

PART THREE

RECOMMENDATIONS FOR A GLOBAL RESOURCE
MOBILIZATION SYSTEM

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RECOMMENDATIONS FOR A GLOBAL RESOURCE MOBILIZATION SYSTEM

The central recommendation of this Study is the design and scope of a systematic global health resource mobilization system which offers reasonable hope for success of the Health for All/2000 objective.

The practical implementation of a global resource system must necessarily be derived from country-specific and external resource-specific data. In the absence of such a system, the first logical step is the establishment of a collaborative pattern which will provide the background upon which major funding choices can be made. In an attempt to be as specific as possible, an illustrative set of organizational and administrative arrangements are proposed. If the underlying context is understood, variation in actual application would be expected. Trial and error, evaluation and progress, and modification of procedure are to be taken for granted.

It is assumed that the time dimension is critical and that the Assembly and the Executive Board are sensitive to the urgency of responding to the Health for All initiative. The recommendations address this urgency. If the suggestions appear to be highly tentative, it is with the hope that they provide a starting point for practical discussions on the configuration of a system which will be perceived as timely, responsive, and genuinely collaborative.

I. BASIC ASSUMPTIONS

Member countries of the World Health Assembly have accepted and approved the following premises:

1. Health for All by the Year 2000 merits an overriding international health priority.
2. Resource acceleration is essential if HFA is to succeed.
3. Health programmes are an essential and inherent component of development programmes.
4. Global and regional information exchange on needs and resources is essential for practical planning.
5. A global mechanism for resource mobilization needs to be established.
6. WHO has a constitutional responsibility to bring into being the necessary cooperative mechanisms for HFA even though the WHO itself may never have more than a comparatively minor responsibility or accountability for health programme implementation at the country level.

II. IMPORTANT CONSIDERATIONS

1. Member countries of the World Health Assembly have already approved the concept of a new international system through their approval of the WHO document "Formulating Strategies For All by the Year 2000" (Paragraph 95):

"95. The global strategy should envisage the strengthening of global mechanisms, such as the establishment of an appropriate body of participating countries for attracting bilateral and multilateral funds and for ensuring that they are channelled into priority activities in countries. For this purpose, estimates should be made of the orders of magnitude of the total resources required for health development in the world, including those required for transfer between countries and regions."

2. Approximately 90% of estimated total current external resources for health are derived from sources other than the World Health Organization.

RECOMMENDATIONS

3. The preponderant external sources are multisectoral and developmental in purpose. Official health-specific sources are few. A design for accelerating external cooperation must take into account that no single source or international institution holds constitutional authority over the spectrum of potential development-related health funds.
4. There is an international consensus that the World Health Organization is the appropriate focus for catalyzing resource mobilization globally with at least two important caveats
 - a) That success of HFA objectives will require the fullest cooperation of development oriented multilateral, bilateral, NGO (private and voluntary) and national institutions which are accountable to their own legal and constitutional authorities as well as to their cooperating partner governments, and
 - b) That the urgency of action for HFA may require a significant readjustment by WHO to a mode of action which is expected to demand a new dimension in assertiveness and initiative
5. The World Health Organization, including its regional offices, as of early 1981 had not yet established a structure or function with the capability of mobilizing resources on a global scale for Health for All.
6. The comparative advantage of WHO, in relation to other external resource institutions, is the universal distribution and size of its professional staff (approximately 2500 worldwide), which permits the potential for development of a systematic global resource mobilization system.

III. FUNCTIONAL REQUIREMENTS

A. OUTPUT TABLE No. 1

Gather systematic and updated information on external financial sources which may be shared with WHO member countries and participating international organizations.

B. OUTPUT TABLE No. 2

Gather systematic and updated information on the needs of member countries for achievement of Health for All" objectives, with particular attention to external financial requirements.

C. OUTPUT TABLE No. 3

Provide a system for periodic analysis of needs in relation to resources in order to rationalize the most effective alternatives for resource use.

D. OUTPUT TABLE No. 4

Provide mechanisms for matching and mobilization of resources through promotion of consultation between member countries and external financial sources.

E. OUTPUT TABLE No. 5

Provide specialized training in resource mobilization requirements to responsible officers in member countries and participating international organizations.

Essential associate requirements are: 1) monitoring and evaluation of progress in the acceleration of resources, 2) administering the PHC Initiative Fund for seed and catalytic actions, and 3) the active promotion of resource mobilization based on the foregoing functions.

GOAL	SUBGOAL	OUTPUT # 1	INPUT				COST \$
			PROCESS	MANAGEMENT			
				ACTION UNIT	LOCATION	STAFF	
"attainment by all citizens of the world by the Year 2000 of a level of health for All by that will permit them to lead a socially and economically productive life" WHA30.43	To accelerate the rate of resource mobilization to enable achievement of Health for All by the Year 2000	Establishment of a system for identification, storage, updating, retrieval and distribution of official data on global resources from: <ul style="list-style-type: none"> Multilateral organizations Bilateral donors NGOs OPEC countries 	1. Designate WHO/HRG interim subcommittee to plan system.	HRG Secretariat	Geneva	HRG and consultants	--
			2. Design system to collect, store and distribute data from multilateral, bilateral, NGO and OPEC countries on the following topics: <ul style="list-style-type: none"> Development policy Health policy Geographic distribution Health and health-related programmes by type & country Programme process Organization Official data sources Special views on HFA/2000 strategy, acceleration and international coordination. 				
			3. <u>System Options:</u> A Unified system based at WHO/HQ for all aspects of donor data management and continued donor liaison. B Place major responsibility with each WHO Regional office to gather donor data in its own region and forward data to WHO/HQ, e.g., EURO - Europe PAHO - North America EMRO - OPEC WPRO - Japan, Australia, N.Z. AFRO - Nigeria C Contract with a professional institute such as the Development Research Centre, Paris, for all data collection, updating, storage, and distribution.	Secretariat	Geneva	1 Coordinator 4 Research officers 5 Secretaries Consultants	\$400,000
			4. Maintain close liaison with donors for current changes and updating.	Secretariat	Geneva and Regional offices	Group B staff (see Administrative Arrangements)	--
			5. Maintain information exchange with major sources of development data such as UNDP and DAC/OECD which have computerized storage banks.	Secretariat	Geneva	Group B staff (see Administrative Arrangements)	--
			6. Distribute donor resource information regularly to: <ul style="list-style-type: none"> Multilateral organizations Bilateral agencies NGOs Developing governments 	Secretariat	Geneva	Group B staff (see Administrative Arrangements)	
		ASSUMPTIONS	ASSUMPTIONS	ASSUMPTIONS		ASSUMPTIONS	
		1. Governments and international agencies are prepared to accept Assembly agreements on information exchange: "98. Relevant and valid information will have to be made available on methods, processes, mechanism and technology. To ensure that information is both relevant and valid, the global strategy will have to provide for the means and resources to collate, distill, synthesize, & validate information so that it will have practical value for countries in solving their health problems. It will also have to ensure the proper distribution of such information to those who need it." "110. WHO will ensure the availability of relevant and valid information to facilitate the formulation and implementation of policies, strategies, and plans of action. To this end, WHO will ensure that the information is distilled, analysed, synthesized and properly disseminated among countries. It will also collect relevant information from other sectors involved in social and economic development as well as from the health sector. As part of the strengthening of its information role, WHO will rely on such mechanisms as regional and national centres for health development as these are progressively established and strengthened." SOURCE: Formulating Strategies for Health for All by the Year 2000, Geneva: WHO, 1979. 2. Official data should be provided by cooperating governments in an officially approved format. 3. Prevailing data systems should be used to the maximum.	1. Governments and donors are prepared to support continuous information exchange under the auspices of WHO, consistent with the Alma Ata Declaration. 2. Information exchange will be supported operationally by other multilateral organizations, UNDP, and UNICEF.	*Participation of development study centres is essential to understanding health policy and financial outlook.	Data management will require full-time staff on direct hire with Secretariat or on contract since donor health staff are limited.		

OUTPUT TABLE # 2 ESTABLISHMENT OF A DATA MANAGEMENT SYSTEM FOR RECIPIENT COUNTRY RESOURCES AND NEEDS

COAL	SUBCOAL	OUTPUT # 2	INPUT				COST \$\$
			PROCESS	MANAGEMENT			
				ACTION UNIT	LOCATION	STAFF	
"attainment by all citizens of the world by the Year 2000 of a level of health that will permit them to lead a socially & economically productive life." WHA30.43	To accelerate the rate of resource mobilization to enable achievement of Health for All by the Year 2000.	Establishment of a global system for identification, storage, retrieval, analysis and sharing of developing country resources and requirements for health with attention to HFA/2000.	1. Designate HRG subcommittee to plan system (same subcommittee as in OUTPUT # 1)	Secretariat	Geneva	Secretariat and consultants	
			2. Collect, store, update official national development plans to identify relative priority, resources and emphasis on health. (Assume that this data is already being collected through UNDP and other sources)	RRUNDP	Member country	RRUNDP	No additional cost to UNDP
			3. Collect, store, update official national health sector plans and programmes with emphasis on HFA/2000 as approved by: <ul style="list-style-type: none"> . National Health Ministries . National Planning Commissions, or equivalent. (Assume that this is already being done in varying degrees)	WHO/WPC	Member country	WHO/WPC in cooperation with UNDP	No additional cost to WHO
			4. Ensure availability of Planning Commission-approved health sector data to external donors resident at country level. (Data sharing with donors at regional and global levels is a function of OUTPUT # 4)	Ministry of Health with WPC assistance.	Member country	MOH WPC/WHO UNDP	No additional cost to WHO
			5. Copy data to UNDP/HQ	RRUNDP	Country	RRUNDP	--
			6. Copy data to WHO Regional office for regional rationalization and resource mobilization.	WHO/WPC	Country	WPC	--
			7. Copy data to WHO/HQ (Plus regional programmes.)	WHO Regional office	WHO Regional office	Group A staff	\$50,000 per Region
			8. WHO/HQ stores & updates country, regional & interregional data as data base for global resource rationalization and mobilization (OUTPUTS #s 3 and 4)	Secretariat	Geneva	Group B staff	\$50,000 per Region (see Assumptions)
			9. WHO/HQ maintains linkage with other major data sources, particularly those with computerized data storage systems, e.g., UNDP, UNICEF, OECD.	Secretariat	Geneva	Group B plus WHO Data and Information services	--
		ASSUMPTIONS	ASSUMPTIONS			ASSUMPTIONS	
		1. See Assumptions under Option # 1. 2. The global system should make the greatest use of prevailing sources of data rather than collecting new information unless reviewed and approved by HRG.	1. The primary responsibility for data acquisition, analysis and rationalization is at the regional level. WHO Regional offices with support of WPCs will play the major role in provision of country and regional services. 2. Since donor data is not readily accessible globally to all regions, interregional/global resource rationalization will require the WHO/HQ data base. 3. The quality and analysis of country-level data is central to the efficiency of the entire system. Therefore, concurrent efforts to support CHP and national Health Development Planning Institutes are essential.			The primary focus of data collection, analysis, rationalization, and mobilization at the Regional level will require two officers: One for resource management and liaison with countries and organizations in the region (Group A) and One for regional liaison with donors and assigned to HQ Secretariat (Group B)	

GOAL	SUBGOAL	OUTPUT # 3	INPUT				COST \$\$
			PROCESS	MANAGEMENT			
				ACTION UNIT	LOCATION	STAFF	
<p>"attainment by all citizens of the world by the Year 2000 of a level of health for All by that will permit them to lead a socially and economically productive life."</p> <p>WHA30.43</p>	<p>To accelerate the rate of resource mobilization to enable achievement of Health for All by the Year 2000.</p>	<p>Rationalization of resource flows:</p> <ol style="list-style-type: none"> 1. Analysis of external resource flows in relation to needs at country and regional and global levels. 2. Identification of gaps and duplication at country, regional and global levels. 3. Development of alternative proposal by regional offices for increasing the efficiency of resource use. 	<p>1. At country level, on basis of national and donor data (OUTPUTS #s 1 and 2), WPC and RRUNDP with other members of country team, e.g., UNICEF, IBRD; National Health Council should develop an annual analysis of national needs and potential resources. Prior emphasis should be placed on efficient use of country resources.</p> <p>The process assumes that country team will be fully advised on donor potential.</p> <p>Results of country analysis will be forwarded to WHO Regional office for review.</p>	National Health Council with support of WPC, UNDP, UNICEF.	Recipient country	National Health Council with support of WHO/WPC, UNDP, UNICEF	Costs to be borne by country
			<p>2. WHO Regional office, in cooperation with other regional multilateral, bilateral and NGO representatives will review country analysis, assess gaps and duplication and develop regional alternatives for improved resource allocation.</p>	WHO Regional HRG Unit	WHO Regional HQs	Group A officers 1 per Region 1 secretary (see Administrative Arrangements)	No additional cost to WHO Regional office
			<p>3. Region refers rationalization assessments and alternatives to WHO/HQ for review.</p>	" "	" "	" "	
			<p>4. WHO/HQ reviews regional alternatives as a basis for developing global rationalization.</p> <p>At HQ, global rationalization should be organized around geographic area requirements as well as global HPA/component functions, e.g., disease control, MCH, water, etc.</p>	Secretariat	Geneva	Full Secretariat staff and consultants with participation of HQ technical directorates and expert multi-sector working group	No added cost
			<p>5. HRG reviews global alternatives presented by Secretariat and comments, modifies, and makes recommendations.</p>	HRG	Geneva	Secretariat	--
			<p>6. HRG-approved report circulated to donors, multilateral organizations, NGOs and member countries.</p>	HRG	Geneva	Secretariat	--
			<p>ASSUMPTIONS</p>	<p>ASSUMPTIONS</p>	<p>ASSUMPTIONS</p>		
	<p>1. "All Governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in accordance with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally."</p> <p>SOURCE: Alma Ata Declaration.</p> <p>2. Primary responsibility for rationalization is with each member government.</p> <p>3. HRG is to suggest alternatives for consideration by countries and donors.</p>	<p>1. At country level, WHO/WHP will assume a more assertive role in supplementing the HRG process by actively promoting improved national planning, training for health development and establishment of Health Development (HD) Institutes and National Health Planning Councils.</p> <p>2. Optimal global rationalization cannot be developed except at the global level since external resource flows are unequal between geographic regions.</p>	<p>1. Rationalization is basically a country and regional action.</p> <p>2. Global alternatives require central assessment.</p>				

GOAL	SUBGOAL	OUTPUT # 4	INPUT				COST \$ \$
			PROCESS	MANAGEMENT			
				ACTION UNIT	LOCATION	STAFF	
"attainment by all citizens of the world by the Year 2000 of a level of health that will permit them to lead a socially and economically productive life". WHA30.43	To accelerate the rate of resource mobilization to enable achievement of Health for All by the Year 2000.	Resource mobilization and matching: 1. Identification of country, regional and interregional health requirements based on OUTPUTS #s 2 and 3. 2. Identification of potential for support from national and regional sources. 3. Identification of potential donors by area of technical and geographic interest OUTPUT # 1). 4. Negotiation between countries and potential donors. 5. Negotiation between regional and interregional representatives and potential donors.	1. On basis of resource and needs analysis (OUTPUTS #s 1 & 2) and rationalization alternatives (OUTPUT # 3), identify resource requirements and potential resource availability.	National Ministry of Health and National Health Council assisted by WHO, UNICEF, RRUNDP.	Country	MOH/Planning Commission WHO/WPC UNICEF UNDP	No additional cost
			2. To the extent that national health requirements have not been reviewed by the Planning Commission (or equivalent bureau), assist MOH or other national entity in the preparation and defense of the requirement in official project form.	MOH	Country	MOH assisted by WHO/UNICEF/UNDP	No additional cost
			3. Review country requirements at regional level in joint consultation with HRG participating organizations (multilateral, NGOs, bilateral).	HRG Regional Unit	WHO Regional Office	HRG Officers (Group A)	See Administrative Arrangements
			4. Identify regional and interregional requirements and prepare proposals which have endorsement of national or regional Planning Commissions and equivalents.	1. WHO Regional HRG Unit plus HRG/HQ Secretariat 2. Proposals prepared by WHO technical offices with HRG guidance 3. Other multilateral & bilateral organizations follow comparable process (UNICEF, UNDP, etc.)	WHO Regional Office	HRG Officers (Group A) Secretariat	" "
			5. Identify potential regional donors.	HRG/HQ and Regional Units	Geneva and WHO Regional offices	Secretariat HRG Group A staff	No added cost
			6. Negotiation: Countries negotiate their own requirements as appropriate through Planning Commission approved channels, e.g., donor resident representatives, Embassies or to external regional or HQ donor offices. Note: for acceleration, country projects should not normally use WHO as an intermediary for transmission of country projects to bilateral donors. ----- Regional or interregional projects would be negotiated by programme representatives with potential donors at regional and global levels. Such proposals would carefully seek member country endorsement if applicable.	MOH or Planning Commission	Country	MOH or other appropriate representatives with support (if requested) of country, WHO, UNICEF, UNDP or other representatives	" "
			7. WHO Regional offices with country WPCs may assist member states on behalf of HRG in the following ways: ----- By approaching Planning Commissions for appropriate endorsement of proposed national programmes. By approaching external donors located within the Region. By approaching external donors located outside the region (through HQ Secretariat). By approaching all donors on behalf of countries through the Secretariat for the following reasons: 1. Geneva provides the only global consultative arrangement and 2. the highly extended work of donors at present lead them to prefer central approaches rather than multiple channels from the same organization.	Representatives of regional associations & country groups Donor organizations, e.g., WHO, UNICEF, UNDP	WHO Regional offices, plus HRG-member organizational HQs	Secretariat (Geneva) Regional & HQ offices for each organization as appropriate	No added cost
			OPTION # 1	WHO/WPC	Country	WPC	No cost
			OPTION # 2	Regional WHO/HRG Unit	WHO Regional office	Group A Officers	Additional travel costs included in OUTPUT # 1 estimate
			SECRETARIAT	SECRETARIAT	GENEVA	GROUP B OFFICERS	" "
			SECRETARIAT	SECRETARIAT	" "	GROUP B OFFICERS, I.E., REGIONALLY ASSIGNED OFFICERS	" "
			8. Convene annual open meeting for all donors and organizations in May prior to WHA (following HRG meeting) to present global requirements and progress for high level development and health representatives.	Secretariat	Geneva	Secretariat as a whole	\$5,000
			ASSUMPTIONS	ASSUMPTIONS			
1. Cooperating organizations and countries are not precluded from independent negotiation outside HRG structure.	Secretariat will serve in an advisory capacity to HRG structure at all levels: HQ, region, & country.						
2. Effectiveness based on thorough training in HRG process for all participating organization personnel.	Basic accountability for HRG performance lies with Regional HRG Units.						

OUTPUT TABLE # 5 TRAINING FOR RESOURCE MOBILIZATION

GOALS	SUBGOAL	OUTPUT # 5	INPUT				COST \$\$
			PROCESS	MANAGEMENT			
				ACTION UNIT	LOCATION	STAFF	
"attainment by all citizens of the world by the Year 2000 of a level of health that will permit them to lead a socially & economically productive life." WHA30.43	To accelerate the rate of resource mobilization to enable achievement of Health for All by the Year 2000.	Establishment and implementation of a cooperative global training programme for personnel from all cooperating organizations and countries.	1. Assign an HRG subcommittee to develop training programmes.	Secretariat	Geneva	Training Unit Consultants	\$20,000
			2. Develop training curriculum based initially on brief courses (7 - 10 days) to include all elements of the process: 2.1 Data management . Donor resources . Developing country resources 2.2 Rationalization 2.3 Mobilization and negotiation process 2.4 Donor program characteristics 2.5 Inter-sectoral linkages 2.6 Monitoring and evaluation	Secretariat	Geneva	Training Unit 1 TRG officer 1 Secretary Consultants	\$200,000
			3. Develop training materials including literature on development and donor systems.	Secretariat	Geneva	Training Unit	\$50,000
			4. Offer periodic workshops at regional and country levels with immediate objectives of reaching key national and external donor personnel, including WHO staff.	WHO Regional office	Region	Group A officers with HQ Secretariat & consultants	Regional funds
			5. Convene periodic workshops in Geneva and elsewhere (by request) with the objective of briefing key leadership in participating HRG organizations, donor countries and NGOs.	Secretariat	Geneva	Training Unit	Participant costs to be paid by sponsoring organizations
			ASSUMPTIONS		ASSUMPTIONS		
			1. Country resource requirements donor systems and processes change continuously. Periodic refresher training offers an effective way to convey system changes and to obtain feedback from system users.		1. Major emphasis will be required on re-orientation of country-level national leadership and aid representatives (WPC, RRUNDF, UNICEF, resident donors).		
2. Resource mobilization and acceleration is a new dimension for technical officers and organizations. Major reorientation will be required for all participating organizations (including WHO itself) and countries.		2. The quality of regional & country performance is critical for success of actual fund transfers since the predominant mode of donor operations is by agreement at the country level.					

IV. ADMINISTRATIVE ARRANGEMENTS

It would be anticipated that a global administrative system would evolve progressively and vary in configuration depending upon location and function. If it is to be assumed, however, that the year 2000 represents a serious target for accomplishment, the proposed structure or its equivalent variation deserves careful attention.

A. CONTEXT

In May 1980 the WHO Health 2000 Resources Group (HRG) concluded that the "HRG should be constituted as a consultative group under the auspices of WHO in fulfillment of its constitutional function as the coordinating authority on international health." Organizational arrangements should reflect this constitutional role in the recommended context of an international consultative group with wide representation which includes developed and developing countries, multilateral organizations, and NGOs.

In contrast to administrative patterns for current WHO-sponsored consultative groups which serve to advise WHO and contribute to approved technical programmes of research or operation (e.g., TDR, HRP, OCP), the HRG context is one of consultation on resource acceleration based upon data management, analysis, and rationalization. The actual (operational) mobilization, transfer, and utilization of funds should remain, as at present, the administrative responsibility of each cooperating donor agency, multilateral organization or developing government. The search for and identification of extrabudgetary funds for WHO programmes would be a continued WHO requirement outside the work of the HRG. Similarly, participating HRG organizations such as IBRD, UNICEF, UNDP, SIDA, CMC, and WHO would be expected to mobilize and administer resources within the approved terms of reference for their respective organizations.

In this context, consultative arrangements do not necessarily imply the administration by the HRG of new or large international funds which are the normal and ongoing responsibility of participating organizations and groups. While the HRG context does not exclude a priori the development of cooperative programmes or administration of joint funding, the underlying HRG principle is that a cooperative international system should be established under the auspices of WHO. The system should provide the data, rationale, and training to permit health resource acceleration on a global scale by all organizations and countries which support the goal of HFA/2000.

B. AUTHORITY

In response to specific Assembly requests to the Director-General for external resource mobilization, an HRG should be established under the authority of the Director-General, subject to agreement of proposed membership to the Terms of Reference.

In the spirit of the officially approved Health for All consensus, it is assumed that the responsibility of the Director-General for coordination is to seek mutually acceptable cooperative mechanisms among donors and recipients in order to accelerate the flow of all resources for health without limitation of preponderant effort to those resources which may be channeled directly only through the WHO intramural programme.

C. TITLE

To give appropriate effect to the HRG context, the "Health 2000 Resource Group" might be renamed to indicate the joint consultative principle.

- Consultative Group on International Health Resource Mobilization (ICGHRM)

RECOMMENDATIONS

- . International Consultative Group on Health Resource Mobilization (ICGHRM)
- . International Consultative Group/Resources (ICG/R)
- . Health Resources Group (HRG)

For purposes of illustration, however, it may be assumed that the new forum is entitled Health Resources Group (HRG).

D. TERMS OF REFERENCE*

The Group should be established to further the efforts of developing countries, WHO, non-governmental, bilateral, and multilateral agencies to achieve the goal of Health for All by the Year 2000 through primary health care.

The mandate should be:

1. To promote the rationalization of all available resources required for primary health care activities in developing countries, aimed towards Health for All by the Year 2000 and in accordance with the priorities recognized in the Alma-Ata Declaration
2. To promote the mobilization of resources, including those of developing countries themselves and of external donors, to achieve the world community's social goal of Health for All by the Year 2000, using Primary Health Care as the basic means

Within the context, the Group should concern itself particularly with the following issues:

1. To foster actions by donor agencies and governments and to reinforce the efforts made by WHO and other organizations through their constitutional organs in according high priority to the development of Primary Health Care activities in the attainment of health for All
2. To facilitate the development of a practical mechanism to match resources and needs between recipient countries and donor agencies
3. To promote the critical review and dissemination of selected aspects of information, relevant to the objectives, collected by WHO and other organizations
4. To identify constraints relating to external funding for the attainment of Health for All and to propose or develop ways to overcome them
5. To encourage and support governmental and nongovernmental sectors, with a view to minimizing the duplication of effort and maximizing substantive collaboration in planning and achieving health development
6. To establish guidelines for and oversee the use of the Primary Health Care Initiative Fund

E. HEALTH RESOURCES GROUP (HRG)

Functions

The functions of the HRG, meeting as a committee at least once a year, are to review progress and actions in each of the essential functions, to provide guidance and guidelines as appropriate, to provide views and recommendations to the Director-General on those actions which the Director-General may wish to transmit to member governments and participating international organizations.

*As approved by HRG in December 1980.

Consistent with the constitutional mandate of WHO to coordinate and promote international cooperation for health and with the approval of the Director-General, the HRG may wish to draw the attention of member governments and international organizations to appropriate actions in support of HFA, whether or not such actions are the direct administrative responsibility of WHO.

Membership*

1. Membership of the Group should be open to the representatives of developing countries, governmental donor agencies, nongovernmental organizations (NGOs), and multilateral agencies committed to the goal of Health for All by the Year 2000.
2. A steering committee, reflecting the categories of HRG membership, should be elected by the Group according to procedures which it should determine. The steering committee should act on behalf of HRG between meetings.
3. To ensure the representation of developing countries from each WHO region on HRG, the regional committees should select member states to appoint representatives in accordance with the following formula:

	No. of Member States to be designated by regional committees
African Region	2
Region of the Americas	1
South-East Asia Region	2
European Region	1
Eastern Mediterranean Region	1
Western Pacific Region	1

Each country so designated is encouraged to send a health representative and, in addition, a second representative who should be a responsible officer from the national planning body or equivalent ministry of that country, giving a total of 16 representatives of developing countries.

The appropriate and assured representation of NGOs in the Group should be decided by existing collaborative groups among NGOs such as the NGO Committee on Primary Health Care and the NGO Committee of UNICEF. The members so designated should provide continuity within HRG and liaison with the rest of the NGOs. This should not exclude participation by other interested and appropriate NGOs within HRG.

Given the interdisciplinary, divisional, and interregional requirements for effective global implementation, it would be expected that Headquarters Divisions as well as Regional Offices would be invited to designate representatives in an ex officio capacity.

Meetings

The HRG should meet once a year in May, prior to the WHA. It would be advantageous for the HRG to appoint a steering committee of not more than six members to meet at least twice (or at four-month intervals) between annual meetings. The function of the steering committee would be to oversee and guide the work of the Secretariat and to report their findings and observations to the annual meeting of the HRG. The steering committee would be appointed by the HRG on a two-year rotation basis.

*Paragraphs 1, 2, 3 incorporate WHO/HRG agreement as of December 1980.

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HRG Open Meeting.--Improved resource mobilization cuts horizontally across most WHO-approved programmes and affects essentially all internal programmes related to HFA/2000. Financial support is common to planning and implementation in both developed and developing countries. It is of importance, therefore, that the work of the HRG be given maximal dissemination to donor countries and organizations as well as to potential recipient countries. In addition to planned distribution and exchange of information, an annual open meeting should be held in conjunction with the annual meeting of the HRG in May of each year prior to the WHA. The timing affords maximum participation of countries and organizations.

F. SECRETARIAT

Functions

The functions of the Secretariat are:

1. To serve as staff for the Director-General on all issues related to HRG functions
2. To provide operational guidelines on each of the HRG System's essential functions and to make recommendations for the development of a global structure to serve the agreed functions
3. To prepare and update guidelines which specify those actions in support of HRG which can be best accomplished at the country, regional, and central levels
 - a) At the country level: identification of country needs
 - b) At the regional level: the gathering of information on member countries needs requirements, provision of donor information, and analysis of regional requirements
 - c) At the central level: donor data collection and interregional analysis
4. To provide the major focus for interregional functions

Structure

Since the outlook for success in acceleration of global resources requires the active participation of major external technical and financial organizations, the location of the Secretariat within the WHO Headquarters structure should not be placed at a level where it is perceived to be an intramural WHO programme. The role of WHO is to serve primarily as a coordinating and catalytic organization.

1. A Secretariat directly responsible to the Director-General should be established in Geneva.
2. The Secretariat should be staffed by WHO and, as appropriate, by secondment from other participating HRG organizations.
3. The total number of staff should be determined in relation to the eight functions defined in the Terms of Reference. Donor data collection, recipient country data collection, and training are distinctly different work functions. Secretariat functions are based on the assumption that the global system requires staff assigned to comparable functions at the regional level.
4. The costs of the Secretariat and administration of HRG should be a charge against the Primary Health Care Initiative Fund.
5. Specific tasks may be assigned by HRG to participating agencies.

G. WHO REGIONAL ARRANGEMENTS

Functions

Consistent with the Assembly-approved document "Formulating Strategies for Health for All by the Year 2000" (1979), it is accepted that a global programme will require specific actions at central, regional, and country levels. Such actions are not limited to WHO actions but require the fullest participation of member countries and international organizations other than WHO.

WHO regional and country functions will be those components of basic HRG functions essential for the accomplishment of global resource acceleration which are defined in joint consultation between the Director-General and Regional Directors.

Structure

The Group A Officers.--Based on the assumption that WHO Regional Offices, in close cooperation with regional participating donors and organizations, will need to take major responsibility for providing support for resource mobilization at the request of member states, each Regional Office will need to establish a special unit with at least one officer and one secretary to oversee regional HRG functions. The primary activity will be to maintain liaison with member states and WPCS on functions of data management, rationalization, and mobilization. These activities will be correlated with Group B Regional Officers. Group A will be accountable to their own Regional Directors.

Group B Officers.--In the interest of maintaining the required performance accountability and responsibility in the Region, each WHO Regional Office may consider the assignment of at least one full-time officer to the Secretariat. Each officer would be responsible and accountable for following all data and transactions from his Region. Having been detailed from the Region, the officer would be ultimately accountable to his Regional Director. The selection and appointment to such positions would be made by the Regional Director with the concurrence of the Director-General.

H. FINANCING ARRANGEMENTS FOR A RESOURCE MOBILIZATION SYSTEM

It is important to draw a clear distinction between the estimated costs for Health for All during the next 20 years and those relatively minor costs associated with support of a resource mobilization system. The study of donor policies and programmes suggest that the magnitude of all concessional aid for health purposes from all external sources is on the order of \$3 billion annually. Although this larger amount is flowing in the absence of any formal resource mobilization system, the Study suggests that total magnitudes can be increased for HFA objectives. Donors now offer to provide preparatory funds to assist governments in the definition and justification of major projects. Seed and catalytic funds are not in short supply. On the other hand, governments and international organizations are not well oriented in the procedures to identify and obtain such funding.

In contrast to the central issue of systematically accelerating and increasing global flows for health, the funding requirements to administer a resource mobilization network based largely on the current WHO organization and staff may not exceed \$1.5 million annually (approximately one-third of one percent of the current WHO budget which may be approaching \$400 million annually). Since the relative demand is small in view of the WHO constitutional mandate for coordination, Secretariat and global network costs could be considered a proper expenditure of WHO funds.

Even though collaborative funding from external sources would always be welcome, the Director-General himself has noted on more than one occasion that management of relatively small funds absorb an inordinate amount of administrative time. The more important perspective is that WHO represents a very large personnel resource from which limited numbers of personnel could be reassigned. Additional personnel may not be required so much as an

RECOMMENDATIONS

operational understanding of resource mobilization requirements by personnel already within the WHO system. This assumption would require WHO's commitment of personnel and special reorientation which, as of early 1981, has yet to be made.

WHO, as well as other UN agencies such as UNICEF which seek extrabudgetary funds, should bear in mind that efforts invested in resource mobilization would be expected to increase total resources not only to governments but to their own intramural, regional, and inter-regional programmes. For purposes of establishing an HRG system, therefore, it would seem more productive to pay major attention to organizational structures, functions, guidelines, training, and other related HRG components than to minor fund management.

The alternative to regular funding by WHO is collaborative funding by donors and international agencies through a Primary Health Care Initiative Fund proposed by HRG. The underlying rationale for joint funding, as proposed by members of the Health Resources Group, is to acknowledge that resource mobilization is a task for many external agencies and cooperating countries. If the Fund were to be the major channel for primary health care, the principle of joint funding would be essential. The HRG has recognized that the Fund itself is relatively minor in relation to total anticipated requirements and should be used more appropriately to promote larger donor sources and support Secretariat costs. A limited number of donors have made commitments to the Fund. It is expected that additional contributions will be made subject to the inherent variability of donor support from year to year.

In contrast to joint research and pilot ventures sponsored by WHO (e.g., TDR, OCP, HRP), where joint funding is entirely logical, the differentiating characteristic of the proposed HRG system is that it is not functionally required to manage or administer the major volume of resources for health which will continue to flow through normal development transactions between external sources; for example, IBRD or the Japanese International Cooperation Agency, and potential recipients. The requirement instead is to catalyze this negotiation through the proposed pattern of data management, rationalization, matching, training, and evaluation.

The concept of joint funding for objectives within the WHO Voluntary Fund for Health Promotion or a specific trust fund is standard practice and one which should be encouraged since WHO itself, like other UN agencies, will continue to require support for its own intramural programmes. The comparison of functions is made to clarify the way in which the HRG system differs from other demands on the WHO programme budget.

By presenting the variation in views on support for the proposed HRG system, it is hoped that participating organizations and countries will be better informed on the relatively modest organizational requirements.

1. DIFFERENTIATING CHARACTERISTICS OF A GLOBAL RESOURCE MOBILIZATION SYSTEM

1. The HRG system is primarily a pattern of strategic resource planning for Health for All by the Year 2000 through data management, analysis, matching, mobilization, training, and evaluation.
2. The HRG system does not propose to substitute for the process of developmental transactions which negotiate a current annual flow of \$3 billion development-related funds for health.
3. Primary responsibility for administration and management of health funds over the next twenty years will remain with the external financial sources and with those countries and international organizations with whom they cooperate.
4. The HRG system does not require responsibility for the management of any major specified fund in contrast to other primary health care related funds in WHO such as those for disease control, nutrition, human reproduction, water supply and sanitation, and maternal and child care. The PHC Initiative Fund, if maintained, is a limited staff support and catalytic fund.

5. The system anticipates the need for extensive retraining and orientation of WHO and non-WHO staff at Headquarters, regional, and country levels on the process and promotion of resource mobilization. It does not anticipate provision of duplicate technical advisory services.
6. In contrast to evaluation of actual progress towards HFA/2000 goals which are the joint responsibility of member governments themselves, HRG progress will be measured by the rate and distribution of resource flows for HFA/2000 operational programmes.

PART FOUR

ILLUSTRATIVE DONOR PROFILES

(Based on information collected in early 1980)

INTRODUCTION

As illustrations of potentially useful official data on donor policies and programmes, the following sixteen profiles suggest a possible basis for the development of a global information system. While the current list is limited to official bilateral or multilateral sources, it is important to consider expansion to nongovernmental organizations and to the substantial resources provided by many developing countries themselves. In this sense, the profiles may offer an approach to accomplishing one of the six key functional requirements of a global health resource system (see PART THREE: RECOMMENDATIONS).

The profiles, as presented here, are not intended to be complete or authoritative documents but rather an effort to describe types of available donor information and the underlying trends of donor agencies. An organized, well-staffed effort to maintain and update such profiles with the cooperation of donor organizations may be one of the single most useful components of the accepted international agreement to develop a resource mobilization system in support of Health for All by the Year 2000.

The reader may wish to review PART ONE: III. A Study of Donor Policies, Programmes, and Perspectives, Background, Process, and Data Sources.

PROFILE OUTLINE

SECTION:

- I. ASSISTANCE POLICY
 - A. Official Development Policy
 - B. Official Health Policy
- II. DISTRIBUTION OF BILATERAL ASSISTANCE
 - A. Distribution of Bilateral Development Assistance
 - B. Distribution of Bilateral Health Assistance
- III. DISTRIBUTION OF MULTILATERAL ASSISTANCE
 - A. Distribution of Multilateral Development Assistance
 - B. Distribution of Multilateral Health Assistance
- IV. ASSISTANCE TO NONGOVERNMENT ORGANIZATIONS
 - A. Development Assistance to Nongovernment Organizations
 - B. Health Assistance to Nongovernment Organizations
- V. TYPES OF ASSISTANCE
 - A. Types of Development Assistance
 - B. Types of Health Assistance
- VI. DEVELOPMENT FUNDING
- VII. HEALTH FUNDING
- VIII. PROGRAMMING PROCESS
- IX. ORGANIZATIONAL STRUCTURE
 - A. Responsible Donor Agency(s)
 - B. Country Representation
 - C. National Health Ministry
 - D. Official Correspondence
- X. DONOR PERSPECTIVE ON HFA/2000
- XI. VIEWS ON ACCELERATION AND COLLABORATION
- XII. VIEWS ON THE ROLE OF WHO

LIST OF PROFILES

1. ASIAN DEVELOPMENT BANK
2. AUSTRALIA
3. AUSTRIA
4. BELGIUM
5. DENMARK
6. EUROPEAN ECONOMIC COMMUNITY
7. FEDERAL REPUBLIC OF GERMANY
8. FRANCE
9. JAPAN
10. NETHERLANDS
11. NEW ZEALAND
12. NORWAY
13. OPEC SPECIAL FUND
14. SWEDEN
15. SWITZERLAND
16. UNITED KINGDOM

