans.

12. Budget

The implementation of the CEPF is integrated into the Disbursement Linked Indicators. 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.

13. Consultations of this CEPF

This draft CEPF 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 social assessment and draft CEPF were provided to the invited stakeholders two weeks (June 23, 2014) before the consultation meetings. The documents were also made publicly available on the websites of MOH

and the World Bank. 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.

Overall, participants expressed their support for the proposed project and welcomed the focus on empowering the community and underserved population groups, and enhancing their participation in the township health planning process.

The key suggestions from the consultations include: (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 has 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. MOH is in the process of preparing operational guidelines for the project which incorporates key principles of the CEPF. The capacity building component of the project will also be extended to both male and female staff of ethnic health organizations. Household data will be collected and disaggregated according to gender and ethnic background.

Summary of Comments/Suggestions and Discussions

Comments/Suggestions	Responses
Convergence between government health service provision and ethnic authorities' health service provision. Does convergence issue fall within the scope of the project? If so, how will this project support MOH engagements with ethnic authorities' health departments to ensure better alignment, coordination and collaboration between these service providers? • Health committees at various levels should have representation of all key stakeholders in the respective geographical areas, not just the public sector. • Recognize personnel/workforce of ethnic health organizations. • Include personnel/workforce of ethnic health organizations in training • Allow some activities (Penta3 immunization) be delivered by NGOs • In townships which have areas under the control of ethnic authorities, there should be collaboration with respective ethnic health authorities. • If there are health plans of ethnic organizations, they should also be incorporated and converged into township health plans.	CEPF under the proposed project intends to support inclusion of ethnic minority organizations in the township health planning process (development of an integrated township health plan). At this time there is no one national policy on convergence. This is linked to the peace process. Progress has been made however at the local and state levels, for example with training and provision of vaccines and commodities. The feedback will be shared and conveyed to decision makers in MOH to determine how best to advance the collaboration with ethnic health organizations.
Role of private sector • What is the role of LNGOs, faith based groups, and private sector in this project? • Would there be a role for private sector in the capacity building component of the project? • How does MOH intend to orientate both internally and with private providers on the concept of Private Public Partnership (PPP)? • Does the Government plan to fund or contract NGOs for service delivery?	The proposed project focuses on the public sector, but recognizes that the role of the private sector organizations is important. Local organizations are included in the CEPF. Under the Strategic Directions for UHC, PPPs is one such direction. There will soon be a convening event to focus on PPPs. Contracting and funding NGOs under this project is unlikely, because most of the external aid funding goes directly to NGOs.
Representation of civil society in national mechanisms • Representation and participation of civil society organizations in National Health Committee is missing. Similarly in M-HSCC, changes are needed so that NGOs, who are representing community, could have a voice.	This message will be conveyed to MOH decision makers and M-HSCC Secretariat.

Comments/Suggestions	Responses
Revitalization of Health Committees • Project should clearly detail and outline the steps on how it proposes to revitalize the health committees. • 3MDG Fund, Global Fund etc are also strengthening the health committees through local NGOs and INGOs. TMOs should be supported to learn from these NGOs' experiences through study tour or exchange visit.	Operations Manual of the Project will describe the TORs of the committees at various levels. The proposed project would support learning from other initiatives.
Project Design • Clarify: (i) Rationale for choosing MNCH as the focus area? Has the actual package for MNCH been defined? Will task shifting be considered and included in the delivery? (ii) Amount of funds that will go to township level; (ii) Criteria for 'hardship' township; (iii) Poverty assessment data by township level should be used in the project. • How will the project support the improvements in demand side? Such as the voucher scheme. • How realistic is US$100M to achieve UHC? • Will the project use money out of IDA loan for the technical assistance? • As the country is moving towards decentralization, state and region level should also be considered for support in the project.	MNCH is a priority area for the Government. It is a start in the long road to UHC. Hardship townships are designated by Government for all sectors. • The proposed project would be linked to support for piloting demand side schemes. • US$100 million is just to support the initial steps in UHC. • The proposed project funds TA, but TA will also be sought from grant sources. • The proposed project will support states and regions with funds.
On Capacity and Focal Point • Ministry of Health has insufficient human resources. The available limited manpower has low motivation and insufficient time which might be consequences of low wages which are not sufficient to make a living. Too much centralization is also another weakness. • Caution is given however to take time to build systems and prepare the key players such as TMOs to be ready capacity-wise to take on the responsibility. Rushing it will cause burden and troubles for TMOs. • Who will be the focal point for the project within MOH for further contact and discussion?	Component 2 of the project focuses on staffing and building capacity of the staff at all levels, in particular township. Focal point for this project under the DOH will be Director General. In addition, Director at the International Health Division can also be reached for further details.

Comments/Suggestions	Responses
On Monitoring and Evaluation • How is the project going to measure the project outcomes? • Quality indicators should be considered. • What is the purpose of data disaggregation by ethnicity (as recommended in CEPF)? Will it not lead to discrimination of certain ethnic groups? • What will WB do when deviations from SOPs are found during implementation? • How would the impact of the project be sustained beyond 4 years? • Does Demographic and Health Survey (funded by USAID) cover non-state ethnic authorities controlled areas?	• The proposed project document details the M&E arrangements. • Disaggregated data will be collected by household surveys (not linked to delivery at the point of service). • WB financing is a small amount of what the Government spends on health and to the front lines, so financing can be sustained. • Info on DHS will be followed up by DHP responsible for DHS.
On Community Participation and Empowerment • How the project is going to make sure vulnerable groups are empowered through the project activities? • How will the project and MOH ensure the identification of needs by bottom-up approach? • How will the project and MOH identify the needs of the people in post-conflict setting?	• The CEPF procedures will be institutionalized at the township level to ensure assessment of needs, in particular of vulnerable groups, and to include these in planning and budgeting.
On Financial Management • Pouring money into the system will not really work unless there is synergy and collaboration at township level between all government structures. In some areas, administrative side does not pay attention or care at all about health even though TMO tries to engage. • Standard Operating Procedures (SOPs) should be developed as early as possible even before the money flows into the system.	• Capacity building and additional staffing at township, state/region, and central levels will strengthen administrative and management. • SOPs will be developed and staff trained prior to disbursement.
On Environmental Management • Project should consider how to do waste disposal without using burners or incinerators. • Waste minimization methods should also be considered.	• The proposed project will support national guidelines on waste management and implementation of these guidelines at the township and below.

Comments/Suggestions	Responses
On Financial Protection • In order to reduce financial burden due to health spending at household level, health insurance can play an important role. Does MOH have a policy on how to develop or encourage agencies that can provide health insurance?	• The proposed project will finance development of the health financing strategy. This will lay out various options, including health insurance.
General Comments • IDA loan for health sector is welcomed and congratulated MOH for preparing the project. However, MOH should pay attention to the difference between loan and grant agreements to ensure the successful implementation of the loan. • Representatives from Health department of Karen ethnic authority welcomed the proposed project. The focus on township level is very relevant. • Overall, the project design which based on the strengthening of township and grassroots level is good. • Good to see focus on Primary Health Care (PHC). For a very long time, it was touted at least politically as the key approach for health for all in the country. But in reality, MOH has had hospital-centric approach in resource allocation. Even among doctors, those who work on PHC did not get much encouragement or support. Without prioritizing PHC, the country cannot achieve UHC.	Well noted