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COUNTRY HEALTH RESOURCE UTILIZATION REVIEW (CRU)

Guidelines for the use of a CRU in providing a
Resource Framework for Primary Health Care Planning

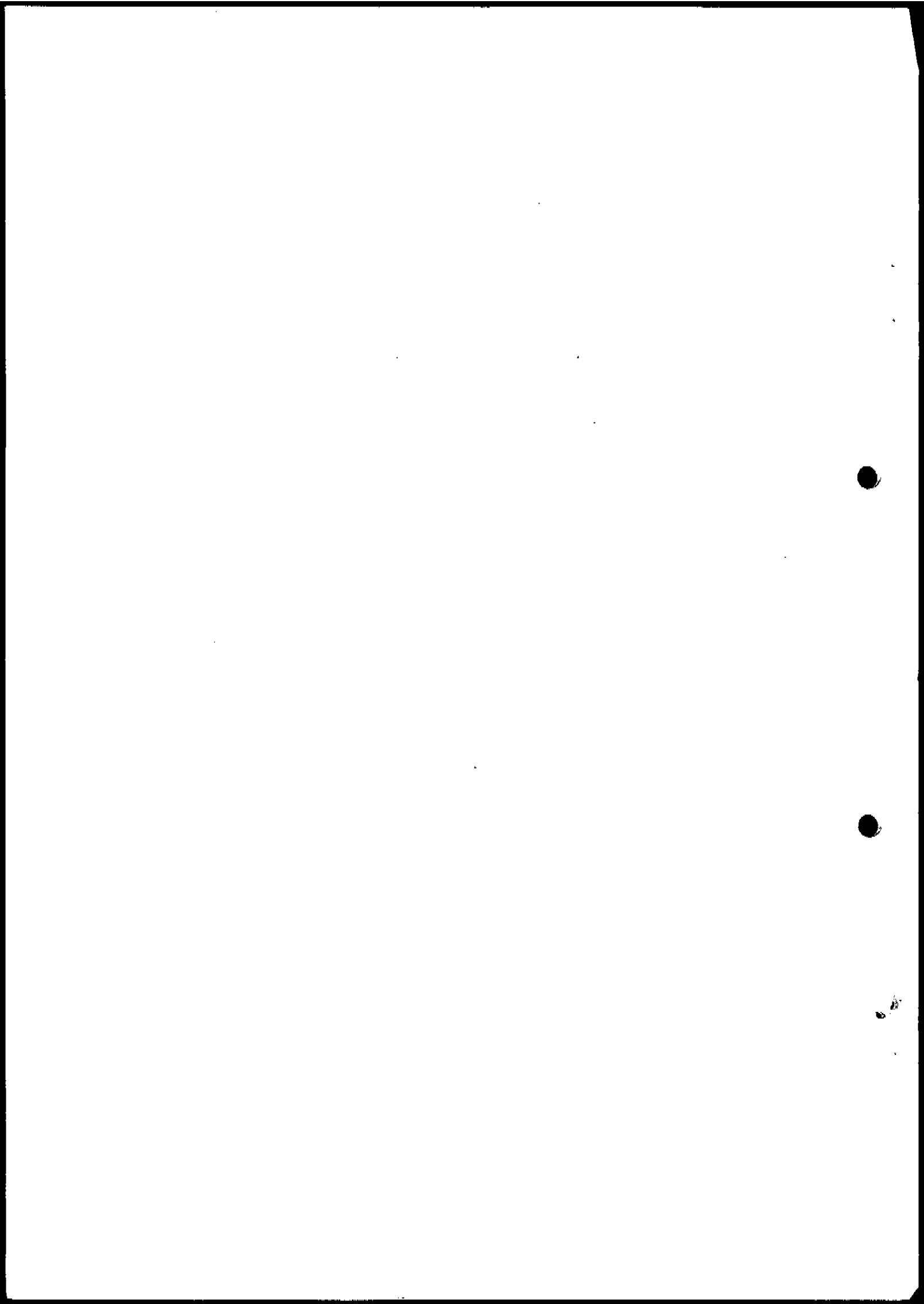
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*Subj: 1. Primary health care - ^{to} learn of - ^{to} organization and administration
2. Health resources - utilization*

A CRU is a useful instrument to facilitate programme budgeting in primary health care as a part of the overall management, monitoring and evaluation process by which countries individually, and together, strive to attain health for all by the year 2000. It provides a careful analysis of the country's health problems and socioeconomic circumstances in support of the search for solutions that are socially and economically feasible. It points the way to decisions that must be made on specific priorities, objectives in relation to these priorities, and the resources needed to attain these objectives. It is a means of indicating the directions for the allocation of the country's own resources for health development, as well as of identifying the needs for additional external resources that may be required for implementing the strategy for health for all, based on primary health care.

These guidelines are designed to help countries in preparing for and carrying out a CRU. As a national process, each CRU will be unique to the country concerned. However, experience has shown that there are a number of common elements that can usefully be included, and a number of steps that all countries will wish to follow. These are outlined in this document, together with a number of illustrative tables.

A CRU becomes a helpful tool in mobilizing health resources only when it is effectively followed up, regularly updated and maintained as one expression of the actions undertaken by a country in pursuit of its national goal of health for all.



COUNTRY HEALTH RESOURCE UTILIZATION REVIEW (CRU)

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", generally 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 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

1.4 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 "which, 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." The Global Strategy further stated that :

"Inseparable from the Strategy is the action required to generate and mobilize all possible resources. All human resources will have to be mobilized, not only health personnel. All types of health personnel as appropriate to the country will have to be motivated and mobilized. The best use will have to be made of available human and financial resources, and investments in health will have to be increased if necessary. The international transfer of resources from developed to developing countries will have to be rationalized and these transfers increased if necessary."

"Health authorities will also assure economic planners and political decision-makers that endeavours to improve health in conformity with the fundamental policies for health for all outlined above are an investment in human development. Health authorities will use the very Strategy for Health for All, based on social justice and on equity in the distribution of resources for health, as an example to be followed by other sectors".

"Ministries of health will review the functions, staffing, planning, design, equipment, organization and management of health centres and first-referral hospitals, in order to prepare them for their wider function in support of primary health care. Before investing in buildings, the cost of running them will be considered."

(1) The Global Strategy is fully described in book No.3 of the WHO "Health for All" Series of publications. This series forms a useful background to the conduct of a CRU review, and includes the following titles:

- 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)
- No.7 Plan of Action for Implementing the Global Strategy for Health for All (1982)
- No.8 Seventh General Programme of Work, covering the period 1984-1989 (1982)

1.5 To generate and mobilize the necessary resources WHO will ensure the international mobilization of people and groups who can support the Strategy, and will foster the coordinated international transfer of resources in support of the strategies of developing countries.

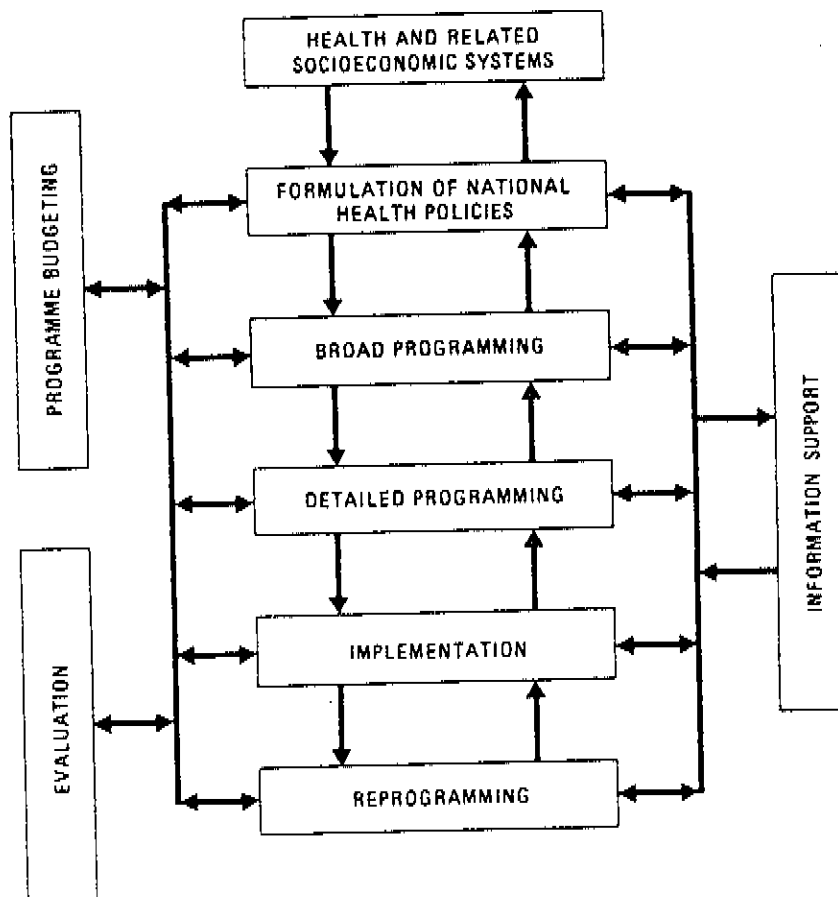
1.6 National efforts aimed at the rationalization and mobilization of all available resources for health can usefully follow some form of managerial process for national health development. The WHO publication, "Managerial Process for National Health Development"; Guiding Principles, World Health Organization, Geneva, 1981 ("Health for All" Series No.5), describes in detail the components of this process. Despite variations from country to country, it is possible to identify certain common components, as follows:

- (a) The formulation of national health policies, comprising goals, priorities, and main directions towards priority goals, that are suited to the social needs and economic conditions of the country and form part of national social and economic development policies.
- (b) Broad programming - the translation of these policies, through various stages of planning, into strategies to achieve clearly stated objectives and, wherever possible, specific targets.
- (c) Programme budgeting - the preferential allocation of health resources for the implementation of these strategies.
- (d) The master plan of action resulting from broad programming and programme budgeting and indicating the strategies to be followed and the main lines of action to be taken in the health and other sectors implement these strategies.
- (e) Detailed programming - the conversion of strategies and plans of action into detailed programmes that specify objectives and targets and the technology, manpower, infrastructure, financial resources, and time required for their implementation through a unified health system.
- (f) Implementation - the translation of detailed programmes into action so that they come into operation as integral parts of the health system; the day-to-day management of programmes and the services and institutions for delivering them, and the continuing follow-up of activities to ensure that they are proceeding as planned and are on schedule.

- (g) Evaluation of developmental health strategies and operational programmes for their implementation, in order progressively to improve their effectiveness and impact and increase their efficiency.
- (h) Reprogramming, as necessary, with a view to improving the master plan of action or some of its components, or preparing new ones as required, as part of a continuous managerial process for national health development.
- (i) Support, in the form of relevant and sensitive information, for all these components at all stages.

1.7 The steps involved in this Managerial Process are graphically presented below:

MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT



1.8 Guiding Principles for a number of the components of the Managerial Process for National Health Development have also been provided⁽¹⁾. The intimate relationship between Programme Budgeting to all steps in the Managerial Process can be seen from the figure in 1.7 above. In Broad Programming, Programme Budgeting creates the opportunity for an economic analysis of health strategies. This tries to ensure that resources (i.e., inputs) are used in such a way as to make the maximum impact on a population's health status (i.e., outputs). Decision makers will need to decide how to spend their limited resources most effectively by tracing out the consequences of various courses of action. Such an economic analysis will provide the justification for priority programmes often required by potential funders when considering requests for finance.

II. THE COUNTRY HEALTH RESOURCE UTILIZATION REVIEW

2.1 One analytical tool, which may be useful in some countries to initiate the tasks of Programme Budgeting in Broad Programming, is a "Country Health Resource Utilization Review" (CRU), already used in a number of developing countries under the guidance of a global "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 the global level." The HRG functions not as a fund-raising body but to provide guidance to WHO in carrying out and effectively following up the support WHO provides to Member States in carrying out CRUs. This WHO support has received priority attention with regard to the Least Developed Countries (LDCs), assisting them in the tasks of rationalizing and mobilizing all possible resources for national health development.

2.2 A CRU is useful in the carrying out of the following tasks:

- contribute an economic and financial element to the situation analysis, and in particular to assess the present and likely future availability of funds in order to provide a resource framework for programming, especially for primary health care;
- contribute an economic and financial perspective to problem analysis, priority determination and objective setting;

(1) These documents are: Broad Programming as a part of the Managerial Process for National Health Development: Guiding Principles, (WHO document MPNHD/81.3); Detailed Programming as a part of the Managerial Process for National Health Development: Guiding Principles, (WHO document MPNHD/81.4); Programme Implementation as a part of the Managerial Process for National Health Development: Guiding Principles, (WHO document MPNHD/81.5); Health Programme Evaluation: Guiding Principles, World Health Organization, Geneva, 1981, ("Health for All" Series, No.6)

- estimate the costs of alternative strategies to achieve objectives;
- undertake an economic appraisal of proposed strategies ;
- put together the proposed programmes and assess their overall balance and financial feasibility.

2.3 A CRU is a means of providing the resource framework for the programming of primary health care. Needs and resources must both be considered together in this planning process. The main task of Programme Budgeting in situation analysis is to indicate resource projections for formulating and implementing national strategies for health for all and an indication of which resources are in shortest supply.

2.4 To build this resource framework, resources available now and likely changes in resource availability in the future should be examined. The analysis should focus on general trends in expenditure and in the availability of funds, but take note if particular resources are likely to be in short supply. The time-span chosen will relate to the period covered by the national health plan. It is desirable to look a number of years ahead, for example, to the year 2000, since the resources implications of proposed priorities may be far-reaching. Within the above framework, many countries in addition will choose a time-span of around five years, for which they will prepare a fairly detailed plan.

2.5 Ideally, future trends in finance and expenditure should be explored for the whole health system, though the method used in a CRU will focus specifically on primary health care. They should be projected on the basis of past trends, adjusted if new factors, such as changed government policies or rising incomes, may alter these trends. Communities, interested groups and voluntary agencies may have future spending plans that can be noted.

2.6 In the government sector, future changes likely to have financial consequences for both capital and recurrent government expenditure should be identified. New facilities may be due to open during the plan period and their recurrent expenditures should be estimated. Demographic changes can lead to increased demands on existing services. Inflation must also be considered, and staff costs may rise regularly because of salary increases, and new training and working agreements. Funds will also be needed to maintain existing buildings and replace equipment.

2.7 On the other hand, it should be possible to make some savings in existing services. Changing disease patterns may release resources. For example, immunization programmes may reduce the need for curative treatment of childhood infectious diseases or improvement in sanitation and water supply may reduce diarrhoeal diseases. There may be scope for producing identical services with fewer or cheaper resources.

2.8 Estimates are also needed of the future availability of funds for the government sector. The starting point will be any guidance on capital and recurrent funds given by the treasury or planning ministry. The recurrent guideline may be an annual real growth rate over the next five-year plan period. If the time span is longer, then much vaguer assumptions are likely to be given. Estimates of the yield from other sources of funds, such as community finance, must be added to government guidance, as well as external assistance if this is not already included.

2.9 Any major financial constraints likely to affect future plans should be noted. For instance, will foreign exchange be in short supply? Which represents the greater constraint on future developments - recurrent or capital? Manpower shortages and inadequate training facilities will impose additional limits to expansion of services.

2.10 Trends in expenditure and the availability of funds for the government sector should then be compared, to produce financial assumptions for the programming activities. If the plan has a medium-term span such as five years, the outcome of the analysis of trends should be estimates of the likely amount of capital funds available during the plan period, and the likely annual growth in recurrent funds. If these are not estimated, subsequent programming will risk being over-optimistic.

2.11 For a longer time-span, correspondingly rougher assumptions will have to be made. On the whole, it is better to choose realistic rather than optimistic assumptions. It is easier to expand the scale of priority activities than to protect plans from cuts if the expected resources fail to appear.

2.12 The conduct of a CRU review will involve intersectoral cooperation at the national level. It will necessarily involve the Ministries of Health, Planning and Economic Development, Finance and others to identify the total requirements of the national health plan, tally the resources available, analyse resource flows and describe opportunities for external funding in relation to the national strategy for health for all. The carrying out of a CRU should be viewed by the national authorities concerned as an analytical tool which forms but one part of their own Managerial Process for National Health Development, a method for sharply focusing the Programme Budgeting for primary health care, a means of succinctly expressing the financial implications of this

budgeting process and, for some countries, a way to approach the Programme Budgeting in the regular re-programming that is necessary. It is thus a managerial tool and not a separate mechanism, a managerial instrument not separate from other planning processes.

2.13 As an economic analysis, the CRU will examine the total economic capacity of the country (i.e., resources) and the share that can reasonably be expected for health (i.e. in competition with other priorities). It is an attempt to assess the utilization of current resources, in comparison with the recent past, and project the financial implications of programme implementation into the future. The CRU will naturally take into consideration all other supportive activities in the country in support of the national health programme, UNICEF/WHO Joint Support to the Implementation of PHC⁽¹⁾, the involvement of WHO and UNICEF programme staff, PHC country reviews, technical support by other multilateral and bilateral agencies and non-governmental organizations, etc.

III. THE COUNTRY HEALTH RESOURCE UTILIZATION REVIEW PROCESS

3.1 The decision to undertake a CRU review will, in most cases, be made by the Ministry of Health, in full consultation with the governmental core group or committee (which is usually of an intersectoral nature) assigned to the task of formulating national strategies and plans of action for the attainment of Health for All by the Year 2000⁽²⁾. Such an intersectoral or interministerial committee usually exists in one form or another and would be the appropriate body to oversee the preparations for and the carrying out of the CRU, and to assume responsibility for the follow up of the CRU.

3.2 Preparation for the CRU will include the updating of national primary health care action plans, updating of information on the allocation of national resources in the health and health-related sectors, and collating information on the flow and utilization of external resources. This will also necessitate consultation with and consideration of the contributions made by nongovernmental organizations (NGOs) as well as other sources of external support.

(1)The UNICEF/WHO Joint Committee on Health Policy (JCHP) agreed in February 1981 to focus attention, in the ensuing years, on "the implementation of primary health care with emphasis on the most effective support that UNICEF and WHO could give jointly to Governments". This entailed reviewing by the best means for achieving an optimal complementary use of the UNICEF and WHO support for cooperation in countries, through "learning by doing" and strengthening the national health development processes for the implementation of primary health care in some countries of the world. The countries participating in this effort are: Burma, Democratic Yemen, Ethiopia, Indonesia, Jamaica, Nepal, Nicaragua, Papua New Guinea and Peru.

(2)Managerial Process for National Health Development: "Guiding Principles" op. cit. page 15 paragraph 16)

3.3 Carrying out the Country Health Resource Utilization Review

The CRU can best be carried out as a focused activity, concentrated during the course of a three-week period. This can be done by a national team of senior officials who have routine responsibility for decision making, health planning, finance and economic development. In principle, the WHO Programme Coordinator and Representative (WPCR) has an important role in this task. The CRU can also be supported by a team of health planners and financial analysts which can be made available by the WHO Regional Office, or by WHO Headquarters Programme for External Coordination (COR) and its Unit of Health Resources Mobilization (HRM). Additional technical support may be available in the form of consultants from interested multilateral or bilateral cooperating agencies. In all cases, the direction and coordination of the CRU review remain under the aegis of the national authorities. The CRU review, and its resulting document, will examine :

1. the trends in the socioeconomic development of the country;
2. the degree of priority given to health and health-related activities in socioeconomic development;
3. the problems and economic restraints which face the country, and the country's capacity to meet these;
4. the national health policy, strategy and targets for attaining health for all; and the relationship of those health policies to the country's socioeconomic development plans;
5. the national health development plan based on the primary health care approach;
6. the design of the health system based on PHC;
7. the main problems and obstacles to be overcome for the implementation of primary health care;
8. the financial implications of the health plan;
9. the necessary reallocation of national resources to meet these implications;
and
10. the additional external resources required with emphasis on their effective allocation in support of health development priorities for health for all.

The external support team, if one is involved, may assist the Ministry of Health in the compilation of the CRU document. Final approval of the document as well as direction for its printing and dissemination will be carried out by the Government, with assistance from WHO if required.

3.4 The CRU document remains a national document which assesses the health resources situation at the time of the review, based on national plans, operations and budgets and reflects the allocation of internal as well as external resources committed or expected. It makes use of existing plans and evaluations and projects the financial implication of future implementation. Whenever a CRU analysis is updated (ideally, perhaps every two years) it should reflect the new economic situation and state of implementation, drawing upon the monitoring and evaluation of progress since the previous review. This involves an essential follow-up of any CRU, without which a CRU will remain an isolated and rapidly out-dated undertaking of little lasting use either to the health authorities or to the donor community.

3.5 Follow-up

It is for the government to decide what type of follow-up action will take place in the future, guided by the health planning committee referred to in 3.1 above.

In follow-up, the CRU document will serve a number of useful purposes:

1. the national authorities may choose to prepare a succinct summary of the CRU document and its main proposals, to be used as a working paper by the Cabinet or some other national planning body. Such a summary may also be useful for briefing appropriate parliamentary committees to ensure political support and to secure high-level endorsement of the policy implications. It is also a useful means for briefing national planning bodies on health sector plans, needs and financial projections;
2. as proposals in the national health plan are identified for support, detailed project formulation may be required, based on the proposals in the CRU document but tailored more precisely to donor interest and priority. Certain donors may be willing to provide technical support for project formulation to meet their own requirements, and assistance can also be offered by WHO Regional Offices and/or WHO/HRM;

3. the national authorities will wish to maintain an updated edition of the CRU document and regularly review and reformulate, as necessary, the proposals it contains. In addition to making the maximum use of the CRU review as a part of the managerial process, such an updated CRU document will assist the regular briefing of bilateral and multilateral agencies on further requirements and adjustments of resource flows;
4. the national authorities may choose to convene a country-level meeting of donor agencies to review proposals for external funding for health sector activities, and to identify those which might be taken up for support by specific agencies. Such country-level donor meetings may be of an ad hoc nature looking exclusively at the health sector. In other cases, the CRU document may be taken into account at a comprehensive UNDP-supported Round Table Meeting or a World Bank-supported Consultative Group meeting. If the CRU review is to provide an effective and valid health sector analysis and form the basis of proposals for external funding to be considered at such donor meetings, the appropriate timing of a CRU review is crucial. A minimum of six months is required to carry out the review, compile of the report, secure approval by the national authorities, print the report and distribute it to participating donors prior to the meeting.
5. since the carrying out of a CRU review forms a useful resource framework for Programme Budgeting for PHC within that step of the managerial process known as Broad Programming, it will constitute the basis for the subsequent steps in that process. It will be the starting point for Programme Budgeting in the detailed programming of PHC, and will assist in leading on from there to Programme Implementation. It will serve as the basis for regular, annual or biennial reviews of the health programme and as a guide to the ongoing monitoring and evaluation of programmes, projects and resource utilization.

3.6 No two country CRU reviews will follow the same pattern; each is unique to the country concerned. Nevertheless, experience has shown that there are common elements worth inclusion in a CRU review, and countries undertaking CRU may wish to have some guidance in preparing for it and carrying it out. The following guidelines are illustrative of the pattern and may be useful to the authorities concerned.

IV. SUGGESTED STEPS FOR CARRYING OUT THE CRU AND PREPARING THE CRU DOCUMENT

4.1 The CRU review and its document may adopt any format and include whatever materials national authorities believe are most relevant to the country situation and to the purposes to be served by the CRU. Experience in a number of countries suggests that a CRU document need not be a detailed or lengthy report, since the initial CRU review is intended to set the stage for more detailed programming, budgeting and project formulation.

4.2 The basic CRU document to emerge from a CRU review may comprise:

- a. Executive Summary
- b. Country Profile at a Glance
- c. List of Abbreviations
- d. Main CRU Chapter on Current Situation in the Country
 - i) National Health Policy and Strategy for HFA/2000, including the Health System Design based on Primary Health Care;
 - ii) Problems, Obstacles, Constraints and Feasibility;
 - iii) National Health Expenditures and International Support
- e. Proposals for External Funding, including Analysis of Financial Implications and Plan for Follow-up Action
- f. Supporting Annexes.

4.3 These components are enlarged upon below:

V. THE CRU DOCUMENT

5.1 Executive Summary

A succinct Executive Summary is very desirable, and should highlight the following :

- 5.1.1 National Health Policy, HFA/2000 Strategy and Health System Design based on Primary Health Care;
- 5.1.2 Brief look at current National Health Expenditures and International Support;
- 5.1.3 Summary of Proposals for External Funding;

5.2 Country Profile at a Glance

This section provides an overview on geography, topography, demography, the economy, health status and health services.

5.3 List of Abbreviations

The inclusion of a list of abbreviations used in the text is useful for all readers.

5.4 Main CRU Chapter on Current Situation in the Country

This chapter can be quite brief, extending perhaps to some 20 pages. This is sufficient to provide the desired overview, yet short enough to be read at one sitting. The situation chapter may be divided into suitable sections for clarity of presentation. Whatever the form of presentation selected, it is suggested that this chapter briefly cover the following main issues:

5.4.1 National Health Policy and Strategy for HFA/2000, including the Health System Design based on Primary Health Care - A brief statement should be made 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 Health for All plan of action been formulated or adopted? This can be shown by presenting a concise outline of the national health system design based on PHC, including its main components, organization of infrastructure and services, integration of services, intersectoral and community action, coverage and expected impact on health, measured by appropriate national targets or indicators. Where appropriate, these can be cross-referenced to specific proposals that are formulated for external funding (see under VI).

5.4.2 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 the proposals for external funding include provision for removing such obstacles and constraints?

5.4.3 National Health Expenditures and International Support - This section must give 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 and resources available or committed from national and external sources.

- (i) 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 maximize the efficiency and effectiveness of health-related activities in all sectors."

This section should normally cover :

- Government financial allocations to the health sector in relation to total government expenditure in all socioeconomic sectors (where figures are available, include estimates on private sector and nongovernmental organizations (NGO) contributions, as well as government grants to NGOs);
- National and external sources of revenue and income to support the national budget;
- Government financial allocations to primary health care in relation to other major health expenditure in the total health budget (again, where possible, cite figures on private sector and NGOs); and
- sources of revenue for the health budget.

All the above may be supported by Illustrative Tables 1 and 2 and any additional tables required. Illustrative Table 1 shows the allocation of total resources for health, drinking water and sanitation, as well as 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 the health budget. It may be useful to provide separate tables on the health budget to reflect Capital Expenditures and Recurrent Expenditures.

- (ii) 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, bilateral and nongovernmental organizations. It may be recalled that the International Conference on Primary Health Care recommended that :

"International organizations, multilateral and bilateral agencies, nongovernmental 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".

The summary of international support to the development of the national health services system can be supported by Illustrative Tables 3-1 and 3-2, followed by an analysis of international support. Illustrative Tables 3-1 and 3-2 are useful for identifying which institutions and donors are interested, participating in or contributing to the various national health 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.

ILLUSTRATIVE PROFORMA TABLE 1

NATIONAL BUDGET
ALLOCATION OF RESOURCES FOR HEALTH
IN RELATION TO OTHER SOCIOECONOMIC DEVELOPMENT SECTORS¹

	(a)	(b)	(c)	(d)
Major socioeconomic development sectors	Amount in millions of local currency (and equivalent in US\$)		Per cent. of total (b)	Per cent. change (b) - (a)
	Prior year 19..	Budget year 19..		
Health Programme	_____	_____	_____	_____
Drinking Water and Sanitation	_____	_____	_____	_____
Sub-total	_____	_____	_____	_____
Education	_____	_____	_____	_____
Agriculture	_____	_____	_____	_____
Industry	_____	_____	_____	_____
Transportation	_____	_____	_____	_____
Energy	_____	_____	_____	_____
Natural Resources	_____	_____	_____	_____
(etc)	_____	_____	_____	_____
Total	NC* _____ US\$ _____	NC* _____ US\$ _____	100%	%

*National Currency (Exchange rate used : NC 1 = US\$..., for each year listed)

(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 (including Water Supply and Sanitation from perhaps another Ministry) compare with resource allocations for other sectors or areas of socioeconomic development.

For more details, consult "Planning the Finances of the Health Sector, a manual for developing countries, E.P. Mach and B. Abel-Smith, World Health Organization", Geneva, 1983

Table 1 (continued)

NATIONAL BUDGET
SOURCES OF FINANCING

	(a)	(b)	(c)	(d)
Source	Prior year 19..	Budget year 19..	Per cent. of total (b)	Per cent. change (b) - (a)
Government revenues	_____	_____	_____	_____
Other domestic sources	_____	_____	_____	_____
External resources (grants, loans)	_____	_____	_____	_____
Total available resources	NC* _____ US\$ _____	NC* _____ US\$ _____	100%	_____ %

* National Currency (Exchange rate used : NC 1 = US\$..., for each year listed)

ILLUSTRATIVE PROFORMA TABLE 2

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

	(a)	(b)	(c)	(d)
	Amount in millions of local currency (and equivalent in US\$)		Per cent. of total (b)	Per cent. change (b) $\frac{\%}{a}$ (a)
Major health programmes and institutions	Prior year 19..	Budget year 19..		
Primary Health Care (including primary level, referral/ supporting levels, services, manpower, supplies)	_____	_____	_____	_____
Drinking Water and Sanitation	_____	_____	_____	_____
Malaria Control	_____	_____	_____	_____
Other major health programmes (etc.)	_____	_____	_____	_____
Research and Development	_____	_____	_____	_____
Hospitals, and specialized institutions	_____	_____	_____	_____
Total	NC* _____ US\$ _____	NC* _____ US\$ _____	100%	%

* National Currency (Exchange rate used: NC 1 = US\$..., for each year listed)

(1) Note: The breakdown of the main sub-sectors within the health budget will depend on the availability and classification of budgetary resources data in the country concerned.

Note: One purpose of this table is to provide an indication of health expenditure by subsector or programme or level of health care.

Table 2 (continued)

HEALTH BUDGET
SOURCES OF FINANCING

	(a)	(b)	(c)	(d)
	Prior year 19..	Budget year 19..	Per cent. of total (b)	Per cent. change (b) $\frac{\%}{(a)}$
Government revenues	_____	_____	_____	_____
Other domestic sources	_____	_____	_____	_____
External resources (grants, loans)	_____	_____	_____	_____
Total resources available	NC* _____ US\$ _____	NC* _____ US\$ _____	100%	%

*N.C. National Currency (Exchange rate used: NC 1 = US\$..., for each year listed)

ILLUSTRATIVE PROFORMA TABLE 3-1

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

Source of Funds ⁽¹⁾ (specify donor agency)	Programme/Project/ Activity ⁽²⁾	Duration of Funding ⁽³⁾ from 19.. to 19 ..	Committed Amount in US\$	Amount Disbursed (by date)
A. _____	a. _____ b. _____ c. _____ etc. _____	_____	_____	_____
B. _____	a. _____ b. _____ c. _____ etc. _____	_____	_____	_____
C. _____	a. _____ b. _____ c. _____ etc. _____	_____	_____	_____

(etc.)

- (1) A, B, C, etc - each one is an individual source of funds. Indicate name of donor agency; include multilateral, bilateral, NGO and other sources of funds.
- (2) One source may frequently be funding several programmes/projects and/or activities, a, b, c, etc.; each of them should be listed separately.
- (3) Duration of aid to each specific programme/project should be indicated in calendar years. Indicate whether loan or grant.
- N.B. Water supply and sanitation should be shown as any other programme even if under jurisdiction of a sector other than health. If any external funding is subject to special conditions, these may be noted by footnote.

ILLUSTRATIVE PROFORMA TABLE 3-2

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

Programme/ Project/ Activity(1)	Source of Funds(2) (specify donor agency)	Duration of Funding(3) from 19.. to 19 ..	Committed Amount in US\$(4)	Amount Disbursed (by date)
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.
a, b, c, etc. list individual donors/sources of funds financing each programme, A, B, C, etc.
- (2)
- (3) Duration of aid provided by a, b, c, etc.
- (4) Committed by a, b, c, etc.

VI. PROPOSALS FOR EXTERNAL FUNDING

6.1. It may be desirable to attach to the CRU document 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 concentrate on 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 (distinguishing between "capital" costs and "recurrent" 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 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 (see section 3.5). In order to justify additional external resources for ongoing projects, each proposal should include a description of 'Past Activities', achievements as compared with originally set objectives and targets, and the total related expenditure by source of funding and amount (see page 23 for outline).

6.2 Proposal for the Implementation of PHC - 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 Proposal for the Implementation of PHC is attached, pages 23 - 30).

6.3 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 document (pages 32 - 33). 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 V.2 in Proposal No.1 below on page 25). Proposals may be made, not only for the primary health care 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 5.4.2) above).

PROPOSAL FOR EXTERNAL FUNDING NO.1

(Suggested format and content)

I. TITLE : PROPOSAL FOR THE IMPLEMENTATION OF PRIMARY HEALTH CARE

II. DURATION AND TOTAL COST :

Duration ----- years, from 19.. to 19..

Total Cost in US\$ ----- (capital -----; recurrent -----)

Proposed external funding in US\$ ----- (capital -----; recurrent -----)

III. BACKGROUND AND JUSTIFICATION:

National Commitment

Major constraints on the present national health network affecting its effectiveness and efficiency (care should be taken to avoid duplication with the section on "Problems, Obstacles, Constraints and Feasibility" in the main situation chapter of the CRU document).

Integration of vertical programmes in the primary health care strategy.

Cost-benefit considerations.

Previous actions and outcome in relation to objectives and targets, cost of such action and source of funding.

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.10 below)

Requirements by the year 19..	Total Required Number	Existing Number	Needed Number
A. Infrastructure:			
Primary Health Care level ⁽¹⁾ (Primary Unit)			
First-Level Referral Unit			
Second-Level Referral Unit			
B. Health Workers for:			
Primary Health Care Level			
First-Level Referral Unit			
Second-Level Referral Unit			

V. DESCRIPTION AND ACTION PLAN

V.1 National Structure of Primary Health Care
(including referral/support system)

An Illustrative Diagram

<u>Primary Health Care Level</u> (Primary Unit)	Community Health Worker (CHW)	Total No. _____; No. linked to each first level referral unit _____; CHW per _____ people; some indication of geographic coverage
<u>First Level Referral Unit</u>	Sub-Centre, Centre or Other	Total No. _____; No. linked to each second level referral unit _____; one centre per _____ population; geographic coverage
<u>Second Level Referral Unit</u>	District Health Office, District Hospital or Other	Total No. _____ one district hospital per _____ population (average); geographic coverage

Describe functional links between various levels :

⁽¹⁾First level of contact of individuals, the family and community with the national health system.

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

Services/Functions(1)	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 including family planning			
5. Immunization			
6. Prevention and control of endemic diseases prevalent in the country			
7. Appropriate treatment of common diseases and injuries			
8. Provision of essential drugs			
9. Training			
10. Supportive Supervision			
11. Logistics Support			
12. Evaluation			
Etc. (Specify)			

(1) Indicate which services and functions 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 worker)

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

Voluntary organizations (NGOs)

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
- 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, socioeconomic 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⁽¹⁾

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					

VI. UNIT COSTS

A. Capital (or Investment) Costs

US\$
Unit Costs

a. Construction of PHC-level unit (include cost/m ²)	
b. Construction of first level referral unit (include cost/m ²)	
c. Construction of second level referral unit (include cost/m ²)	
d. Cost of training of an individual health Worker (for categories see V.3) including reorientation/refresher courses, continuing education, etc. (these costs may be enumerated on a separate sheet to be attached to this table)	
e. Cost of initial supplies and equipment (including transport) for:	
- primary health care level	
- first-level referral unit	
- second-level referral unit	

(1) 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.

B. Annual Recurrent Expenditure: Maintenance and Operating Costs per:

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

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

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 overall drug management (procuring, storing, distribution).

VIII. PARTICIPATING INSTITUTIONS

National: Actual

Potential

International: Actual

Potential

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

IX. NATIONAL APPROVAL

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

PROPOSAL FOR EXTERNAL FUNDING - NO.1 : IMPLEMENTATION OF PRIMARY HEALTH CARE

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

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

- Exchange rate (as at) National currency 1 = US\$...			Ongoing National		Next National	
			Development Plan		Development Plan	
			19.. - 19..		19.. - 19..	
Estimated annual inflation rate = ...% for (year) Included in these estimates ? Yes No			National	US\$	National	US\$
			Currency	Equivalent	Currency	Equivalent
I. Total Estimated		a. Capital				
Budgetary Requirements		b. Recurring				
		c. Total				
	2.1 Government	d. Capital				
		e. Recurring				
II. Source of Funds		f. Total				
	2.2 External	g. Capital				
	Aid Committed/	h. Recurring				
	Estimated	i. Total				
III. Net External Resources		j. Capital				
Required		k. Recurring				
		l. Total				

Explanatory Notes:

- I. Total Estimated Budgetary Requirements include estimates of both capital and recurring budgets for the Ongoing National Development Plan and, separately, for the Next Development Plan.
- II. Source of Funds shows both National funds budgeted for the ongoing Plan and the unofficial projection for the next Plan, as well as a summary of External Aid Committed and/or estimated for the two Plans.
- III. Net Resources Required are derived, in principle, by deducting what is committed/estimated under II from Total Estimated Requirements under I as follows:

$$j = a - (d + g) \quad k = b - (e + h) \quad l = c - (f + i)$$

Other proposals can be presented following the format on pages 32 and 33 provided they form integral elements of the primary health care plan of action. Examples of such supplementary proposals might include:

- Health Manpower Development
- Water Supply and Sanitation
- Expanded Programme on Immunization
- Essential Drugs and Vaccines
- Strengthening Health Services Management
- Public Information and Health Education
- Health Learning Materials
- Maternal and Child Health and Family Planning
- Specific Disease Control Programmes, such as for malaria, leprosy, tuberculosis, and the like.

The practice in most cases has been to include four to six such elements as supplementary proposals.

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. Past Activities - (Achievements compared to originally set objectives and targets, and the total related expenditure by source of funding and amount. The information should be provided for the previous five years for projects of more than five years' duration, or since inception for projects which started within the last five years. For ongoing projects, a clear justification has to be made for the request for additional external resources).
- VII. Budgetary Resource Requirements: (see attached table)
- VIII. Supplies and Equipment:

(List of required supplies and equipment, if available)
- IX. Participating Institutions:

(Actual and potential collaboration partners, national and international)
- X. Evaluation Criteria and Process:

(Criteria, method and mechanism for evaluation.)
- XI. National Approval

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

PROPOSAL FOR EXTERNAL FUNDING NO. : (name of programme)

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

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

Exchange rate (as at) National currency 1 = US\$...		Ongoing National Development Plan 19..- 19..		Next National Development Plan 19.. - 19..	
		National Currency	US\$ Equivalent	National Currency	US\$ Equivalent
Estimated annual inflation rate = ...% for (year) Included in these estimates? Yes No					
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				

Explanatory Notes:

- I. Total Estimated Budgetary Requirements include estimates of both capital and recurring budgets for the Ongoing National Development Plan and, separately, for the Next Development Plan.
- II. Source of Funds shows both National funds budgeted for the ongoing Plan and the unofficial projection for the next Plan, as well as a summary of External Aid Committed and/or estimated for the two Plans.
- III. Net Resources Required are derived, in principle, by deducting what is committed/estimated under II from Total Estimated Requirements under I as follows:

$$j = a - (d + g) \quad k = b - (e + h) \quad l = c - (f + i)$$

6.4 Financial Implications of Proposals for External Funding

Discussion of the financial implications should be based on information available in 5.4.3 on "National Health Expenditures and International Support", as well as on financial information included in the various proposals for external funding.

In many countries, there will be a limit to the absorption of capital investment in development proposals, as new programmes generate additional recurrent expenditures which must be realistically absorbed into the national budget. This will be a factor to indicate the scope, the allocation and the utilization of any external funds that become available.

While international partners may look favourably at financing certain capital investment requirements for PHC development, this is often not the case with additional recurrent expenditure. Therefore, ways and means of how best to meet these recurrent costs will need to be explored. For instance, the national authorities will consider to what extent financial means may be reallocated from the overall National Development Plan and its Recurrent Expenditures Estimates in favour of the Health Sector, and subsequently any preferential allocations to PHC within the Health Sector Budget. Potential cost-recovery methods should also be explored.

Ultimately, the national authorities may consider carrying over implementation of certain proposals into the next National Development Plan should financial and/or manpower constraints so demand.

VII. SUPPORTING ANNEXES

7.1 There is a natural tendency in preparing a CRU document to assemble more material than can be usefully absorbed in a document of this nature. It is therefore 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, 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 the following Annexes:

- (a) Socioeconomic information directly related to health
- (b) Health status data, targets and indicators of health for all
- (c) National health development plans and process

(d) National health financing and expenditure patterns and trends

(e) More detailed information on other related health programmes (including, for example, a summary of NGO programmes, the health services of private enterprises, or others).

Certain parts of the annexed material may be presented in tabular form, designed to facilitate simplified presentation of essential statistical, budgetary or expenditure data.

ANNEX

Related Health Development Indicators

When considering which proposals for external funding are particularly worth promoting (Section VD) as well as what selective background information is worth annexing to the CRU report (Section VII 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 per cent 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 one 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 per cent
- (12) The gross national product (GNP) per capita exceeds US\$ 500

[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 and have their own financial resource implications]