

PHC - Local Organization  
Health Resources Util.

MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT

COUNTRY HEALTH RESOURCE UTILIZATION REVIEW (CRU)

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



As part of the overall planning and managerial process, which includes health resource mobilization in support of implementing the national strategies for health for all, it is essential to review in some detail the allocation and utilization of all available resources, both domestic and committed external investment, and also to assess the national capacity to move forward in consonance with the PHC approach. Establishing such a resource framework, determining the resource needs for PHC development with regard to recurrent cost implications of any new capital investment, and then preparing proposals for external funding to make up the resource gap, will all be necessary. These review steps are available to national authorities in the Country Health Resource Utilization Review (CRU). This is a national undertaking for which WHO is able to provide concrete support as well as cooperation with the concerned government in following up the CRU proposals for external funding with potential donors. The government may choose to carry out a CRU as part of preparation for meetings of donor partners or to create the means for negotiation with bilateral or multilateral donor agencies on an individual basis.

CRU reviews have proved to be useful in providing a comprehensive look at the health sector as a background for the dialogue that takes place with donors in the course of UNDP-supported round Table Meetings (RTMs) and World Bank-supported Consultative Group (CG) meetings. Adequate support in this preparation can be mobilized by WHO Programme Coordinators/National WHO Programme Coordinators, Regional Offices and headquarters.

A CRU review is one way to complete certain steps in the overall Managerial Process for National Health Development, related to Programming and Programme Budgeting. To be truly useful it should be carefully followed-up, reviewed and regularly up-dated.

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## 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).

1.4 The Thirty-fourth World Health Assembly (May 1981), in resolution WHA34.36, adopted a "Global Strategy for Health for All by the Year 2000,"<sup>(1)</sup> 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 "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".

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<sup>(1)</sup>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 (MPNHD). 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. Guiding Principles for a number of the components of the Managerial Process for National Health Development have also been provided<sup>(1)</sup>.

#### 11. PURPOSE OF 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. WHO support to Member States in carrying out CRUs 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 summarizes the financial information required to implement a well defined National Strategy for HFA, in order to make sure that resources are allocated to priorities corresponding to globally accepted policies. It places emphasis on the resources required for implementation of primary health care, based on a fully developed Plan of Action. This should be expressed in terms of detailed programming of the national health plan for the next plan period. Without this background, a CRU may be premature.

A CRU is the responsibility of a government, not of WHO. It should be a continuing national effort - with phased reporting to the government at certain points in time.

(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)

2.3 Within the resource framework for the programming of primary health care needs and resources must be considered together. Resources available now and likely changes in resource availability in the future should be examined, identifying particular resources which are likely to be in short supply, including manpower, material and financial requirements.

2.4 In the detailed process of resource analysis the time span will relate to the ongoing and the next national health plan. In broad terms it would be desirable to look to the year 2000. In addition to public financing, CRU will review the ongoing and projected projects by the communities, other interested national groups, non-governmental organizations (NGOs) and international partners in health. Any major constraints likely to affect future health plans will be noted, in particular the implications of new capital investments which invariably generate additional recurrent expenditures.

2.5 Ultimately, a CRU will indicate directions for the allocation of the country's own resources for health development as well as the needs for additional external resources that may be required for implementing the national strategies for health for all, based on primary health care. It will demand careful preparation, carrying out and follow up as described in Chapter III.

### III. THE COUNTRY HEALTH RESOURCE UTILIZATION PROCESS

(Preparation, Carrying out, Follow up)

#### 3.1 Deciding to undertake a CRU

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, preferably of an intersectoral nature, assigned to the task of formulating national health development plans, strategies and plans of action for attaining Health for All by the Year 2000. Such an intersectoral or interministerial committee usually exists in one form or another, within the framework of MPNHD, and it would be an appropriate body to oversee the preparation for and carrying out of the CRU, and to assume responsibility for its follow up.

The WHO Programme Coordinator (WPC) should play a crucial role in ensuring that the country is ready for an actual CRU.

3.2 Timing of CRU - A CRU should ideally be undertaken, as already stated, after the national HFA strategies had been well formulated and officially approved. It should be timed so as to take place when the national officials concerned and the WPC can be made available for full participation. The WPC should keep the Regional Office fully informed of other resource mobilization action in the country, such as official visits by the World Bank or other major donors, with a view to ensuring the complementarity of such actions and missions, and thus prevent duplication.

3.3 Preparations for a CRU

When WHO support is requested, actual preparations could be enhanced by a timely communication from the Regional Director to the Ministers of Planning and Health, or alternatively, a letter of understanding signed by the government and WHO, spelling out the modalities, requirements and responsibilities for a CRU.

Technical preparations will include updating of all related documentation, including :

- National health strategies and broad programmes;
- Plan of action for implementing the strategies;
- Primary health care design and the master plan for its implementation;
- Information on the allocation and utilization of national resources in the health and health-related sectors;
- Collating information on the flow and utilization of external resources.

This will necessitate consultations with locally represented UN agencies, funding agencies, other donors and Nongovernmental Organizations (NGOs).

Essential documents and information should be made available to the WHO CRU support team well in time, preferably a month ahead of their arrival in the country.

Under optimum conditions, during the preparatory stage the interministerial committee (3.1) should gather all the above basic working documents which would substantially save time and effort during a CRU and benefit its efficient conduct.

WPC should undertake to brief local representatives of international agencies, bilateral and other donors about the purpose, scope, modality and timing of the CRU. He/she should also undertake an advance distribution of the CRU Guidelines to all those likely to be involved.

Office accommodation, secretarial services and transport should be firmly arranged in advance rather than relying on ad hoc arrangements during the mission.

It is considered beneficial that a regional WHO staff member pay an exploratory "pre-visit" to the country to emphasize the extent and nature of a CRU and to promote the necessary preparations.

#### 3.4 Carrying out a CRU

Subject to adequate preparations, the CRU can best be carried out as a focused activity, concentrated during the course of a three-week period. This period of time is considered adequate where a WHO support team takes part, working together with a national team of senior officials responsible for decision-making, socio-economic development, finance and health planning. Invariably, the WPC plays an essential role in this task.

The WHO support team is usually composed, in addition to WPC, of a public health planner and an economist/financial analyst, made available by the WHO Regional Office. WHO Headquarters may be requested to assist in the recruitment of these consultants if necessary. 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 a CRU review remains under the aegis of the national authorities.

The CRU review and its resulting CRU 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 and external 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 work schedule of the CRU support team follows a certain pattern:

- Initial briefing provided by the WPC;
- Courtesy visit to the Ministry of Health on arrival of the WHO support team;
- Visit to the UN Resident Coordinator;
- An early coordinating meeting of all officials involved in the CRU: Ministries of Health, Planning, Finance and other related ministries, and including where appropriate UNDP, UNFPA and UNICEF. This meeting will establish a work plan for the CRU, division of tasks and working partnerships.
- The work then begins with gathering and analysing information and financial data, formulating proposals in selected programme areas and drafting sections of the CRU document. This will call for visits to relevant departments of government ministries, agencies of the UN system, NGOs and other "major partners in health" donors. The WPC should participate fully in all meetings and his office should make all the necessary appointments, in consultation with the key officials of the Ministry of Health.
- Short field visits to a sample of health facilities and training institutions;
- A final round-up meeting of all concerned to secure endorsement of the Ministry of Health for the draft framework of the CRU document and its proposals.

It should be possible to have the first draft of the CRU document ready before departure of the WHO support team from the country, or as a minimum requirement, an expanded and annotated outline. In the latter case the proposed content of the document must be fully discussed on the spot. Final approval of the CRU document as well as directions for its printing and dissemination will be given by the government, with assistance from WHO as required. It may be emphasized again that the CRU is a national planning process and the outcome remains a national document.

Whenever a CRU analysis is updated (ideally, perhaps every two years) it should reflect the latest economic situation and state of implementation, drawing upon the monitoring and evaluation of progress since the previous review. Without a follow-up, the CRU is 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

A CRU review may be considered as an ongoing process for the essential coordination of health resources, involving internal coordination in the country and donor coordination.

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:

The CRU document will serve a number of useful purposes in follow-up :

- a. 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.
- b. 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 headquarters;
- c. 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.
- d. 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 the 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 after having carried out the review, to compile the CRU document, secure approval by the national authorities, print the document and distribute it to participating donors, prior to such a meeting.

c. Since the carrying out of a CRU review provides a useful resource framework for Programme Budgeting for PHC, preferably after the 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 FORMAT AND CONTENTS OF THE CRU DOCUMENT

##### 1. Format

4.1.1 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. However, in order to facilitate the preparations of the document, a tentative format and contents are suggested as follows:

4.1.2. 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.

4.1.3 These components are enlarged upon below:

#### 4.2 Contents

##### 4.2.1 Executive Summary

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

- (i) National health policy, HFA/2000 strategy and health system design based on primary health care;
- (ii) a brief look at current national health expenditures and international support;
- (iii) a summary of proposals for external funding.

##### 4.2.2 Country Profile at a Glance

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

#### 4.2.3 List of Abbreviations

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

#### 4.2.4 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:

4.2.5 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 formulated for external funding (see under VI).

4.2.6 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?

4.2.7 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 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 shown in these guidelines and any additional tables required. Illustrative Table 1a 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. Table 1b provides information on various sources from which the national budget is financed. It may be useful to provide separate tables on the health budget to reflect Capital Expenditures and Recurrent Expenditures. Illustrative Table 2a reveals to what extent the national policy and strategy based on PHC is being reflected in actual resource allocations within the health budget. Table 2b shows various sources from which the national health budget is financed.

- (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-a and 3-b, followed by an analysis of international support. Illustrative Tables 3-a and 3-b 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 to the situation in the country and most useful in meeting the objectives of the government in having such a document.

## ILLUSTRATIVE PROFORMA TABLE 1a

NATIONAL BUDGET  
ALLOCATION OF RESOURCES FOR HEALTH  
IN RELATION TO OTHER SOCIOECONOMIC DEVELOPMENT SECTORS<sup>1</sup>

	(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 1b

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 2a

HEALTH BUDGET  
ALLOCATION OF HEALTH RESOURCES FOR PRIMARY HEALTH CARE,  
HEALTH PROGRAMMES AND INSTITUTIONS<sup>1</sup>

Major health programmes and institutions	(a)	(b)	(c)	(d)
	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..		
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 2b

HEALTH BUDGET  
SOURCES OF FINANCING

	(a)	(b)	(c)	(d)
	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 resources available	NC* _____ US\$ _____	NC* _____ US\$ _____	100%	%

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

## ILLUSTRATIVE PROFORMA TABLE 3a

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

Source of Funds <sup>(1)</sup> (specify donor agency)	Programme/Project/ Activity <sup>(2)</sup>	Duration of Funding <sup>(3)</sup> 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 3b

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.
- (2) a, b, c, etc. list individual donors/sources of funds financing each programme, A, B, C, etc.
- (3) Duration of aid provided by a, b, c, etc.
- (4) Committed by a, b, c, etc.

#### 4.3 Proposals for External Funding

4.3.1 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 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 24 for outline).

4.3.2 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, 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 24 - 32).

4.3.3 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 34 - 35). 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 5.2 in Proposal No.1 below on page 26). Proposals may be made, not only for the primary health care strategies, but also for "complementary" strategies or

actions, such as strengthening of 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 4.2.6 above).

#### 4.4 Financial Implications of Proposals for External Funding

Discussion of the financial implications should be based on information available in 4.2.7 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 generated by development proposals, as new programmes generate additional recurrent expenditures which must be realistically absorbed into the national budget. This will be a factor in indicating 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.

#### 4.5 Supporting Annexes

4.5.1 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 in the main CRU text. Among the kinds of information that has 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.

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 5.10 below)

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

## V. DESCRIPTION AND ACTION PLAN

5.1 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.

5.2 Health Care Delivery and other Functions at Various Levels  
(National Concept)

Services/Functions <sup>(1)</sup>	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 nutrition and family planning			
5. Prevention and control of communicable diseases including immunization			
6. Prevention and control of non-communicable diseases prevalent in the in the country, including oral health, mental health, cancer, other			
7. Appropriate treatment of common diseases and injuries			
8. Provision of essential drugs (procurement, storage, distribution)			
9. Training			

(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.

## 5.2

Health Care Delivery and other Functions at Various Levels  
(National Concept) (continued)

: 10. Supportive Supervision and referral services	:	:	:	:	:	:	:	:
: 11. Logistics Support	:	:	:	:	:	:	:	:
: 12. Evaluation	:	:	:	:	:	:	:	:
: 13. Health services Research	:	:	:	:	:	:	:	:
: Etc. (Specify)	:	:	:	:	:	:	:	:

5.3 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

5.4 Functions and Responsibilities of Health Workers at the Above Levels  
(Separately for each category of health worker)

5.5 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)

5.6 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

5.7 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.

5.8 Management

- 5.8.1. - Responsibilities for MPNHD at various organizational levels and communications between the levels
  - Reallocation of resources in support of primary health care
  - Management of manpower
  - Supplies, equipment, transport (overall logistics, including maintenance) (particular attention should be given to the procurement, storage and distribution of drugs)
- 5.8.2. - Monitoring (responsibility, mechanism)
- 5.8.3. - Evaluation (responsibility, mechanism, components, indicators, evaluation by the community)
- 5.8.4. - Reprogramming (authority, mechanism)
- 5.8.5 - Information support

5.9 Primary Health Care Implementation Strategy:

Institutional responsibility for implementation. (Interpretation of vertical programmes/projects. Overcoming regional variations due to geographic, health, socioeconomic and other factors.

5.10 Phasing (annualization) of Implementation:

(see IV.3)

a. Infrastructure Units (new)

Level	198 No.	198 No.	198 No.	Subsequent Years	Total
Primary health care level (primary unit)	:	:	:	:	:
First-level referral unit	:	:	:	:	:
Second-level referral unit	:	:	:	:	:

Infrastructure Units (to be rehabilitated)

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<sup>(1)</sup>

(This table will include additional staff required to bring up the existing health institutions to the standard staffing pattern and to fully staff the new health institutions).

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					

(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.

## VI. UNIT COSTS

## A. Capital (or Investment) Costs

US\$

Unit Costs

a.	Construction of PHC-level unit (include cost/m <sup>2</sup> )	
b.	Construction of first level referral unit (include cost/m <sup>2</sup> )	
c.	Construction of second level referral unit (include cost/m <sup>2</sup> )	
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	

## 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 .....)		Next National Development Plan		Next National Development Plan	
National currency 1 = US\$ ...		19.. ~ 19..		19.. ~ 19..	
Estimated annual inflation rate = ...% for (year)		National Currency		National Currency	
Included in these estimates ?		US\$ Equivalent		US\$ Equivalent	
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 External 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:  

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

Other proposals can be presented following the format on pages 34 and 35 provided they form integral elements of the primary health care plan of action. The practice in most cases has been to include four to six such elements as supplementary proposals, depending on national priorities.

Examples of such supplementary proposals might include:

- Health Learning Materials
- Health Manpower Development
- Water Supply and Sanitation
- Expanded Programme on Immunization
- Essential Drugs and Vaccines
- Strengthening Health Services Management
- Public Information and Health Education
- Maternal and Child Health including Nutrition and Family Planning
- Specific Disease Control Programmes: communicable and non-communicable.

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

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

ANNEX

Related Health Development Indicators

When considering which proposals for external funding are particularly worth promoting (Section 4.3) as well as what selective background information is worth annexing to the CRU report (Section 4.5 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]

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