



HEALTH RESOURCES CONSORTIUM FOR PRIMARY HEALTH CARE (HRC)

INDEXED

Report on the second meeting of the Interim Planning Group

Geneva, 30 September 1980



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1. Introduction

The second meeting of the Interim Planning Group (IPG) took place at WHO headquarters, Geneva, on 30 September 1980. The agenda and list of participants are attached as Annexes III and IV.

2. Recommendations of the IPG

In addition to considering the agenda items, and as a priority, the IPG agreed to appoint a drafting group to propose amendments to the mandate of the Health 2000 Resources Group, the recommendations of which are attached as Annex I. These recommendations include altering the title of the Group, which should now be known as the Health Resources Consortium for Primary Health Care (HRC), and affect its membership, secretariat and the organization of its meetings.

The drafting group also formulated recommendations regarding the fund to be established, which should be entitled Primary Health Care Initiative Fund (PHCIF), its administration and the use to which it should be put. These recommendations are attached as Annex II.

These substantial recommendations with regard to the HRC and the PHCIF were adopted by the IPG as a whole and will be put for approval to the HRC at its second meeting on

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4-5 December 1980. The other three issues put to the IPG: resource/needs matching; country resource utilization; problem solving, will be submitted for endorsement to the HRC (see also section 4).

3. Collection and dissemination of information on resource flows in the field of health

The IPG expressed its sincere appreciation of the pioneering and truly impressive collection of information on resource flows and donor policies, programmes and perspectives in the field of health that had been brought together by Dr Lee M. Howard.

The IPG made the following recommendations:

(a) Information gathering about actual and potential resource flows in the field of health was part of WHO's regular activities and should remain so. With regard to the nature of the information gathered, it was felt that this task should naturally continue to fall within the mandate of the Cooperative Programmes for Development unit at WHO headquarters. The IPG further underlined that information gathering and dissemination would have to be an on-going activity, presupposing periodic (but not too frequent) updating and reassessment.

(b) In view of the all-encompassing nature of the information collected, it was deemed desirable that the information gathered be carefully studied with a view to maximizing its usefulness, not only for the work of the HRC but also for WHO's general and regular activities.

(c) It was felt that, having been condensed, sifted and pruned, the information material might, with advantage, be used in particular for the orientation of WHO field staff (e.g. for briefing sessions and recurrent training courses for WHO programme coordinators). The material might also be used as the basis for a handy informative guide or source of reference for staff at WHO headquarters and/or in the field.

(d) It was further felt that, with regard to the general informational value of the material gathered, a guide or a summary of the main findings should in time be distributed to all such international organizations, official development aid agencies, nongovernmental organizations and developing countries as now engage in primary health care development efforts.

(e) It was further noted that much of the information collected clearly indicated that a great deal in terms of mobilization and/or rationalization of resources for health development efforts might be gained if WHO's programme coordinators could, in future, assume a more active or aggressive role - as disseminators of information, advocates, mediators and coordinators of health development efforts - within their areas of responsibility than was now generally the case.

4. Problems to be presented to the HRC

The IPG felt that, while all five problem areas identified by the Secretariat readily lent themselves to discussion by the HRC at its December meeting, Nos. 2, 4 and 5 related to WHO programmes and could be considered later. A start might be made, perhaps, by considering problem area No. 3 - Orientation of WHO programme coordinators to needs/resource matching mechanisms and action to be taken at country level - and/or problem No. 1 - The visibility of health in development.

5. Documents to be presented to the December meeting of the HRC

The IPG felt that, in view of the importance and complexity of the documents dealing with the structure and aims of the HRC and the PHCIF, no additional documentation would be called for or needed for the December meeting.

HEALTH RESOURCES CONSORTIUM FOR PRIMARY HEALTH CARE (HRC)

It is recommended that the HRC be established as a consortium to further the efforts of developing countries, WHO and nongovernmental, bilateral and multilateral agencies to achieve the goal of health for all by the year 2000, through PHC.

The mandate will be:

- to promote the rationalization of all available resources required for primary health care activities in developing countries, aimed towards health for all by the year 2000, in accordance with the priorities recognized in the Alma-Ata Declaration;
- to mobilize resources, including those of developing countries themselves and of external donors, to achieve the world community's social goal of health for all by the year 2000, using primary health care as the main means.

Within this context the HRC will concern itself particularly with the following issues:

- (1) to devise ways of promoting in all relevant sectors of government the high priority due to the development of primary health care activities in the attainment of health for all;
- (2) to facilitate the achievement of better relation of resources to needs between countries and agencies;
- (3) to promote the collection and critical review of selected aspects of information relevant to the objectives;
- (4) to identify constraints relating to external funding for the attainment of health for all and propose or develop ways to overcome them;
- (5) to encourage and support governmental and nongovernmental sectors, with a view to minimizing duplication of efforts and maximizing substantive collaboration in planning and achieving health development;
- (6) to establish guidelines for and oversee the use of the Primary Health Care Initiative Fund.

Membership

The HRC shall be composed of representatives of developing countries, donor governments, nongovernmental organizations and multilateral agencies. There should be continuity of membership, achieved by staggered two-year terms of a group representing each of these categories of participants. The meetings of the HRC, however, should be open to the participation of representatives of any developing country, organization or agency committed to the goal of health for all by the year 2000.

Designation of developing countries to be represented on the HRC shall be carried out by the regional committee in each WHO region. Each country may send a health representative and in addition a second representative who shall be a responsible officer from the national planning body or equivalent ministry of that country.

Representation on the HRC by NGOs will be decided by existing collaborative groups among NGOs, such as the NGO Committee on Primary Health Care and the NGO Committee of UNICEF. These members will provide continuity on the HRC and liaison with the rest of the NGOs. As indicated above, this will not exclude participation by other interested and appropriate NGOs within the HRC.

Annex I

The Director-General of WHO shall serve in person as Chairman of the HRC, recognizing the role of WHO as lead agency in the pursuit of the goal of health for all by the year 2000.

Secretariat

There shall be a secretariat responsible to the HRC, located in WHO headquarters, Geneva. The secretariat of the HRC, while independent of WHO, will be located administratively at WHO. The secretariat should include a very small core group to provide continuity of service, supplemented by temporary staff seconded and supported by agencies, and by assignment of specific tasks to other agencies.

The costs of the secretariat and administrative functions of the HRC would be a charge against the Primary Health Care Initiative Fund.

Meetings

The HRC shall meet at least once each year. The agenda, documentation, site of meeting and such other matters of procedure shall be proposed to the HRC by the secretariat, in consultation with the Chairman.

The expenses of attendance at meetings for all representatives shall be a charge against their organizations, with the exception of the designated representatives of developing countries, which shall be a charge against the Primary Health Care Initiative Fund.

PRIMARY HEALTH CARE INITIATIVE FUND

The Interim Planning Group (IPG) recommends that the trust fund to be set up by the Director-General of WHO be now entitled Primary Health Care Initiative Fund. This Fund should be used for initiating seed and catalytic work, for which alternative funding is not available, in support of activities which are highly relevant to attaining health for all by the year 2000, principally based on primary health care. The Fund should be active in identifying suitable initiatives for its use, rather than merely responding to requests.

The Fund shall be established in accordance with the financial regulations of WHO as a trust fund of WHO, and would consist of two component accounts: one to receive contributions for unspecified activities and the other contributions for specified activities.

As regards the use of contributions made for unspecified activities, the Director-General would be guided by the general advice of the HRC as to type of activities (including their geographical area or other main characteristics) which should be financed, and he would also periodically inform the HRC on the actual utilization of these contributions.

Contributions for specified activities would be applied to the purpose indicated by the donor and the Director-General would subsequently report to the HRC on the contributions received and the activities for which the funds in question have been spent.

The Director-General shall administer the Primary Health Care Initiative Fund on behalf of the Health Resources Consortium (HRC), according to guidelines to be developed by the HRC and according to such administrative and reporting mechanisms as the HRC shall establish.

The range of activities undertaken by the Fund are intended to strengthen the development of primary health care systems by developing countries on a country-wide scale. This may encompass such activities as specific assistance to a country in preparing or amplifying a national primary health care strategy, planning for the detailed implementation of such a strategy, preparing a fundable package for presentation to donors and to facilitate the establishment of the necessary national processes, mechanisms and institutions to enable countries to carry out these activities.

Whatever the eventual size of the Primary Health Care Initiative Fund, it will never be large enough to provide directly the bulk of resources needed for primary health care development on a global basis. The Fund's most important impact is seen to be its indirect leverage upon the much larger total of external donor resources, and the even larger multiplier effect represented by the generation of the internal resources of the developing countries themselves.

As an initial target, the Fund is envisaged as being in the range of US\$ 10 million.

ANNEX III

AGENDA

MAJOR ISSUES TO BE ADDRESSED

- | | | |
|-------|----|------------------------------------|
| 9.00 | 1. | Resource/needs matching |
| 10.30 | | Coffee |
| 11.00 | 2. | Country resource utilization |
| 12.30 | | Working lunch |
| 1.30 | 3. | Problem solving |
| 3.15 | | Tea |
| 3.30 | 4. | Health Development Initiative Fund |
| 4.30 | | Conclusions |

LIST OF PARTICIPANTS

Participant

Mr S. Abelin	Director, Population, Health and Nutrition Division Swedish International Development Authority (SIDA) <u>Stockholm</u>
Mr Newton Bowles	Senior Adviser, Programme Policy UNICEF <u>New York</u>
Dr John Evans	Director, Population, Health and Nutrition Department The World Bank <u>Washington</u>
Dr Stephen Joseph	Deputy Assistant Administrator, Development Support Bureau USAID <u>Washington</u>
Dr Stuart Kingma	Associate Director Christian Medical Commission <u>Geneva</u>
Mr Alexandre A. Kisselev	Counsellor USSR Permanent Mission <u>Geneva</u>
Dr G. W. Lungu	Ministry of Health <u>Malawi</u>
Mr William T. Mashler	Senior Director, Division of Global and Interregional Projects UNDP <u>New York</u>
Dr S. Falkland	Consultant
Dr Lee Howard	Temporary Adviser, USAID, <u>Washington</u>
Mr W. A. C. Mathieson	Consultant

WHO Secretariat

Dr H. Mahler	Director-General
Dr J. L. Kilgour	Director, COR
Dr J. Cohen	DGO
Mr A. Groenendijk	Director, BFI
Mr P. Lawton	Chief, CPD
Mr A. Piel	Admin. Office of Mr Furth, ADG
Miss P. O'Doherty	EXR/CPD
Miss P. Brice	CPD

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