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Health, Population, and Nutrition Sector Development Programme (HPNSDP)

Technical Review of the Thematic Area: Budgeting, Planning, and Financial Management

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BREAKING NEW GROUND

THINKWELL

Report of the Independent Review Team

IRT Members: BP&FM

ThinkWell
@thinkwellglobal
www.thinkwellglobal.com

Authors:
This report was prepared by Siddiqur Rahman Choudhury and Yogesh Rajkotia.

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EXECUTIVE SUMMARY

Planning, budgeting, and financial management are key ingredients to achieving the overall objectives of the HPNSDP. The health sector is challenged by historic institutional attributes of the Bangladesh public sector, such as the complex civil service structure and centralized planning system. The plurality of financing mechanisms by development partners further complicates effective planning and financial management. Despite these challenges, the sector has made many improvements over the years and has worked creatively to overcome structural complexities with innovations such as local level planning and outsourcing human resources. Overall, the HPNSDP is on the right track, as evidenced by the marked improvement in health indicators and increasing willingness by development partners to use government systems for financing.

RESULTS AND ACHIEVEMENTS

Since the last APR in 2009, the MOHFW has made significant progress. The sector program has attracted increased resources from DPs into the RPA pooled fund, reflecting the high degree of confidence in the country public financial management system by international community. The empowerment of the Financial Management and Audit Wing (FMA Wing) to oversee all financial functions for both the revenue and development budget (under the Joint Secretary of Finance) is a welcome step towards harmonization. The MOHFW is on track to outsource critically needed financial management and audit staff on a temporary basis to support the FMAU and line directors, thereby mitigating a major concern in previous APRs. Internal audit has been strengthened. According to APIR 2012, financial management and audit trainings have occurred at all levels of the system, which has greatly contributed in improving overall financial management, reducing financial irregularities and consequently audit objections. Though much work is still needed, the development of the ADP Monitoring System has proven to be a powerful financial management tool for the MOHFW. Finally, the quality and timeliness of financial management reporting has improved, facilitating on-time reimbursement by DPs.

CHALLENGES AND CONSTRAINTS

Several challenges in resource planning, budgeting, and financial management still confront the health sector. Our key areas of concern are:

1 **The HPNSDP is not on track to be financed by the amounts set forth in the PIP.** Only about 60% of the OP provision for 2011-12 was allocated in the RADP of the same year and the actual utilization stood at 53% of the OP provision. The ADP allocation in 2012-13 indicates further decline in the trend, as only 58.5% of the OP provision has been allocated for the year. In 2011-12, overall budget execution was 87%, though in some OPs it is below 50%. Bottlenecks to budget execution include delays in the release of fund, shortage of trained FM staff, and inadequate delegated financial power of LDs. The recent revision of the fund release procedure by the MOF restricting the authority of the line ministries to release more than one quarter of the fund at a time without the approval of the MOF will further slowdown the process of fund release and consequently the utilization of ADP allocation.

2 **Systems for comprehensive resource planning and tracking do not exist**. As previous APRs have pointed out, Bangladesh has had a historic disconnect between the

development and non-development budgets in health, which still exists today. The planning wing is responsible for the preparation of the development budget, with almost no interaction with the FMAU, which prepares the non-development budget. This lack of coordination has led to sub-optimal resource allocation.

Further to this historic phenomenon, the assessment team was also concerned about the lack of systematic planning and coordination of DPA and parallel funds. Systems for ensuring that development partners coordinate their efforts through joint work planning and honor their aid commitments were not evident. Systematic expenditure tracking for DPA and parallel funds was also not evident, thus it was not possible to clearly ascertain the sources of all financing supporting the HPNSDP and the priorities financed from those sources within the HPNSDP. Finally, a joint systematic review process, in which all SWAp partners jointly evaluate resource utilization by each partner, was also not evident.

3 **Lack of human resources in health finance and financial management is a major impediment.** The outsourcing of financial management and audit staff should help relieve these constraints in financial management, however planning for permanent staffing is needed once this stop gap measure ends. The organogram of the FMAU appears to have too many support staff and not enough technical staff. HEU still faces serious human resource capacity constraints, especially in light of the critical work ahead. Staff reposting and technical knowledge in health economics and finance were described as the most pressing human resource issues.

4 **Resource allocation is not based on need.** Development budget is prepared on the basis of multiyear plan (OPs). Allocations are often made without making field level needs assessment on annual basis. Cost centers at the field level have virtually no participation in budget preparation. As a result, the budget is often not need-based, causing under allocation in certain priority areas as well as over-allocation of resource in certain activities. LLP attempted to resolve this, and strong progress was made in training and the preparation of LLP plans nationwide. Unfortunately, despite the PAD and PIP recommendations, the LLP plans were still not linked to budget allocation, thus very little practical impact of LLP is evident.

RECOMMENDATIONS

1 **Ensure adequate resource allocation and efficient utilization to achieve HPNSDP results.** A joint review by GOB and DPs should be undertaken immediately to analyze the growing trend of underfunding OP provisions of PIP. In addition, discussions with the finance division must be held to relax the newly-imposed quarterly fund release for RPA. Other actions include more aggressive monitoring by planning wing for budget execution by OPs and improved performance of MOHFW in clearing procurements for World Bank approval. Finally, joint OP planning with districts can help allay CS and DDFP concerns of underfunding while improving OP spending.

2 **Implement comprehensive resource planning and tracking system**. A comprehensive picture of all planned and expended finances in the HPNSDP is critically needed to ensure strong planning and sector management. Building from the unified workplan developed in previous years, an online system should be developed that accounts for planned and expended budgets from all sources of financing of the HPNSDP: non-

development, development, DPA, RPA and parallel funds that support HPNSDP. An expert team should be constituted to assess current resource planning tools, develop joint annual work plan classifications, and develop a blue print and action plan.

3 **Increase human resource capacity in health financing and financial management in the health sector.** An immediate review of the current staffing structure of FMAU is needed, with an eye towards revising the organogram to increase professional posts and reduce support staff. Also, a review of human resource needs to accomplish objectives in health economics OP should be undertaken, and a strategy to fill human resource gaps should be developed. This strategy should be jointly developed with DPs (including parallel funders), who can help close the technical manpower gap.

4 **Link local level planning with fund allocation.** LLP is a powerful mechanism to ensure need-based resource allocation. However, without concrete steps to mainstream LLP into the national budgeting process, the initiative will not succeed. Financial mechanisms to operationalize LLP must be put in place. Financial management procedures must be developed for LLP administration. Legal, administrative, and procedural actions to enable the delegation of financial and administrative authority should be completed. The PAD and PIP outline the necessary actions, however, little progress has been made. An expert team should be constituted to develop a phased action plan for operationalizing these steps.

1 THEMATIC AREA BACKGROUND INFORMATION AND CONTEXT

Planning, budgeting, and financial management are key ingredients to achieving the overall objectives of the HPNSDP. The sector program can only be successful if resources are rationally allocated, strong financial controls are in place, budgets are properly executed, and joint reviews are transparently taking place. Bangladesh has made good progress over the years in this regard, as evidenced by the increasing willingness by development partners to use government systems for financing.

Planning, budgeting, and financial management has been challenged by historic institutional attributes of the Bangladesh public sector, such as the complex civil service structure and centralized planning system. The plurality of financing mechanisms by development partners has also led to complexity in overall financial management. Despite these challenges, the sector has made many improvements over the years, and worked creatively to overcome the structural challenges with innovations such as local level planning and outsourcing human resources.

This review will analyze the overall system of planning, budgeting, and financial management in the health sector. We will cover areas including resource planning, resource coordination, budgeting, internal control, funds flow, financial reporting, audit, MIS systems (IBAS, ADP monitoring), coordination, and budget execution. We cover two OPs: Improved Financial Management and Health Economics and Financing.

2 APIR: ANALYSIS AND PRINCIPAL FINDINGS AND RECOMMENDATIONS

2.1 OPERATIONAL PLAN ANALYSIS: IMPROVED FINANCIAL MANAGEMENT (IMF)

The major objective of the OP is to improve overall Public Financial and Fund Management of the Health, Population and Nutrition sector. The OP has five major components, (i) Accounting and Reporting, (ii) Development of Accounting and Asset Management System, (iii) Internal Control and Audits, (iv) Institutional Capacity Development and (V) Aid Modality and Fund Management.

The total allocation for FY 2011-12 was only TK 2.20 Crore against OP provision of TK 5.95 Crore. The major activities accomplished in the last financial year were training of FM personnel, initiating process of strengthening internal audit, and operationalization of Interim Unaudited Financial Report (IUFR) generation system. The OP has yet to initiate any activity under its major component relating to development of financial management information system. More than one third of the total OP budget has been allocated to this component. According to APIR 2012, in the last financial year targets of four indicators out of seven (57%) have been achieved. APIR have identified shortage of manpower and delayed fund release as the major challenges faced by the OP in the last year. However, the area where the major attention needed now is how to use the allocation for development of Financial Management Information System (FMIS). MOHFW has a number of MIS in operation, one of them is ADP monitoring system which appears to be a robust system. With suitable customization this system

can meet the FMIS need of the Health Sector. A proper needs assessment is therefore necessary before adopting a particular system.

2.2 OPERATIONAL PLAN ANALYSIS: HEALTH ECONOMICS AND FINANCING

The major objective of this OP is to provide overall health economics and financing support to the health sector. The OP has 7 objectives, which range from high-level objectives such as "to provide policy guidance for cost-effective, gender responsive, efficient health care service delivery" to activity-level objectives such as "develop resource allocation formula".

The total allocation for FY 2011-12 was TK 8.30 Crore against the OP provision of TK 5.95 Crore. Only 62% of GOB allocation was expended, while 84% of PA allocation was expended. The OP, despite staff shortages, has had some major accomplishments. Most noteworthy is the development of the national health financing strategy and the development of the SSK health insurance pilot. The health financing strategy provided an overarching framework to deal with issues of raising revenues, promoting equitable access, and promoting strong performance. The SSK pilot put forth an innovative approach to reduce financial barriers to access for the poor.

According to the APIR, ten indicators out of fourteen (71%) have been achieved. The indicators in the OP are clear, achievable and appropriate. As with many other OPs, delay in fund release and shortage of staff were the two biggest challenges faced by the OP.

The APR team is concerned about the manpower requirements needed to fulfill the targets of the OP. For example, this OP is tasked with developing and institutionalizing an overall resource tracking system, though last year only a concept note has been developed and the last NHA was completed in 2007. The adaptation of a resource allocation formula is a key objective of the OP which has been recommended by previous APRs, yet very little practical progress has been made over the years beyond the drafting and redrafting of a formula concept note. Going forward, the APR team recommends that an analysis of human resource needs for the HEU be undertaken, and a practical plan be developed to ensure that these major deliverables are on track to be completed. This plan may involve bringing on long-term TA and engaging parallel DPs to support the objectives.

3 THEMATIC AREA-SPECIFIC ANALYSIS AND PRINCIPAL FINDINGS AND CONCLUSIONS

3.1 ORGANIZATION OF PFM

Reorganization of Financial Management (FM) Functions is a positive step towards harmonization of FM functions. There has been a recent reorganization in the allocation of FM functions in the MOHFW. Previously the revenue budget preparations and its implementation monitoring and audit of revenue expenditure were the responsibilities of the Administration wing of the Ministry. Under the reorganization, the functions of FMA wing has been expanded to include management of revenue

budget and audit of revenue expenditure in addition to their original functions of development fund release and FMAU functions like financial management reporting, internal audit, and resolution of FAPAD audit observations.

This reorganization has brought all financial functions except preparation of development budget under FMA wing. Preparation of development budget in the form of ADP and monitoring of ADP implementation however continue to be the function of the planning wing. With this reorganization, the recommendation of the last successive APRs to bring all FM functions under one wing has been implemented partially. However, despite this progress, lack of effective coordination between development and revenue budget management continues to persist.

Systems for PFM are strong, but compliance with policies and procedures needs improvement. The assessment team was generally impressed with the financial management systems of the MOHFW. While there is room for improvements in a range of areas, overall the systems for internal and external control are strong. The system is properly structured such that adequate controls are in place. That said, we observed that compliance with these systems required improvement. For example, line directors were often delayed in submitting financial information into the ADP Monitoring tool and the consequences of unresolved audit objections were not clear.

3.2 RESOURCE AVAILABILITY FOR THE HPNSDP

The allocation pattern of HPNSDP is not consistent with the levels set forth in the PIP. As described in the 2012 APIR, there is a significant mismatch between annual OP provision and ADP allocation (table 1). Only about 60% of the OP provision for 2011-12 was allocated in the RADP of the same year and the actual utilization stood at less than 53% of the OP provision. How the achievement of program targets were affected by this under funding could not be assessed with the available data, however, if this trend of underfunding continues the realization of program targets will seriously be undermined. The ADP allocation in the current year, 2012-13 indicates further decline in the trend. Only 58.5% of the OP provision for the year, 2012-13 has been allocated in the current year's ADP. A reason for underfunding is perhaps due to limited fiscal space available to the government for providing adequate resources to match the OP provision. However, it is not clearly understood, why there is so much underfunding from PA resources. Another reason for under allocation is due to low absorptive capacity of the government, which also needs to be improved. A joint review of the situation by GOB and DPs is urgently needed to find realistic solutions for improvement.

Table 1. **Figures in TK Crores**

	OP Provision for the Entire Program	OP Provision for 2011-12	RADP Allocation for 2011-12	% of OP Provision	Actual Utilization	% of OP Provision
Total	22,176	3,786	2,270	60	1,992	53
GOB	8,603	1,325	790	60	750	56
PA	13,573	2,461	1,480	60	1,242	50

Local government allocation for health not available at upazilas. According to the Local Government Division's Upazila Parishad Development Fund Utilisation Directive (Dhaka, 10 April 2010), the upazila parishad should allocate between 10% (min) and 15% (max) of its annual grant to health and social welfare. Neither the CS nor DDFP were aware of any local allocation towards health in any upazilas visited by the APR team except for Shantiya. In Shantiya, strong engagement by the upazila parishad and MP in health resulted in a 7% local government allocation for health, which was used mostly to buy equipment for the UHC and CC.

Discretionary public budget for health does not exist at the upazila and district levels. The CS of the districts visited by the APR team commented that the lack of budget authority and limited responsiveness from Dhaka hinders their ability to provide support to the UHS. For instance, the CS in Syhlet mentioned that the amplifying mechanism for the x-ray machine had needed replacement for several years, but despite many requests to Dhaka, they still had not received the parts. He commented that this problem could be easily solved if the CS had greater discretionary budget authority. Other CSs had similar thoughts – one suggested creating a local referral transportation system with discretionary budgets, while another discussed making basic upgrades to community clinics.

Upazila parishads are even more constrained, in that they must relay all requests to the CS, which eventually are fed up to Dhaka. Some upazila parishad members commented that they are under great pressure from their constituents to make improvements, but lack the resources to do so.

Availability of local private funds have motivated upazilas to greatly improve performance. Shantiya UHC is a 50 bedded hospital that receives GOB resources for only 31 beds, but bed occupancy is consistently over 200% based on a 50 bedded denominator. The resources to finance the operations at such high occupancy are largely financed from private donations (table 2). Similarly, the APR team discovered that in Chaugacha, private donations allowed the UHC to hire 16 staff, medical equipment, repair parts, and other critical items. In Shantiya, 4.2 lakhs taka of local funds were generated last fiscal year. These local funds have enabled the UHC to self-upgrade itself into an EMOC facility where C-sections are now regular practice. To date, this facility is still not designated and resourced as an official GOB EMOC center. Items purchased include an ultrasound machine, operation light, hydrolic OT table, and laboratory equipment.

Local Funds Strengthen UHS in Shantiya

Civil Society Contributions

- Laptop
- E.C.G. machine
- Multimedia projector
- Grass cutting machine
- Digital camera
- Scanner and photocopy machine
- Build canteen
- Build stand of Honda/Cycle

Union Parishad Contributions:

- Ultra sonogram machine
- Dental set with dental chair
- Operation light
- Hydrolic O.T. yable
- Bio-chemical reagents
- Medicines for CC and pregnant
- Laboratory upgrade

3.3 BUDGETING

There still remains a disconnect between revenue and development budget. MOHFW continues to follow separate procedures for preparation, monitoring, and approval of

revenue and development budget. There is also no effective mechanism to coordinate the two processes. As a result, it is difficult for decision makers and managers to take a holistic view on the allocation of resource. Such compartmentalized budgeting system always has the risk of duplication and under-allocation of resources in priority areas.

Many activities of both the budgets are complementary to each other and a particular activity of one budget is dependent on the implantation progress of an activity of the other budget. Coordinated monitoring is therefore necessary for attaining the budget targets, which is currently missing.

As a consequence of the implementation of certain activities under development budget sometimes an additional resource demand is created in the non-development budget to sustain those activities. Due to a compartmentalized budgeting process, there is no forward planning to assess the requirement of resources needed for meeting such demands and making necessary provision in the upcoming budget.

About two years back the government announced its intention to unify the two budgets, however, due to some technical and administrative limitations, the government has not yet decided the actual date of implementation. Successive APRs of HNPSP have recommended developing a ministry wide single work plan for combined revenue and development budget as a step towards better coordination and attaining the ultimate goal of budget unification. Accordingly the ministry has developed a draft single work plan, which still awaits its implementation.

Preparation of development budget is not based on need. Development budget is prepared on the basis of multiyear plan (Ops). Allocations are often made without making any field level needs assessment on annual basis. Cost centers at field level virtually have no participation in the preparation on the budget. Line directors often do not consult with civil surgeons or deputy directors of family planning to prepare annual OP budgets. As a result, budget is often not need-based causing under-allocation in certain priority areas as well as over-allocation of resource in certain activities. This mismatch in allocation is frequently a cause for under-utilization of the ADP.

3.4 FUND RELEASE

Slow fund release can significantly undermine implementation of HPNSDP. According to APIR 2012, most of the LDs have identified delay in the release of fund as a major constraint in the implementation of their OPs during the FY 2011 – 2012. Late approval of the PIP, Ops, and joint financing agreement, with the consequent delayed startup of the program, has been attributed as the major cause for the delay. As the last financial year was the first year of the new program those could be the valid reasons for the delay. However, over the years delay in the release of fund has consistently been a constraint requiring improvement. Delay in the submission of request for fund from LDs, slow processing in the MOHFW and MOF often causes the delay. Delay is also caused due to non-timely receipt of SOEs from field offices.

MOF restrictions limiting fund release to single quarterly installments is hampering the ability of MOHFW to clear large procurements. The recent revision of the fund release procedure by the MOF, restricting the authority of the line ministries to release more than one quarter of the fund at a time without the approval of the MO, will further slowdown the process of fund release and consequently the utilization of ADP

allocation. The main reason behind the revision by the MOF is to improve the cash availability, which has come under serious stress in recent time. Under the pooled funding arrangement, DPs provide an advance equivalent to six month's estimated RPA expenditure to a special (FOREX) account established in the central bank. This arrangement enables the CGA to recover from the FOREX account the amount spent by the GOB to meet RPA expenditures of HPNSDP. Therefore the release of two quarters of RPA allocation at a time for HPNSDP should not affect the government's cash availability. So there is a scope for MOHFW to raise the issue with the MOF for relaxation of the restriction to release two quarters at a time for HPNSDP expenditure. However, despite this restriction in place the pace of release of fund can be significantly improved if prompt actions are taken by MOHFW and LDs to get the funds released within the first week of a quarter.

3.5 DELEGATION OF FINANCIAL AND ADMINISTRATIVE AUTHORITY

Revision of delegation of financial power to LDs is needed. The government order delegating the financial power to officials of different levels of the MOHFW, Heads of Departments (DGs), and LDs for implementation of OPs was last issued in June 2008. With the new health sector program in place and a high rate of inflation experienced by the country in recent years, the delegation calls for a review and revision. Many LDs have reported that they have difficulties in implementing their OPs with the current level of delegation in the wake of rising prices of goods and services. A major complain is about limited delegation with respect to repair of equipment and vehicles.

Revision of delegation of financial and administrative authority at the district level is needed. Limited delegation hampers the ability of the local level to reallocate resources based on need. The APR team frequently heard about situations where basic supplies or repairs could not be completed by the local level without permission from Dhaka, which often resulted in long delays (sometimes even years). The delegation of financial and administrative authority will be critical if local level planning is to be fully operationalized, yet we have seen limited movement towards delegation even after major efforts to institutionalize LLP. Finally, many of the recommendations in the health financing strategy, including the implementation of the SSK insurance program, assume and require delegation of authority.

3.6 HUMAN RESOURCES FOR PUBLIC FINANCIAL MANAGEMENT

Staff shortages are debilitating the public financial management system. Shortage of FM staff in the offices of LDs, as well as in the FMAU, has been identified as a key challenge in APIR 2012 towards improving financial management of the MOHFW. Currently, FMAU is functioning without any IT and accounting staff.

The permanent setup of FMAU has high proportion of supporting staff, 16 out of 29, which needs to be revised by increasing the number of professional staff and accordingly reducing the number of supporting staff without enhancing the manpower cost. Except the post of the head of FMAU, who is a deputy secretary, all other permanent posts of FMAU are currently lying vacant. Those posts cannot be filled up due to the absence of an approved recruitment rule. A recruitment rule has been

prepared for filling up the permanent staff of FMAU and has been sent to Ministry of Public Administration for final approval of the government.

An initiative has been taken to hire 20 FM staff for FMAU and LDs through outsourcing as an interim arrangement. As of this writing, proposals received from the shortlisted firms are being evaluated.

Rapid progress by GOB in skill development for FM has already shown results. One of the major achievements of the 'Improved Financial Management' OP during last HNPSP was imparting training on Financial Management and Audit to different level of officials and staff working at Headquarters LDs, district and upzilla offices of the MOHFW. According to APIR 2012, the training program has greatly contributed in improving overall financial management thereby reducing financial irregularities and consequently audit objections. As a continuation of the previous training program, 137 FM personnel from different offices of MOHFW received local training and three officials received foreign training in the FY 2011 – 2012 under the current HPNSDP. However, retention of trained manpower still remains a challenge.

3.7 FINANCIAL REPORTING AND DATA INTEGRITY

Financial reporting systems for MOHFW funds are adequately structured. The FMAU is tasked with the preparation of overall financial reporting of the sector as well as the preparation of the interim unaudited financial report (IUFR), which is required for release of funds from the RPA pooled fund. Currently the system is structured such that the DDO attached to each line director must work with the CAO to reconcile finances with IBAS data on a quarterly basis. Once this reconciliation is complete, the LD sends the financial report to the FMAU. The FMAU staff compiles the financial data to prepare the IUFR and submits, on a quarterly basis, to World Bank for approval in the case of the RPA pooled fund and to JICA in the case of RPA 'other' fund. Disbursement from the RPA accounts occurs on a quarterly basis.

The overall process to produce the financial report involves numerous manual steps. That said the system contains the necessary checks for accurate financial reporting. The FMAU faces the burdensome task of following up with each LD's DDO for quarterly reports, compiling the data, and manually preparing the IUFR.

While further automation of this process would increase overall efficiency, the risks and costs of further automation outweigh the benefits. For example, previous recommendations to allow FMAU direct access to IBAS data, thereby bypassing the CAO, would most certainly reduce the time and effort needed to produce the IUFR. However, bypassing the CAO would also remove an important check into the system. Additionally, we do not recommend allowing IBAS access to line directors. The IBAS system is a government-wide accounting system, not a health sector financial management system. Instead, we recommend further building out the capabilities of the APR Monitoring tool to serve as a full-fledged financial management system for the health sector.

Financial reporting of DPA is not sufficiently transparent. Development partners provide the DDO of LDs with financial statements on a monthly basis. DDOs then submit the statements to the CAO, which in turn inputs the data into the IBAS system.

Several weaknesses were identified within this system. First, LDs are not in a position to verify expenditures or expenditure coding by DPs, and therefore operate largely on a 'trust' basis without applying scrutiny. The CAO reported the same concern – he was not in any position to question or scrutinize the statements by DPs, and therefore took them to be truth. The CAO also noted that the DP reports are not received in a consistent format, which causes confusion and additional work for LD and CAO staff. For example, DPs were reportedly not using IBAS item numbers to code their expenditures, leaving the DDO and CAO to make assumptions on the appropriate expenditure category.

3.8 AUDIT

Internal audit has improved significantly. A major achievement in the area of financial management during the last SWAP was strengthening of internal audit in the MOHFW. A private audit firm was engaged to carry out the internal audit. This initiative has been sustained in the current program and the MOHFW has already started the process of engaging a private audit firm to conduct internal audit of the program. Short-listing of audit firms has been completed and "Request for Proposal" (RFP) will be issued shortly. In addition to the audit by the outsourced audit firm, seven in-house core audit teams of this MOHFW are also performing an internal audit. However, despite the progress, effective response to internal audit observation still requires further improvement and a stronger persuasion is necessary to follow up the implementation of the recommendations of the internal audit report.

External audit has improved but still needs strengthening. The external audit of the first year (FY 2011 – 2012) of HPNSDP by the Foreign Aided Project Audit Department (FAPAD) of the C&AG will be conducted shortly. A new Audit Strategy has been drafted for HPNSDP, which is currently awaiting the approval of the C&AG. The strategy will highlight the audit coverage focus and steps for effective and timely resolution of audit observations. The external audit of the last program, HNPSP, undertaken by FAPAD were timely and in conformity with the agreed coverage, scope, and methodology. Despite the progress in the resolution of serious audit observations, as identified by the World Bank, the pace of resolution of audit observations in general remains slow and requires further improvement.

3.9 RESOURCE PLANNING

Significant progress to scale local level planning has been made, but LLP is still not mainstreamed into the OP budget and allocation process, thus undermining effectiveness of the initiative. Local level planning is being rolled out across the country. The APIR 2012 states that under the PMR OP of DGHS, LLP plans were prepared in 170 upazilas in 20 districts and 560 health personnel were trained on LLP. In the PME-FP OP of DGFP, 482 upazila plans were prepared from 64 districts and a total of 11,940 people across the country were trained in LLP preparation. Unfortunately, a coordinated mechanism to fund LLPs across all relevant OPs still does not exist. The PIP and PAD listed key actions necessary to link LLP to budget, but little progress has been made. Therefore, LLPs are minimally funded, if at all. Moreover, the financial and administrative authority still does not lie with the district or upazila level,

therefore constraining the overall objective of LLP to cater towards local need. This has seriously undermined the LLP process.

MOHFW has made progress in deepening their use of MTBF. Deepening of MTBF process continues in the MOHFW. The government has initiated certain actions like, revision of the composition and TOR of budget committee and budget working group for bringing institutional changes for revitalizing the MTBF process. The ministry prepares its budget on the basis of a single resource envelope as indicated by MOF. The MOHFW is delegated to determine what should be the split between revenue and development. There are visible efforts to identify priority areas of spending in PIP, linking resource allocation to attain policy objectives and established key performance indicators. In the absence of any updated evaluation it is not feasible to ascertain the effectiveness of these efforts. Furthermore, it is still unclear to what extent the MOHFW uses the MTBF as a planning instrument, in light of the separate procedures of the planning commission.

Planning and coordination between various financing modalities needs strengthening. The HPNSDP is financed through a variety of sources, including GOB, RPA pooled funding, RPA other, DPA, and parallel funding. Our review demonstrated that greater coordination is needed across these modalities. For example, the financing of community clinic training is currently stalled, as there is controversy as to whether this should be funded from RPA pooled funding or RPA JICA. There were concerns that activities to be financed using RPA were also supported by parallel donors funders. Finally, there have been concerns that the lack of coordination between the GOB development and non-development budgets has led to double programming of activities from both budgets.

3.10 RESOURCE MONITORING & TRACKING

Comprehensive system of resource tracking across all funding modalities does not exist. Sound data on financial flows within the health sector is necessary for effective budgeting and planning within the health sector and for benchmarking health system performance. Bangladesh has attracted large numbers of international and domestic NGOs into the health sector, though it is not always clear what level resources these organizations bring and exactly how these organizations are spending their resources. DP to DP transfers and DP to NGO transfers further compound resource tracking complexities, often times resulting in double counting. A variety of methodological frameworks for measuring and categorizing resource flows into the health sector exist, such as the National Health Accounts (NHA), Public Expenditure Review (PER) and various ad hoc tracking exercises. These exercises use different methodologies, yield figures that are often inconsistent, and do not adequately and routinely capture Development Partner and NGO resource flows. Moreover, these resource tracking exercises are often conducted as one-off surveys/studies and are not institutionalized as a core element of National planning, budgeting, and performance monitoring/review.

Development partner commitments and disbursement information are not transparent. Total DP commitments for the HPNSDP were found in the PIP, but the APR team was informed that these commitments had changed greatly. The APR team could not systematically locate updated figures for DP commitments. Data on total

committed to date and disbursed was gathered by the World Bank in preparation for the APR (Table 2). Two DPs (KFW and UNDP) did not report their financials. Other DPs gave incomplete information. Some DPs who provided direct TA, such as JICA and GIZ, did not put a dollar value on their TA. Overall, the tracking of commitments and disbursements by DPs is not transparent and causes difficulty for the MOHFW to accurately plan and manage the sector.

Table 2: Development Partner Self-Reported Allocation and Disbursements

Donor	Fiscal Year	Pool Allocation	Pool Disbursement	DPA Allocation	DPA Disbursement	Off-budget Allocation	Off-budget Disbursement	Notes
World Bank IDA Credit	July-Jun	$358,900,00	$92,000,000	$0	$0	$0		
Netherlands	Jan-Dec	$5,126,000	$0	$0	$0	$4,485,250	$3,422,246	
Ausaid	July-Jun	$8,029,000	$8,029,000	$0	$0	$15,488,200	$15,488,200	
UNICEF	Jan-Dec	$0	$0	$10.484.963	$3.646.963	$1.836.424	$1.836.424	
WHO	Jan-Dec	$0	$0	$7,400,000	$5,300,000	$250,000	$200,000	
CIDA	Apr-March	$0	$0	$9,794,295	$9,794,295	Incomplete	$3,327,847	
JICA	Apr-March	$64,512,000	$10,099,200	$0	$0	$0	$0	In kind not reported
SIDA	Jan-Dec	$12,160,000	$12,160,000	$228,000	$0	$3,617,600	Incomplete	
DFID	Apr-March	$40,312,500	$40,312,500	$11,287,500	$10,465,125	$322,500	$262,838	
USAID	Oct-Sept	$8,000,000	$8,000,000	$0	$0	$53,483,000	$53,483,000	
GIZ	Jan-Dec	$0	$0	$0	$0	$0	$0	In kind only
KFW	** No Response **							
UNDP	** No Response **							
UNAIDS	Jan-Dec	$0	$0	$0	$0	$320,722	$242,415	
TOTAL		**$497,039,500**	**$170,600,700**	**$39,558,758**	**$29,206,383**	**$79,803,696**	**$78,262,969**	

4 OVERALL THEMATIC AREA CONCLUSIONS AND RECOMMENDATION (AND LESSONS LEARNED)

Planning, budgeting, and financial management of HNPSDP continues to show improvement. The growing reliance of the DPs on country financial systems is indicative of this progress. As the program evolves, new challenges evolve with it. The APIR 2012 recommends the following actions to sustain the positive trajectory for planning, budgeting and financial management.

Recommendation 1: Ensure adequate resource allocation and efficient utilization to achieve HPNSDP results. A joint review by GOB and DPs should be undertaken

immediately to analyze the growing trend of underfunding OP provisions of PIP. In addition, finance division to relax the newly-imposed quarterly fund release for RPA, more aggressive monitoring by planning wing for budget execution by OPs, and improved coordination between MOHFW, LDs, and World Bank in clearing procurements for approval.

Action 1. Conduct a study to understand all root causes of underfunding of OPs, and develop concrete strategies to rectify. A joint review by GOB and DPs should be undertaken immediately to analyze the growing trend of underfunding OP provisions of PIP and to find a realistic solution to improve the situation.

Action 2. Streamline the fund release process to ensure the release of fund in the first week of each quarter. Ministry of finance should be approached to relax the restriction recently imposed on the release of two quarters of RPA of HPNSDP at a time in view of the fact that DPs provide requisite fund to meet RPA expenditure as advance to FOREX account of the government in Bangladesh Bank.

Action 3. Develop and enforce maximum time limits for submission of procurement/training requests (LDs) and approval/disapproval by MOHFW and World Bank. Delays were reported at all levels of the system, from the production of requests by the LD, the consolidation and approval by MOHFW (especially for training), and final approval from the World Bank. These delays were cited as a major reason for lower budget execution. The APR team recommends agreeing upon maximum time limits for each stage of the process to ensure timely approval and execution.

Action 4. Enhance LD financial power. Review and revise the existing delegation of the financial power to LDs to make it compatible with the requirement of the new program and taking into consideration the price escalation due to inflation.

Recommendation 2: Ensure comprehensive planning and tracking of resources across the HPNSDP. A comprehensive picture of all planned and expended finances in the HPNSDP is critically needed to ensure strong planning and sector management. Building on the unified workplan developed in previous years, an online system should be developed that accounts for planned and expended budgets from all sources of financing of the HPNSDP: non-development, development, DPA, RPA and parallel funds that support HPNSDP. An expert team should be constituted to assess current resource planning tools, develop joint annual work plan classifications, and develop a specific action plan. The following action items are needed to operationalize this recommendation. Given the highly specialized technical nature of the work, the APR team recommends TA to move forward each activity.

Action 1. Expand and implement single annual workplan based on health accounting classifications. A single annual workplan was developed in response to previous APR recommendations as means to harmonize the revenue and development budgets. This workplan was limited in scope to unify the revenue and development budgets, and has not yet been implemented. We recommend that the scope of this workplan be expanded to include information from DPA and parallel funding partners for the HPNSDP. It is critical that this single annual workplan is built around standardized health accounting classifications to allow for rigorous and meaningful resource planning and tracking. Finally, the single annual workplan should automatically 'map' to MTBF categories to ensure that the MTBF is better utilized for sector planning.

Action 2. Build an online platform to implement single workplan and resource tracking. To ensure systematic collection of planned and actual expenditures, an online resource tracking system is needed. This financial management/resource tracking system should be separate from the IBAS system, but linked in for the purposes of reconciliation. The ADP monitoring tool already possesses impressive capacity and could serve as the backbone for such a system as long as it does not overburden or dilute its core functionality. We recommend commissioning a study to evaluate all of the existing MIS platforms in Bangladesh that could serve this purpose, with recommendations on the way forward.

Action 3. Reinvigorate resource tracking steering committee and enforce regular reporting by all stakeholders supporting the HPNSDP. Resource tracking is a complex undertaking that requires strong stewardship from the GOB. Joint resource planning and tracking can only work when all partners actively participate in the process. We recommend that the GOB require all partners of the HPNSDP to report their planned budgets twice per year and their expenditures once per year, to coincide with the GOB fiscal year. To enable this, we recommend that the resource tracking steering committee be reinvigorated and serve as the main stewardship body overseeing the development and implementation of the resource tracking initiative.

Action 4. Integrate joint bi-annual reviews of planned spending, as well as annual reviews of expenditures, into the annual budget process. The output of the online platform should be jointly evaluated by GOB and DPs to ensure that resources are coherently and equitably planned across the program. Annual expenditure reviews should also be jointly held so that all partners in the SWAp can hold each other mutually accountable for commitments.

Recommendation 3: Increase human resource capacity for health financing and financial management in the health sector.

Action 1. Review current staffing structure of FMU and revise to increase professional posts. The organogram of the FMU should be suitably revised to increase the number of professional posts. The number of supporting staff may be reduced as required so the total cost for salary and allowances remains within budget provision. The finalization of the proposed recruitment rule and filling up of vacant positions in FMAU should be expedited.

Action 2. Undertake review of human resource needs to accomplish objectives in health economics OP. Many of the recommendations of the APR team in health financing may require implementation by the health economics unit. It is therefore critical that the total human resource needs be carefully assessed and a strategy developed for filling the gaps. Strategies could be long term consultants, support from parallel projects, or reaching out to expert staff in other parts of the MOHFW.

Recommendation 4: Link local level planning to fund allocation

Action 1. Develop practical roadmap to mainstreaming LLP into national budget process. Progress on rolling out LLP has been impressive except in a few limited cases where LLP is not linked to the national budget process. The PAD and PIP outlined the major actions that were needed, but little progress has been made to implement these recommendations. The APR team recommends developing a practical roadmap that clearly outlines the steps, actions, and processes necessary for the LLP to be

mainstreamed into the national budget process. The roadmap must be structured in phased approach, with actions that are feasible and practical. The final roadmap should be disseminated to all LLP districts and upazilas.

Action 2. Design and implement system to delegate financial and administrative authority at district and upazila levels. The full potential of LLP can be met if adequate financial and administrative authority is delegated to the district and upazila levels. Again, this was discussed in detail in the PAD and PIP, however little progress has been made. An implementation plan should be developed that outlines all of the necessary actions, including the legal, administrative, and procedural modifications needed. A phased and practical approach should be used, with clear deadlines for implementing each action.

Action 3. Design policies and procedures for financial management of LLP funding. LLP implementation with financial and administrative delegation will require strong financial management procedures. A policy should be developed that clearly deals with reporting, data integrity, reconciliation, fund release frequency, and audit procedure. These procedures will need to conform to national policy and procedures. Based on this policy, a procedures manual should be developed for the districts and upazilas. Local level staff, who are not traditionally used to these procedures and controls, will need to be sensitized and trained.

ANNEX 1

IMPLEMENTATION OF PAD RECOMMENDATIONS ON PLANNING, BUDGETING AND FINANCIAL MANAGEMENT

PAD measures to be completed by September 2011	Status of implementation	Remarks
Develop revised FMU organogram and job description of FMU staff	No revised organogram prepared yet. Job description of FMU staff is in place. Draft recruitment rule is awaiting approval of public administration ministry.	APR team recommends revision of the organogram so that more professional staff are substituted for support staff.
One OP for FM capacity development in place of 3 OPs	Completed	
Development of agreed action plan for fund disbursement	Implemented	
Customization of IBAS to generate IUFR	Partially implemented	Information obtained from IBAS is used to manually prepare IUFR. Current system is working well. APR team recommends reconsideration of PAD recommendation to customize IBAS any further.
Initiation of a procurement process to hire private audit firm for internal audit	Implementation in progress: shortlisting of firms completed	

ANNEX 2
OP INDICATOR ANALYSIS

OP: Health Sector Planning, Budgeting and Health Financing (HEF)

Sl	OP Indicators	Baseline	Target Mid-2014	Achievement (Jul '11-Jun '12)	Status/ Progress	APR Team Comments
1.	Number of training conducted/organized by batch/local and foreign	Local training - 04 course Foreign training- 01 post graduation HEU	20 Local batches Foreign training- 10 persons Local long training -3 persons	- 08 batches local training (100 persons) - 01 batch foreign training (4 persons trained)	Achieved	
2.	Number of study/ research conducted	09 researchers/ studies HEU, 2010	15 study reports	07 policy relevant studies conducted	Achieved	It would be important to track the use of the studies conducted for policy purposes.
3.	Number of workshops/seminars /conferences conducted	09 dissemination workshops HEU, 2010	15 workshops/ seminar	10 workshops organized	Achieved	
4.	Health care financing framework designed and implemented	NA, HEU, 2010	Designed	Draft Health Care Financing Strategy developed and consulted with various stakeholders at Regional and National level	Achieved	Strategy finalized and awaiting final approval.
5.	Health insurance piloted and results disseminated	NA, HEU, 2010	Piloted	- Draft Health Insurance Model developed - 07 pre-pilot studies conducted and results disseminated	Achieved	Human resource needs to achieve the goal of piloting the insurance program will need to be assessed.
6.	Advisory committees on health financing constituted and activated	NA, HEU, 2010	2 committees 4 meetings at least 2 decisions	- 01 Inter-ministerial Steering Committee & -01 Working Committee formed - 01 meeting of Working Committee held	Achieved	

Sl	OP Indicators	Baseline	Target Mid-2014	Achievement (Jul '11-Jun '12)	Status/ Progress	APR Team Comments
7.	Institutionalization of public expenditure tracking system	NHA-01, PER-01 HEU (2010)	NHA-01, Annual PER with 1 focused area	- Five year work plan for NHA institutionalization developed & work under progress - 01 PER conducted for the FY: 2007/08 – 2008/09	Achieved	Public expenditure tracking system is not institutionalized at all. Currently expenditure tracking occurs on an ad hoc basis and is not integrated into any national budgeting or planning process. This is a multi-year activity that takes focused effort and strong technical HR.
8.	Adaptation of Resource Allocation Formula (RAF)	NA, HEU, 2010	Designed	Some preparatory work done (meeting with stakeholders held and requested for TA support)	Achieved	Resource allocation formula has not been implemented. Design of RAF has been there for several years.
9.	EGVNP strategies developed	NA	2	No progress	Not achieved	HR Constraints
10.	Number of training conducted (EGVNP)	Local training-04 batches HEU, 2010	15 local batches (250 participants) Foreign training (6 participants)	02 batches local training on EGV held (70 persons trained)	Achieved	
11.	Policy research conducted (EGVNP)	01, HEU, 2010	8 studies with reports	Target – 1 study Not achieved	Not achieved	HR Constraints
12.	Workshops conducted (EGVNP)	05, HEU, 2010	15 workshops	Target – 2 workshops Not achieved	Not achieved	
13.	EGVNP and stakeholders issues piloted	NA, HEU, 2010	Piloting started	To begin in FY: 2012/13	Not achieved	
14.	Analyzing health expenditure, service utilization, HR etc. from gender and equity perspectives	NA, HEU, 2010	1	1 PER conducted, focusing gender	Achieved	This needs to be done on a much more regular basis, rather than through ad hoc surveys.

APR Team analysis: Human resource constraints in the HEU should be analyzed vis-à-vis the ambitions goals in the OP, notably the implementation of the health financing strategy, which contains many complex components. Resource tracking indicator is an

important area of work and its implementation resource requirements must be thought through carefully. Currently, it does not appear that there are adequate resources or even an adequate vision for this activity. Target should be more concrete for this indicator. One example could be: "resource tracking system developed and used by all SWAP partners as part of routine annual/bi-annual SWAP reviews".

OP: Financial Management (IFM)

Sl	OP Indicators	Baseline	Target Mid-2014	Achievement (Jul '11-Jun '12)	Status/ Progress	APR Comments
1.	Software to be developed and all LDs to use Computerized Accounting System	Not applicable LD, IFM	50%	iBAS connection established at FMAU	Not achieved	FMAU states that connectivity not established
2.	Number of financial reports to be prepared annually	NA LD, IFM	2	Will be prepared after 30th June	Not considered	IFUR on track
3.	Strengthening of Internal Audit	N/A	50%	07 core audit teams are performing internal audit from MOHFW (indicator to be defined later)	Achieved	
4.	Strengthening of Internal Audit (outsourcing)	N/A	1	REOI completed	Partially achieved	Selection process underway
5.	Number of FM personnel trained at all levels	1800 FMAU	1500	137 FM personnel from various levels were trained in Bangladesh and 03 person were trained in abroad	Partially achieved	
6.	Adopt and use IUFR (Interim Unaudited Financial Report)	32 FMAU	Done	Done	Achieved	
7.	Number of batch for refresher course on Audit and Financial	-	10	06 batches by DGHS	Achieved	
8.	Number of workshops conducted on Audit and Financial	-	15	10 workshops by DGFP	Achieved	

APR Team Analysis: The indicators for this OP are appropriate and feasible. The APR team recommends adding an additional indicator to reflect the further development and mainstreaming of the ADP monitoring tool as a key financial management system for the MOHFW. Rapid progress on human resource outsourcing is laudable and timely.

ANNEX 3
RESULTS FRAMEWORK

RESULT	Results Framework Indicators	IRT Member OP(s) Reviewed	
		IFM	HEF
Goal: Ensure quality and equitable health care for all citizens of Bangladesh	Infant mortality rate (IMR)		X
	Under 5 mortality rate		X
	Neonatal mortality rate		X
	Maternal mortality ratio		X
	Total fertility rate (TFR)		X
	Prevalence of stunting among children under 5 years of age		X
	Prevalence of underweight among children under 5 years of age		X
	Prevalence of HIV in MARP		X
Additional indicators	*Prevalence of anaemia reduced in < 5 y, adolescent girls and pregnant women*		X
	Prevalence of night blindness among children < 5 sustained		X
	Prevalence of iodine deficiency reduced by 1/3		X
Result 1.1 Increase utilization of essential HPN services: maternal, neonatal, and child health; family planning and reproductive health; communicable diseases; nutrition services	% of delivery by skilled birth attendant		X
	Antenatal care coverage (at least 4 visits)		X
	Postnatal care within 48 hours (at least 1 visit)		X
	Contraceptive prevalence rate (CPR)		X
	Unmet need for FP		X
	Measles Immunization Coverage by 12 months		X
	% of children (0-59 months) with pneumonia receiving antibiotics		X
	TB case detection rate		X
	% of children (6-59 months) receiving Vitamin A supplementation in the last 6 months		X
Additional indicators	*Increased utilization of community clinic by 200%*		X

RESULT	Results Framework Indicators	IRT Member OP(s) Reviewed	
		IFM	HEF
Community services	*Increased # patients referred to higher level if needed by 160%*		X
Result 1.2 Improve equity in essential HPN service utilization (MDGs 1, 4, 5 and 6)	Proportion of births in health facilities by wealth quintiles		X
	Use of modern contraceptives in low performing areas		X
	# of upazilas with women targeted by improved voucher scheme for having institutional deliveries		X
	Increased # patients referred to higher level if needed by 160%		X
Result 1.3 Improved awareness of healthy behavior (MDG 1, 4, 5)	Rate of exclusive breastfeeding in infants up to 6 months		X
	% of children 6-23 months fed with appropriate Infant and Young Child Feeding (IYCF) practices		X
Additional indicators	*75% of pregnant women report more food intake during pregnancy*		X
Result 2.1 Strengthened planning and budgeting procedures	% of MOHFW budget allocated to upazila level or below	X	X
	% of annual work plans with budgets submitted by LDs by defined time period (July/Aug)	X	
Result 2.2 Strengthened monitoring and evaluation systems	MIS reports on service delivery published and disseminated annually		
	Performance report of OPs reviewed with policy makers, MOHFW, Directorates and DPs, six monthly and annually		
Result 2.3 Improved human resources – planning, development, and management	Proportion of service provider positions functionally vacant at upazila/district level and below, by category		
	# of additional providers trained in midwifery at upazila health facilities/deployed		
	No. of comprehensive EmOC facilities with functional 24/7 services covering all districts		
Additional indicators	*# CEmOC facilities with 3 pairs of skilled personnel*		
	Comprehensive evidence based HR plan developed and implemented		

RESULT	Results Framework Indicators	IRT Member OP(s) Reviewed	
		IFM	HEF
	Developed, reviewed and updated existing rules and guidelines on recruitment, deployment, transfer, promotion and carrier ladder		
Result 2.4 Strengthened quality assurance and supervision systems	Case fatality rate among admitted children with pneumonia in Upazila health complex		X
Result 2.5 Sustainable and responsive procurement and logistic system	% of health facilities, by type, without stock-outs of essential medicines at a given point in time	X	X
	% of facilities without stock-outs of contraceptives at a given point in time	X	X
Result 2.6 **Improved infrastructure and maintenance**	% of facilities (excluding CCs) having separate, improved toilets for female clients		

APR Team Comment: Health financing impacts the entire sector and is critical to the achievement of almost all results framework indicators related to health outcomes, outputs, and service availability. Planning, budgeting, and financial management are also highly cross cutting, and support the overall achievement of the entire HPNSDP.

ANNEX 4

PERSONS CONTACTED

MOHFW
Mr. Zakir Hussain, Joint Secretary (FM)
Mr. MD Asadul Islam, Joint Secretary (HEU)
Ms. Niru Shamsunnahar, Joint Chief, Planning Wing
Ms. Nargis Khanam, Planning Wing
Mr. Moshiur Rahman, Deputy Secretary, FMAU
Mr. Mujibur Rahman, Assistant Chief, Planning Wing
Mr. Sayed Abu Jafar Md Musa, Line Director, MNCH
Professor Abul Kalam Azad, Line Director, HIS & E-health

Foreign Aided Project Audit Division (FAPAD)
Mr. AKM Jashim Uddin, Director General
Ms. Saheda Khanam, Director

Office of the Controller General of Accounts, Ministry of Health
Mr. Md Abdus Sobhan, Chief Accounts Officer

Planning Commission
Mr. Masood Ahmed, Member, Social infrastructure division

Development Partners
Ms Bushra Alam, World Bank
Hasib Chowdhury, World Bank
Suraiya Zannath, World Bank
Jacqueline Mahone, World Bank
Alana Albee, DFID
Maki Nagai, JICA

Ministry of Finance
Ranjit Kumar Chakraborty, Additional Secretary
Mr. Mohiuddin, Team leader, SPEM
Mr. Md. Zahidul Haque, Deputy Secretary
Mr. Saiful Islam, Assistant Secretary
Mr. Muslim Choudhury, Additional Secretary, and team leader of Component II, SPEM

ANNEX 5

LIST OF DOCUMENTS REVIEWED

Annual Program Implementation Review 2012

Bangladesh Health Sector Profile, 2010

FM Assessment of HPNSDP, 2011

Updated Results Framework, HPNSDP

Governance and Accountability Action Plan (GAAP)

Medium Term Budget Framework 2012

Annual Development Program 2012

Public Expenditure and Financial Accountability (PEFA) Assessment, GOB, 2011

Options for Aid modalities for the Health sector pool funding mechanism, Scanteam report 2011

Program Implementation Plan (HPNSDP)

Project Appraisal Document (HPNSDP)
Needs-Based Geographic Resource Allocation in the Health Sector of Bangladesh (2010) DRAFT

Annual Program Review 2009

Bangladesh Maternal Mortality Survey

Bangladesh DHS

Strategic Plan for HPNSDP 2011-2016

National Health Accounts Report 2007

Public Expenditure Review 2007

Public Expenditure Review 2012

Delegation of financial power order, 2008, Order, Ministry of Health

Revised LLP toolkit, Government of Bangladesh

Draft health financing strategy, Government of Bangladesh