

**Health Resources Group
for Primary Health Care**





WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

INDEX

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GUIDELINES FOR PREPARATION OF THE
COUNTRY HEALTH RESOURCE UTILIZATION REVIEW (CRU) DOCUMENT



These guidelines are designed to help those engaged in the preparation of a national CRU document. Although each CRU is unique to the country concerned, some common elements are worth noting. It is suggested that a CRU document may consist of (a) a main report, (b) summary proposals for external financing, and (c) information annexes. Some illustrative tables are also provided.

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GUIDELINES FOR PREPARATION OF THE NATIONAL COUNTRY
HEALTH RESOURCE UTILIZATION REVIEW (CRU) DOCUMENT

I. INTRODUCTION

1.1 At the Thirtieth World Health Assembly (May 1977), all the Member States unanimously adopted resolution WHA30.43, which decided that "the main social target of governments and WHO in the coming decades should be the 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", popularly known as "Health for All by the Year 2000" ("HFA/2000").

1.2 The International Conference on Primary Health Care (Alma-Ata, September 1978) declared that "Primary health care is the key to attaining this target," and called on all countries "to support national and international commitment to primary health care and to channel increased technical and financial resources to it, particularly in developing countries." The Health Assembly endorsed the Declaration of Alma-Ata and invited all Member States to formulate national policies, strategies and plans of action for HFA/2000, based on primary health care (PHC).

1.3 The Thirty-fourth World Health Assembly (May 1981), in resolution WHA34.36, adopted a "Global Strategy for Health for All by the Year 2000,"¹ including the identification, rationalization and mobilization of resources for HFA/2000. Resolution WHA34.37 urged all Member States "to allocate adequate resources for health, and in particular for primary health care and the supporting levels of the health system." It urged those Member States "that, for the implementation of their strategies for health for all, require external sources of funds in addition to their own resources, to identify those needs."

1.4 One approach, which may be useful in some countries to initiate action for the rationalization and mobilization of internal and external resources for national strategies for HFA/2000 based on PHC, is a "country health resource utilization review" (CRU), as proposed and field-tested in several developing countries at the suggestion of an international "Health Resources Group" (HRG), convened by the Director-General of WHO "to help initiate international action, generate innovative ideas and provide a forum for discussion and guidance at global level."

¹ "Global Strategy for Health for All by the Year 2000," published in "Health for All" Series No. 3 (1981).

1.5 The country health resource utilization review process may be initiated by the preparation by the nationals concerned (with or without the participation of a small HRG support team) of a brief, analytical CRU document, which may serve as a basis for country-level follow-up in the form of country resource utilization review meetings or discussions convened by the national authorities with interested partners to go into the resource requirements analysis in greater detail.

1.6 Although the preparation of CRU document may be carried out with the help of an HRG support team or other external partners, it is essentially an internal, national document, and not an external assessment study. The CRU assesses the health resources situation at one point in time, based on national plans, operations, budgets and commitments or expectations. The CRU is not itself a programming or evaluation exercise, although it does make use of existing plans and evaluations, and the CRU leads to further integral development of policies, plans and operations in accordance with the Managerial Process for National Health Development.¹

1.7 A country health resource utilization review (CRU) document is thus a study carried out by a developing country itself, involving the Ministry of Health, Ministry of Planning, Finance and other sectoral authorities, to analyze resource flows, identify total requirements, resources available or committed, and opportunities for reallocation of internal resources and mobilization of external resources in relation to HFA/2000 generally and PHC in particular.

1.8 No two country CRU documents can be the same; each is unique to the country concerned. Nevertheless, experience has shown that there are common elements worth inclusion in a CRU document. Countries undertaking a country health resource utilization review may wish to have some guidance in preparing the initial CRU document. The following guidelines represent informal suggestions and illustrative materials which may be useful to nationals concerned.

¹ See "Managerial Process for National Health Development - Guiding Principles", published in "Health for All" Series, No. 5 (1981); and "Health Programme Evaluation - Guiding Principles", published in "Health for All" Series No. 6 (1981).

II. FORM OF PRESENTATION AND CONTENT OF THE CRU DOCUMENT

2.1 The CRU document, being a national document, may follow any format and include whatever materials national authorities believe will be most relevant to the country situation and to the purposes to be served by the CRU document. Experience in a number of countries suggests that a CRU document need not be a highly detailed or lengthy report, since the initial CRU document is intended to set the stage for more detailed analyses and follow-up at country level. It may be useful to divide the CRU document into:

1. Main CRU Report
2. Summary Proposals for External Funding
3. Supporting Annexes

III. MAIN CRU REPORT

3.1 It is suggested that the main CRU report may be quite brief; indeed some 20 pages should suffice. This is long enough to provide the desired overview, yet short enough to be read at one sitting.

3.2 The main CRU report may be divided into suitable chapters or sections for clarity of presentation. Whatever the form of presentation selected, it is suggested that the CRU report briefly cover the following main issues:

- (a) National Health Policy and Strategy for HFA/2000 - A brief statement showing that the country is committed at the highest policy levels to a HFA/2000 policy and strategy based on PHC. State the essence of that policy and strategy. Has an official national health development plan of action been formulated or adopted?
- (b) Primary Health Care System Design or Approach - A concise outline of the national health system design based on PHC, including its main components, reorganization of infrastructure and services, integration of services, intersectoral and community action, and expected impact on health and coverage, measured by appropriate national targets or indicators, and cross-referenced to specific proposals (see Sections IV-VI below).
- (c) Problems, Obstacles, Constraints and Feasibility - Briefly indicate how the HFA/2000 actions based on PHC relate to, seek to overcome, or are limited by health and social problems, as well as political, managerial, technical, human or financial resources affecting absorption capacity. Do proposals include provision for removing such obstacles and constraints?

- (d) Financial Implications and Health Expenditures - An indication of current expenditures and budgetary allocations for health, and particularly for primary health care, together with an indication of total requirements for a specified period of time, resources available or committed from national and external sources, and the net shortfall or gap required to finance the national strategy for HFA/2000 based on PHC.

IV. SUMMARY PROPOSALS FOR EXTERNAL FUNDING

4.1 It may be desirable to attach to the CRU report brief summaries of proposals for external funding of programmes that form an integral part of the national strategy for HFA/2000 based on PHC. Such summaries would briefly highlight and refer to national programme actions which were already operational, planned or proposed for a defined period of time. In each case it is suggested that a budgetary table be used to summarize: (a) the total estimated resources requirements (preferably distinguishing between "capital" investment and "recurring" costs); (b) the resources committed or reasonably expected to become available from national or external sources; and (c) the net shortfall or resources still required to carry out the programme for the current and next medium-term plan period. It should be understood that these are not final, official detailed proposals, but rather summaries of worthwhile opportunities for external participation designed to elicit interest and follow-up consideration by potential external partners concerned with health development in the country.

4.2 The Main PHC Proposal - Primary health care is based on self-reliant health care by individuals, families and local communities, with the support of trained manpower and a lasting health system infrastructure capable of providing essentials of PHC in an integrated manner. In many countries, the action at community level and its immediate support constitute the main or central PHC proposal. It is suggested that the summary of this main PHC or PHC-support proposal be placed first. The PHC proposal should briefly illustrate the PHC system design or concept, which characteristically often includes a PHC level backed by a first and second support level. It is useful to briefly indicate the overall technical, manpower, material and financial resource requirements, and either including significant unit costs, capital investment and recurring costs, or referring to other documentation where the information can be found. (For convenience, a suggested model format for summarizing the main PHC or PHC-support proposal is attached, pages 17 to 24).

4.3 Related Proposals - Other closely related health development programme proposals which form part of the HFA/2000 strategy based on PHC may also be attached to the CRU report (pages 26 and 27). In considering what related proposals may be appropriate, it is useful to recall the essentials that should be covered by any HFA/2000 strategy based on PHC (see Section VI below). Proposals may be made, not only for the primary strategies, but also for "complementary" strategies or actions, such as strengthening planning, operational management, or health systems research and evaluation intended to overcome identified obstacles and constraints, or enhance programme feasibility and absorption capacity (see paragraph 3.2 (c) above).

V. SUPPORTING ANNEXES

5.1 There is a natural tendency in preparing a CRU report to assemble more material than can be usefully absorbed in a document of this nature. It is suggested therefore that whenever possible it is preferable to exclude detail which can be found in and cross-referenced to other official documentary sources. Where background or other supporting information is nevertheless considered worth including in the CRU document, without encumbering the main CRU report, it is recommended that such materials be provided in separate annexes, suitably cross-referenced with the main CRU text. Among the kinds of information that have sometimes proved useful in support of the main CRU report are:

- Socioeconomic information directly related to health.
- Health status data, targets and indicators of health for all.
- National health development plans and processes.
- National health financing and expenditure patterns and trends.
- More detailed information on the primary health care approach.
- More detailed information on other related health programmes.

5.2 Certain parts of the annexed material may be presented in tabular form, designed to facilitate simplified presentation of essential statistical, budgetary or expenditure data. Purely illustrative proforma tables are attached. Illustrative Table 1 shows the allocation of total resources for health, drinking water and all other major areas of socioeconomic development, with a view to revealing where health stands in terms of socioeconomic development resource priorities. Illustrative Table 2 reveals to what extent the national policy and strategy based on PHC is being reflected in actual resource allocations within health development. Illustrated Tables 3-1 and 3-2 are useful for identifying which institutions and donors are interested, participating in or contributing towards which national health development programmes. Each CRU document will nevertheless contain only those annexes or tables that are most relevant and significant to the situation in the country and to the purposes to which the national CRU document is being put.

VI. CHECKLIST OF REFERENCE MATERIALS

6.1 The CRU review is only a part of a much wider national policy making, planning, management, implementation and evaluation process. A checklist of some important related concepts and reference materials having a bearing on the CRU effort are mentioned below for convenience:

6.2 Essentials of Primary Health Care - It should be recalled that in accordance with the Recommendations of the International Conference on Primary Health Care, PHC should include at least:

- Education concerning prevailing health problems and the methods of identifying, preventing and controlling them;
- Promotion of food supply and proper nutrition
- An adequate supply of safe water and basic sanitation;
- Maternal and child health care, including family planning;
- Immunization against the major infectious diseases;
- Prevention and control of locally endemic diseases;
- Appropriate treatment of common diseases and injuries;
- Promotion of mental health;
- Provision of essential drugs.

6.3 Related Health Development Indicators - When considering which proposals for external funding are particularly worth promoting (Section IV) as well as what selective background information is worth annexing to the CRU report (Section V above), it may be useful to consider their relevance in terms of national targets for attainment of HFA/2000. In addition, it may be useful to consider the national situation in relation to the short list of global indicators adopted by WHO, namely the number of countries in which:

- (1) Health for all has received endorsement as policy at the highest official level;
- (2) Mechanisms for involving people in the implementation of strategies have been formed or strengthened and are functioning;

- (3) At least 5 percent of the gross national product is spent on health;
 - (4) A reasonable percentage of the national health expenditure is devoted to local health care, i.e., first-level contact, including community health care, health centre care, dispensary care and the like;
 - (5) Resources are equitably distributed, in that the per capita expenditure as well as the staff and facilities devoted to primary health care are similar for various population groups or geographical areas, such as urban and rural areas.
 - (6) The number of developing countries with well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries.
- (7) Primary health care is available to the whole population, with at least the following:
- safe water in the home or within 15 minutes' walking distance and adequate sanitary facilities in the home or immediate vicinity;
 - immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis;
 - local health care, including availability of at least 20 essential drugs, within one hour's walk or travel;
 - trained personnel for attending pregnancy and childbirth and caring for children up to at least 1 year of age.
- (8) The nutritional status of children is adequate.
- (9) The infant mortality rate for all identifiable sub-groups is below 50 per 1 000 live-births.
- (10) Life expectancy at birth is over 60 years.
- (11) The adult literacy rate for both men and women exceeds 70 percent.
- (12) The gross national product per head exceeds US\$ 500.

N.B. Note that four out of the 12 indicators in the global short list deal explicitly with resource allocation. In addition, all the indicators are interrelated.

6.4 Allocation of National Resources for PHC - In considering how to make the case for additional external resources for health development in the country, attention should be given to the related allocation of national resources for PHC. The International Conference on Primary Health Care recommended in this connexion, that:

"Government, in progressively increasing the funds allocated for health, should give first priority to the extension of primary health care to underserved communities; encourage and support various ways of financing primary health care, including, where appropriate, such means as social insurance, cooperatives, and all available resources at the local level, through the active involvement and participation of communities; and take measures to maximum the efficiency and effectiveness of health-related activities in all sectors."

6.5 International Support for PHC -It will be useful in preparing the CRU to identify and consider the appropriate role of all partners including international, multilateral, governmental and non-governmental organizations. It may be recalled that the International Conference on Primary Health Care recommended that:

"International organizations, multilateral and bilateral agencies, non-governmental organizations, funding agencies, and other partners in international health acting in a coordinated manner should encourage and support national commitment to primary health care and should channel increased technical and financial support into it, with full respect for the coordination of these resources by the countries themselves in a spirit of self-reliance and self-determination, as well as with the maximum utilization of locally available resources."

6.6 "Health for All" Series Publications - When preparing a CRU document it is necessary to be familiar with, and refer to or use as appropriate, the following publications in the brightly colored WHO "Health for All" series:

- No. 1 Primary Health Care - Report of the International Conference (1978)
- No. 2 Formulating Strategies for Health for All by the Year 2000 (1979)
- No. 3 Global Strategy for Health for All by the Year 2000 (1981)
- No. 4 Indicators for Monitoring Progress towards Health for All (1981)
- No. 5 Managerial Process for National Health Development - Guiding Principles (1981)
- No. 6 Health Programme Evaluation - Guiding Principles (1981)

ILLUSTRATIVE PROFORMA TABLE 1

ALLOCATION OF TOTAL RESOURCES FOR HEALTH,
DRINKING-WATER AND OTHER SOCIOECONOMIC DEVELOPMENT¹

Major socioeconomic development sectors	(a)		(b)	(c)	(d)
	Amount in millions of local currency (and equivalent in US \$)		Per cent. of total (b)	Per cent. increase (a) → (b)	
	Prior year 19--	Budget year 19--			
<u>Health Development</u>	_____	_____	_____	_____	
<u>Drinking-Water and Sanitation</u>	_____	_____	_____	_____	
Sub-total	_____	_____	_____	_____	
Education	_____	_____	_____	_____	
Food and Agriculture	_____	_____	_____	_____	
Industry	_____	_____	_____	_____	
Transportation	_____	_____	_____	_____	
(etc.)	- - - -	- - - -	- - - -	- - - -	
(etc.)	- - - -	- - - -	- - - -	- - - -	
Total	NC* _____ \$ _____	NC _____ \$ _____	<u>100%</u>	___%	

* National currency.

SOURCE OF FINANCING

Source	(a)		(b)	(c)	(d)
	Prior year 19--		Budget year 19--	Per cent. of total (b)	Per cent. increase (a) → (b)
National regular budget	_____	_____	_____	_____	
Other national sources	_____	_____	_____	_____	
External aid	_____	_____	_____	_____	
Total	NC _____ \$ _____	NC _____ \$ _____	<u>100%</u>	___%	

¹ Note: the breakdown of major socioeconomic sectors or programmes will depend on the availability and classification of budgetary resources data in the country concerned. One purpose of this table is to see how resource allocations for health compare with resource allocations for other sectors or areas of socioeconomic development.

ILLUSTRATIVE PROFORMA TABLE 2

ALLOCATION OF HEALTH RESOURCES FOR PRIMARY HEALTH CARE,
HEALTH PROGRAMMES AND INSTITUTIONS¹

Major health programmes and institutions	(a)	(b)	(c)	(d)
	Amount in millions of local currency (and equivalent in US \$)		Per cent. of total health budget (b)	Per cent. increase (a)→(b)
	Prior year 19--	Budget year 19--		
<u>Primary Health Care</u> (including primary level, referral/ supporting levels, services, manpower, supplies)	_____	_____	_____	_____
Major health programmes:				
Drinking Water and Sanitation	_____	_____	_____	_____
Malaria Control (etc.) (etc.)	_____	_____	_____	_____
Research and Development Hospitals, institutions (etc.) (etc.)	_____	_____	_____	_____
Other	_____	_____	_____	_____
Total	NC _____ \$ _____	NC _____ \$ _____	<u>100%</u>	____%

SOURCE OF FINANCING

	(a)	(b)	(c)	(d)
	Prior year 19--	Budget year 19--	Per cent. of total (b)	Per cent. increase (a)→(b)
National regular budget	_____	_____	_____	_____
Other national sources	_____	_____	_____	_____
External aid	_____	_____	_____	_____
Total	NC _____ \$ _____	NC _____ \$ _____	<u>100%</u>	____%

¹ Note: the breakdown of health programmes will depend on the availability and classification of budgetary resources data in the country concerned. One purpose of this table is to provide an indication of health expenditure by level of health care.

ILLUSTRATIVE PROFORMA TABLE 3-1

EXTERNAL AID - HEALTH SECTOR, BY SOURCE OF FUNDS,
PROGRAMME/PROJECT/ACTIVITY, DURATION OF AID AND AMOUNT

Source of Funds	Programme/Project/(1) Activity	Duration of Aid(2) from 19-- to 19--	Committed Amount in US\$ Thousands
A. _____	a. _____ b. _____ c. _____ etc. - - - - -	_____ _____ _____ - - - - -	_____ _____ _____ - - - - -
B. _____	a. _____ b. _____ c. _____ etc. - - - - -	_____ _____ _____ - - - - -	_____ _____ _____ - - - - -
C. _____	a. _____ b. _____ c. _____ etc. - - - - -	_____ _____ _____ - - - - -	_____ _____ _____ - - - - -

(etc.)

A, B, C, etc. - each one is an individual source of funds:

(Multilateral, multilateral, bilateral, other sources of funds - specify each.)

- (1) One source may frequently be funding several programmes/projects and/or activities, a, b, c, etc.; each of them should be listed separately.
- (2) Duration of aid to each specific programme/project should be indicated in calendar years.

N.B. Water supply and sanitation should be shown as any other programme even if under jurisdiction of a sector other than health.

ILLUSTRATIVE PROFORMA TABLE 3-2

EXTERNAL AID - HEALTH SECTOR, BY PROGRAMME/
PROJECT/ACTIVITY, SOURCES OF FUNDS, DURATION
OF AID AND AMOUNT

Programme/Project/(1) Activity	Source of Funds(2)	Duration of Aid(3) from 19-- to 19--	Committed(4) Amount in US\$ Thousands
A. _____	a. _____ b. _____ c. _____ etc. - - - -	_____ _____ _____ - - - -	_____ _____ _____ - - - -
B. _____	a. _____ b. _____ c. _____ etc. - - - -	_____ _____ _____ - - - -	_____ _____ _____ - - - -
C. _____	a. _____ b. _____ c. _____ etc. - - - -	_____ _____ _____ - - - -	_____ _____ _____ - - - -

(etc.)

- (1) A, B, C, etc. indicate titles of individual programme, project, or activity.
- (2) a, b, c, etc. indicate individual donors/sources of funds financing A, B, C, etc.
- (3) Duration of aid provided by a, b, c, etc.
- (4) Committed by a, b, c, etc.

PROPOSAL FOR EXTERNAL FUNDING NO. 1

(Suggested format and content)

I. TITLE:

Primary Health Care

II. DURATION AND TOTAL COST:

Duration _ _ _ _ years, from 19__ to 19__

Total Cost in US\$ _ _ _ _

Proposed external funding in US\$ _ _ _ _

III. BACKGROUND AND JUSTIFICATION:

National Commitment

Major constraints on the present national health network affecting its effectiveness and efficiency.

Integration of vertical programmes in the primary health care.

Cost-benefit considerations.

IV. SPECIFIC OBJECTIVES AND TARGETS

- (1) Overall objective
- (2) Specific objectives and targets
- (3) Developmental end-results to be achieved by the year 19__:

(see V.3 and V.10)

Requirements by the year 19__	Total Required Number	Existing Number	Needed Number
<p>A. <u>Infrastructure:</u></p> <p>Primary Health Care Level* (Primary Unit)</p> <p>First Level Referral Unit</p> <p>Second Level Referral Unit</p>			
<p>B. <u>Health Workers For:</u></p> <p>Primary Health Care Level</p> <p>First Level Referral Unit</p> <p>Second Level Referral Unit</p>			

*First level of contact of individuals, the family and community with the national health system.

V. DESCRIPTION AND ACTION PLAN

V.1 National Conceptual Structure of Primary Health Care

(including referral/support system)

An Illustrative Diagram

Primary Health
Care Level
(Primary Unit)

Community Health Worker
(CHW)

Total No. _____
No. linked to first
level referral unit _____
CHW per _____ people _____

First level referral
unit

Sub-Centre, Centre
or Other

Total No. _____
No. linked to
second level referral
unit _____

Second level
referral unit

District Health Office,
District Hospital, or
Other

Total No. _____

Describe functional links between various levels:

V.2 Health Care Delivery and other Functions at Various Levels
(National Concept)

Services/Functions*	Primary Health Care Level	First Referral Level	Second Referral Level
1. Health Education			
2. Promotion of food supply and proper nutrition			
3. Supply of safe water and basic sanitation			
4. Maternal and child health care incl. family planning			
5. Immunization			
6. Prevention & control of locally endemic diseases			
7. Appropriate treatment of common diseases & injuries			
8. Provision of essential drugs			
9. Training			
10. Supportive Supervision			
11. Logistics Support			
12. Evaluation			
Etc. (Specify)			

* Check as appropriate services and functions which are being carried out at different levels. Note that this check list includes all the essentials of primary health care as defined in the Declaration of Alma Ata.

- V.3 Proposed Staffing Pattern at Various Levels:
(Enumerate categories and numbers of health workers assigned to various levels.)
- Primary health care level:
First referral level:
Second referral level:
- V.4 Functions and Responsibilities of Health Workers at the Above Levels
(Separately for each category of health workers)
- V.5 Training, Reorientation Training and Continuing Education:
- Responsibilities for training.
Training strategy.
Training capacities.
Teaching/training staff at various levels and their training.
Training outputs (present/planned).
- V.6 Promotion of Community Participation:
- Community participation, pattern and components.
Envisaged promotion of community participation in terms of self-help and self-reliance.
Village level committees, composition and roles.
Rural voluntary organizations.
Other.
- V.7 Involvement of Other Sectors:
(agriculture, animal husbandry, food, forestry, industry, education, housing, public works, communications, transportation and others)
- Mechanism of intersectoral coordination at various levels.
- V.8 Management
- V.8.1. - Responsibilities at various organizational levels and communications between the levels.
- Strategy for integration of special programmes into the general health system/primary health care.
- Management of manpower.
- Reallocation of resources in support of primary health care.
- Procurement, supplies, logistics, transport, overall maintenance.
- V.8.2. - Monitoring (responsibility, mechanism)
- V.8.3. - Evaluation (responsibility, mechanism, components, indicators, evaluation by the community).
- V.8.4. - Reprogramming (authority, mechanism)
- V.8.5. - Information support
- V.9 Primary Health Care Implementation Strategy:
- Institutional responsibility for implementation. Overcoming regional variations due to geographic, health, socio economic and other factors.

V.10 Phasing (annualization) of Implementation:
(see IV. 3)

a. Infrastructure Units

Level	198 No.	198 No.	198 No.	subsequent years	Total
Primary health care level (primary unit)					
First level referral unit					
Second level referral unit					

b. Health Workers*

Level	198 No.	198 No.	198 No.	subsequent years	Total
Village level workers (Community Health Workers)					
First level referral unit workers team					
Second level referral unit workers team					

*The primary health care level shows the numbers of village level workers (community health workers).

The other two levels show the numbers of health workers in teams, according to the standard staffing pattern described under V.3.

VI. UNIT COSTS

A. Capital (or Investment) Costs

U.S.\$

a.	Construction of first level referral unit	
b.	Construction of second level referral unit	
c.*	Cost of training of an individual health worker (for categories see V.3) including reorientation /refresher, etc.	*These costs may be enumerated on a separate sheet to be attached to this table
d.	Cost of initial supplies and equipment (including transport) for:	
	- primary health care level	
	- first level referral unit	
	- second level referral unit	

B. Annual Recurring Expenditure or Operating costs per:

	- primary health care level (unit)	
	- first level referral unit	
	- second level referral unit	

What is the feasibility of Government's bearing the estimated additional recurrent cost?

VII. SUPPLIES AND EQUIPMENT

Attach list of required supplies, equipment and transport at:

- primary health care level
- first referral level
- second referral level

Particular attention should be given to the list of essential drugs as well as to the overall drugs' management (procuring, storing, distribution).

VIII. PARTICIPATING INSTITUTIONS

National: Actual
 Potential

International: Actual
 Potential

Brief description of their roles in promoting the national primary health care.

IX. NATIONAL APPROVAL

(Indicate date of submission to, or preferably approval by the national planning or other authorizing authorities.)

PROPOSAL NO.1

PRIMARY HEALTH CARE
SUMMARY OF TOTAL ESTIMATED BUDGETARY REQUIREMENTS,
RESOURCES AVAILABLE AND NET RESOURCES REQUIRED

(Amounts shown in millions of national currency and the US\$ thousands)

	Ongoing National Development Plan 19__ to 19__		Next National Development Plan 19__ to 19__	
	National Currency	U.S.\$ Equivalent	National Currency	U.S.\$ Equivalent
I. Total Estimated Budgetary Requirements				
	a. Capital			
	b. Recurring			
	c. Total			
II. Source of Funds				
2.1 Government*	d. Capital			
	e. Recurring			
	f. Total			
2.2 External Aid Committed/ Estimated	g. Capital			
	h. Recurring			
	i. Total			
III. Net Resources Required	j. Capital			
	k. Recurring			
	l. Total			

N.B. The main purpose of this table is to arrive at the "Net Resource Required" (3) which in fact is the balance between the "Total Estimated Budgetary Requirements" (1) and "Source of Funds" (2) (available or estimated to become available). Thus, the computation is simple, as follows: Total "l" = Total "c" minus sum total of "f" plus "i". Similar computation could be applied for arriving at figures "j" and "k."

*National Government figures represent actual budget for the ongoing national development plan and unofficial projection for the next plan.

It should be mentioned whether the figures include the estimated inflation rates (national).

Other proposals can be presented following the format on pages 26 and 27 provided they form an integral part of the primary health care plan of action.

S U M M A R Y

PROPOSAL FOR EXTERNAL FUNDING NO. ...
(3-4 pages)

- I. Title:
(Name of programme, project or activity proposed for external funding.)
- II. Duration in calendar years from _____ to _____
- III. Background and Justification:
(Relationship to overall primary health care action plan.)
- IV. Specific Objectives and Targets:
(End-results to be achieved within planned time-frame.)
- V. Description and Action Plan:
(Approaches, activities and milestones for implementation.)
- VI. Budgetary Resource Requirements: (see attached table)
- VII. Supplies and Equipment:
(List of required supplies and equipment, if available.)
- VIII. Participating Institutions:
(Actual and potential collaboration partners, national and international)
- IX. Evaluation Criteria and Process:
(Criteria, method and mechanism for evaluation.)
- X. National Approval
(Indicate date of submission to, or preferably approval by the national planning or other authorizing authority.)

PROPOSAL NO.

SUMMARY OF TOTAL ESTIMATED BUDGETARY REQUIREMENTS,
RESOURCES AVAILABLE AND NET RESOURCES REQUIRED

(Amounts shown in millions of national currency and the US\$ thousands)

	Ongoing National Development Plan 19__ to 19__		Next National Development Plan 19__ to 19__	
	National Currency	U.S.\$ Equivalent	National Currency	U.S.\$ Equivalent
I. Total Estimated Budgetary Requirements	a. Capital			
	b. Recurring			
	c. Total			
II. Source of Funds	d. Capital			
	e. Recurring			
	f. Total			
	2.1 Government*			
	2.2 External Aid Committed/ Estimated			
III. Net Resources Required	g. Capital			
	h. Recurring			
	i. Total			
	j. Capital			
	k. Recurring			
	l. Total			

N.B. The main purpose of this table is to arrive at the "Net Resource Required" (3) which in fact is the balance between the "Total Estimated Budgetary Requirements" (1) and "Source of Funds" (II) (available or estimated to become available). Thus, the computation is simple, as follows: Total "l" = Total "c" minus sum total of "f" plus "i". Similar computation could be applied for arriving at figures "j" and "k."

*National Government figures represent actual budget for the ongoing national development plan and unofficial projection for the next plan.

It should be mentioned whether the figures include the estimated inflation rates (national).