Chapter 13
International Health Development

1. The Changing Scopes, Functions, Organizations and Mechanisms of International Health

1.1 The Scopes : International health encompass:-

"Public Health areas that go beyond national boundary, with shared interests among countries, and which countries consider them to be more efficiently implemented through international cooperation."

The scopes of International Health is **moving from** mere cooperation on control of epidemics **to** broader areas of health development, e.g., food and drug control, knowledge development, and international trade.

1.2 The Functions

1.2.1 Criteria for International Health Functions

There are two types of international public health functions, i.e.,

(1) Collective problems: Those that respond to needs or problems that are common to all or most nations and can only be effectively met by governments acting in collaboration, because their solution transcends the limits of sovereignty of any one state. For example, like SARS and Avian Influenza.

(2) Specific problems: Those that are specific to individual countries or populations, but that justify international collective action due to shortcoming in national performance or because of moral imperatives. For example, HIV/AIDS epidemic in poor countries; health of the dispossess in poor countries; health in crisis like Tsunami.

1.2.2 Essential International Health Functions

(1) The constitution of WHO, one of the main international health actors, defines 22 functions of the organization.

(2) The Conference on World Health Cooperation beyond 2000, held at the Mexican Health foundation in April 1998, identified a set of six global health functions, i.e.,

(2.1) Health Surveillance: establishing early warning systems on looming health crises and monitoring trends in health and disease to identify future needs.

(2.2) Targeted Health Problem Solving: tackling specific global health challenges, from the HIV/AIDS to smoking pandemics to the drug-resistant microbial threats spreading across borders.

(2.3) Regulation and Setting of Norms and Standards: establishing or harmonizing regulations and scientific, technical, and ethical norms and standards that crystallize the most current scientific approaches to health problems and issues.

(2.4) Knowledge Management: setting up mechanisms that enable research findings and lessons learned in one country to be shared so that others may benefit in the widest, most effective manner.

(2.5) Serving as an Agent for Vulnerable Populations: safeguarding the health of vulnerable populations in extraordinary situations, in which there is a breakdown of the state, or the state becomes the perpetrator of human rights violations against its own population, as in the case of displaced persons, victims of human rights abuses, and civil conflicts.

(2.6) Strengthening National Capacity and Performance: building on national efforts to improve health outcomes and strengthen the foundations of a global health systems.

2. The International Health Organizations/Mechanisms

2.1 The Evolution

The attempts at international health cooperation started as the result of some important epidemics that affected countries all over the world, dating back to the middle decades of the last century (Table 13.1). The early international health organizations were finally developed into the UN agencies such as the WHO, which was created in 1948. Todays, a number of different UN organizations and the development banks have effective mandates in health (Table 13.2).

Table 13.1 Landmarks in international health

1830	Cholera overruns Europe,
1834	An official in France's Higher Council of Health makes the first call for an international conference to standardize prevention measures to fight the proliferation of disease and harmonize quarantine restrictions that obstruct commerce.
1851	The first International Sanitary Conference is held in Paris to produce an international sanitary convention, but fails.
1892	The International Sanitary Convention, restricted to cholera, is adopted.
1897	Another international convention dealing with preventive measures against plague is adopted.
1902	The International Sanitary Bureau, later renamed Pan American Sanitary Bureau, and subsequently Pan American Sanitary Organization, is set up in Washington, DC.
1907	L'Office international d'hygiene publique (OIHP) is established in Paris, with a permanent secretariat and a permanent committee of senior public health officials of Member governments.

1926	The International Sanitary Convention is revised to include provisions against smallpox and typhus.
1935	The International Sanitary Convention for aerial navigation comes into force.
1945	A United Nations conference in San Francisco unanimously approves the establishment of a new, autonomous, international health organization.
1946	The International Health Conference in New York approves the Constitution of the World Health Organization (WHO).
1948	The WHO Constitution comes into force on 7 April (now marked as World Health Day each year).
1951	The text of new International sanitary regulations is adopted by the World Health Assembly, replacing the previous International Sanitary Conventions.
1969	These Regulations are renamed the International health regulations, covering only cholera, plague, smallpox and yellow fever.
1978	A Joint WHO/UNICEF International Conference in Alma-Ata, adopts a Declaration on Primary Health Care as the key to attaining the goal of Health for All by the Year 2000.
1979	A Global Commission certifies the worldwide eradication of smallpox, the last known natural case having occurred in 1977.
1981	The Global Strategy for Health for All by the Year 2000 is adopted by the World Health Assembly and endorsed by the United Nations General Assembly, which urges other international organizations concerned to collaborate with WHO.
1988	The World Health Assembly resolves that poliomyelitis will be eradicated by the year 2000.
1994	WHO's Executive Board launches reform of the Organization in response to global change.
1997	WHO started the process for drafting the Framework Convention on Tobacco Control (FCTC). The FCTC was ratified by 40 member states on 30 November 2004. The FCTC comes into force on 28th February 2005. It is the first international health law under the constitution of WHO.

Source: Adapted and updated from the World Health Report 1998.

Table 13.2 U.N. Organizations and Comparative Advantage

Organizations	Perceived Strengths	Perceived Weaknesses
World Bank (+ Regional development bank)	• financial resources, policy advice, and technical assistance • links to ministries of finance and planning	• centralized, weak country offices • narrow economistic approach to health • perceived as Western dominated and ideologically driven
UNICEF	• effective at operational level • resources at country level • strong country offices (85% staff at country level) • advocacy role	• too driven by New York and narrow goals • sustainability of initiatives • vertical approach to health
UNFPA	• resources • strong advocacy role (family planning) • limited technical capacity • effective procurement service	• small, undergoing paradigm change from rigid population control to reproductive health • subject still vulnerable to political differences
UNDP	• broad development orientation • close ties to government • coordination role	• diverse competence at country level • poor on advocacy because of ties to government
WHO	• technical and scientific knowledge • network of experts • links with ministries of health	• weak at country level • two-thirds staff (of 5700) at central or regional level

Source: Enhancing Performance of International Health Institutions: Pocantico Retreat, 1996.

In addition, many philanthropic organizations contribute significantly to international health, e.g., Wellcome Trust, Rockefeller Foundation, Ford Foundation, and Gate's Foundation. Recently, to tackle the emerging problems more effectively, some new mechanisms are created. The most significant are GAVI (Global Alliance on Vaccine Initiative) and GF (Global Fund to Fight AIDS, Tuberculosis and Malaria). These mechanisms are managed based on a non UN participatory governing structures.

2.2 The Need for Reform

2.2.1 Increasing Complex Health Challenges from Epidemiological Transition.

(1) Preventable health problems affecting the poor and vulnerable populations.

(2) Health problems associated with development and aging.

(3) New and emerging diseases, environment-caused risks, and behaviour-associated problems.

2.2.2 The Impact of Globalization and Interdependence

(1) International health risks from travel, trade and environmental risks.

(2) International and regional trade agreements such as those under WTO (e.g., GATT, TRIPS, GATS, TBT, and SPS), APEC, NAFTA and AFTA, as well as bilateral trade agreements.

2.2.3 Altered Institutional Landscape

More and changing roles of international health actors, i.e.,

(1) UN agencies (stable or declining)

(2) Bilateral agencies (declining)

(3) Development banks (increasing)

(4) Civil society (increasing)

(5) Business (increasing)

2.2.4 Outmoded UN Organizational Structures

(1) Confine only to government sectors

(2) Outmoded regional structures

(3) Strong bureaucracy

2.2.5 Inadequate Partnership with other Actors

2.2.6 Lack of Mechanisms for Sharing Experiences between Countries.

2.3 Proposal for reform

The Conference for World Health Cooperation Beyond 2000 also offers three proposals for revitalizing the cooperation between key actors in international health cooperation, i.e.,

2.3.1 The international institutions and the member states that own them should redirect their current reform efforts from immediate structural issues toward more strategic issues, mainly concerning which essential functions must be performed.

2.3.2 International organizational active in health should reemphasize that international health functions are central to their role.

2.3.3 The performance of the essential functions must be strengthened above current standards at both the national and global levels.

3. Recent Successes in International Health Forum (2000-2004)

3.1 In World Health Organization (WHO)

3.1.1 Leading roles in the Regional Committee (RC) and the World Health Assembly (WHA)

Thai delegates are well prepared for every agenda item. In certain cases, Thai representatives were invited to chair drafting groups in the World Health Assembly for example the WHA resolution on SARS (WHA 56.29) and WHA resolution on migration of health workers (WHA 57.19).

These constructive leading roles have resulted in better connection to the senior level

administrator of WHO. Senior Thai health administrator was invited to be members of international committee/ commission, for example, Dr.Pakdee Pothisiri as the commissioner in the Commission of Intellectual Property Rights, Innovation and Public Health (CIPIH).

3.1.2 The first Thai to be elected Regional Director of WHO South East Asia Region (WHO/SEAR)

Dr.Samlee Plianbangchang was elected by SEAR member states to be the new Regional Director from March 2004 to February 2009.

3.1.3 Convening International Forum

Several International meetings were convened by Thailand with the support of WHO, e.g., the biregional workshop on the GF, the biregional workshop on SARS and the biregional workshop on Avian Influenza.

3.1.4 Role and member of the Executive Board

Thailand becomes member of the Executive Board (EB) since May 2004 until May 2007. It is also the member of the newly created Programme Budget and Administration Committee (PBAC).

3.1.5 Reform of the WHO Office in Thailand

This work started since 1996, which resulted in more efficiency, transparency and participatory management.

3.2 Roles in other International Health forum

Senior health officials and experts were invited to lead many international health mechanism, i.e.

COHRED (Council for Health Research and Development) invites Prof.Charas Suwanwela as the chair. Now, Dr.Somsak Chunharas is one of the board member.

GFHR (Global Forum for Health Research) used to have Prof.Charas Suwanwela as chair.

GF Thai representative (Dr.Suwit Wibulpolprasert) was the board member and the Vice Chair of the Board from January 2003 to March 2004.

GAVI invited Dr.Viroj Tangcharoensathien to chair its Technical Review Committee and now the member of the Evaluation Committee.

IFCS (Intergovernmental Forum on Chemical Safety) approved Dr.Suwit Wibulpolprasert to be its President from November 2003 to September 2006.

3.3 Organization of Important International Meetings

Several big international meeting were successfully hosted by Thailand. The biggest one was the XV International AIDS Conference in July 2004. Thailand is going to host the 6th Global Conference on Health Promotion in August 2005.

3.4 Bilateral health Cooperation

Thailand has successfully engaged in bilateral health cooperation with all its neighboring countries. These cooperation enable better and more efficient control of cross border epidemics.

4. Situational Analysis of the International Health in Thailand

4.1 Problem of the Existing Systems

4.1.1 Inadequate direction: The clear vision and strategies of international health development has not been clearly developed at the national level.

4.1.2 Inadequate structures: The existing structures narrowly confine themselves in the government sectors, particularly the Ministry of Public Health (MOPH). The **International Health Division** of the MOPH mainly provide international relation services and lack the capacity for technical public health cooperations.

4.1.3 Inefficient mechanisms: The existing mechanisms are mostly fragmented, with little cooperation, lack of solidarity and work in a passive manner.

4.1.4 Weak institutional capacity: There is no such thing as international health experts in Thailand, and there is no definite plans to develop them. Those that used to work in this area are usually depend on personal capacity without continuity of wisdom. All international health information is scattered and can not be retrieved easily.

4.2 Need for reform: Apart from several changes at global level as mentioned in 2.2 above, there are also changes at the country level, during the past decade, which push for the reform of the existing system ,i.e.,

4.2.1 Level of development of the country: Thailand has become middle income country since the last decade. Inspite of the economic crisis, the GDP/capita is still at the level of $US 2,000. This result in great reduction of international and bilateral aids grant to the country. Most bilateral health aids are terminated. The WHO country budget, at the level of $US 6 millions-the 8th rank of the global WHO country budget, is going to be reduced. We even develop a "Thai AIDS Fund" to support the development of the poorer neighboring countries. This fund used to be as big as $US 8 millions in 1996 and was reduced to $US 2 millions in 2000.

4.2.2 The economic dynamics: The current economic crisis reduce greatly the public health budget as well as the Thai AIDS Fund. Thus the international health cooperation is becoming more important to health development. The increasing roles of the development bank in various structural adjustment programs, including health, are clearly evident. The recent economic recovery has again increase the Thai support to neighboring countries.

4.2.3 Increasing health development capacity: The past success in several aspect of health development in Thailand resulted in the accumulation of great social asset in health, both at the institutional and individual level.

This can be used to strengthen the Thai role in international cooperation and even help improve foreign currency situation. The number of WHO fellowships to Thailand (339 in 1997, and 225 in 1998) is at the level comparable to USA (Table 13.3). The difference is that fellowships to Thailand are more short term in nature.

Table 13.3 Top Ten Host Countries for WHO Fellowships, 1992-1996

Country	Region					Total for top 10 countries	Remarks
	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
1. United States of America	10.0						Africa has no countries represented among the top 10 host countries for WHO fellows. The top three countries in Africa are Benin (87 fellows), Kenya (74) and Senegal (65), totalling 1.8% of all awards.
2. Thailand		10.0					
3. India		8.5					
4. United Kingdom			7.5				
5. Egypt				6.2			
6. Indonesia		5.2					
7. Australia					4.7		
8. Jamaica	3.4						
9. France			2.7				
10. Philippines					2.6		
Regional share of top 10 countries	**13.4**	**23.7**	**10.2**	**6.2**	**7.3**	**60.8**	
All others (121 countries)			**39.2**			**100.0**	

Source: Global database, WHO.
No data available for years prior to 1992.
All figures include intraregional fellowships.

4.2.4 Increasing regional and bilateral collaborating mechanisms: Recently many new regional and bilateral health related collorations are developed, e.g., the Mekong Basin Disease Surveillance Project (MBDS), ASEAN subcommittee on health and nutrition, the bilateral cooperation agreements with neighbouring countries, and the south-south collaboration. To benefit and contribute most to these collaborations, there is a need to rapidly strengthen the international health capacity.

4.2.5 Increasing international health politics: Issues related to resources allocation in International Organization, vested interests in international trade, politics in international organizations are affecting and maneuvering all developing countries including Thailand. Although the roles of the Thai delegates in these negotiating forum are quite significant, they depend mainly on individual capacity, there is no guarantee for continuity.

5. Future International Health Development

5.1 Development of Clear Vision and Strategies

Strategic plan for International Health Development (IHD) was developed and brainstormed in several multidisciplinary and multisectoral fora. It was then finally proposed to and approved by the International Health Development Policy Committee in July 1998. This strategic plan is still up to date and need further development.

5.1.1 The vision :

"International Health Development will be strengthened to facilitate development of the Thai Health Care Systems, to solve the priority health problems, to protect the benefits of the country and to foster the Thai image in international health fora".

5.1.2 The strategies :

(1) Development of effective international health structures and mechanisms

(2) Human resources development

(3) Development of Knowledge-based IH systems.

5.2 Framework for development

The future development should be based on conceptual framework in Figure 13.1, 13.2, and 13.3.

Figure 13.1 Conceptual Framework for IHD

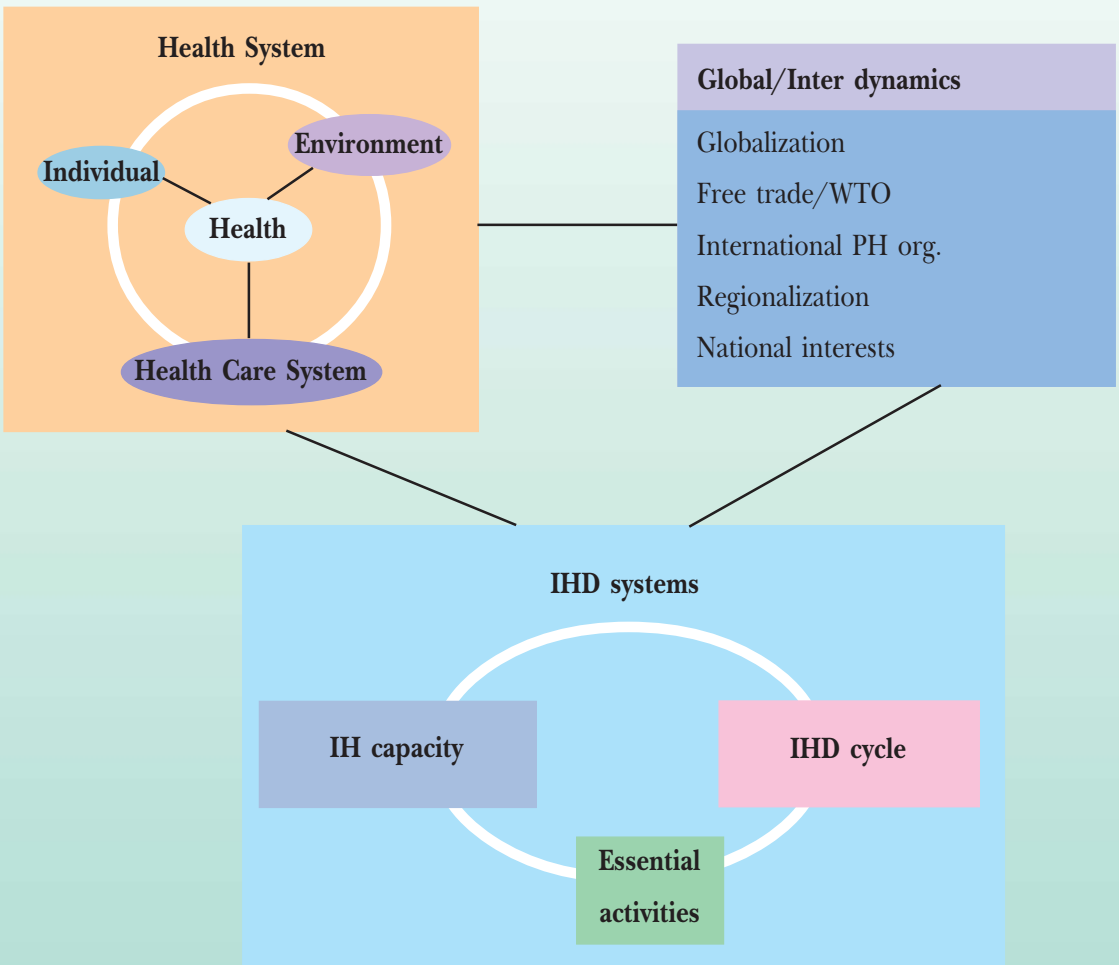
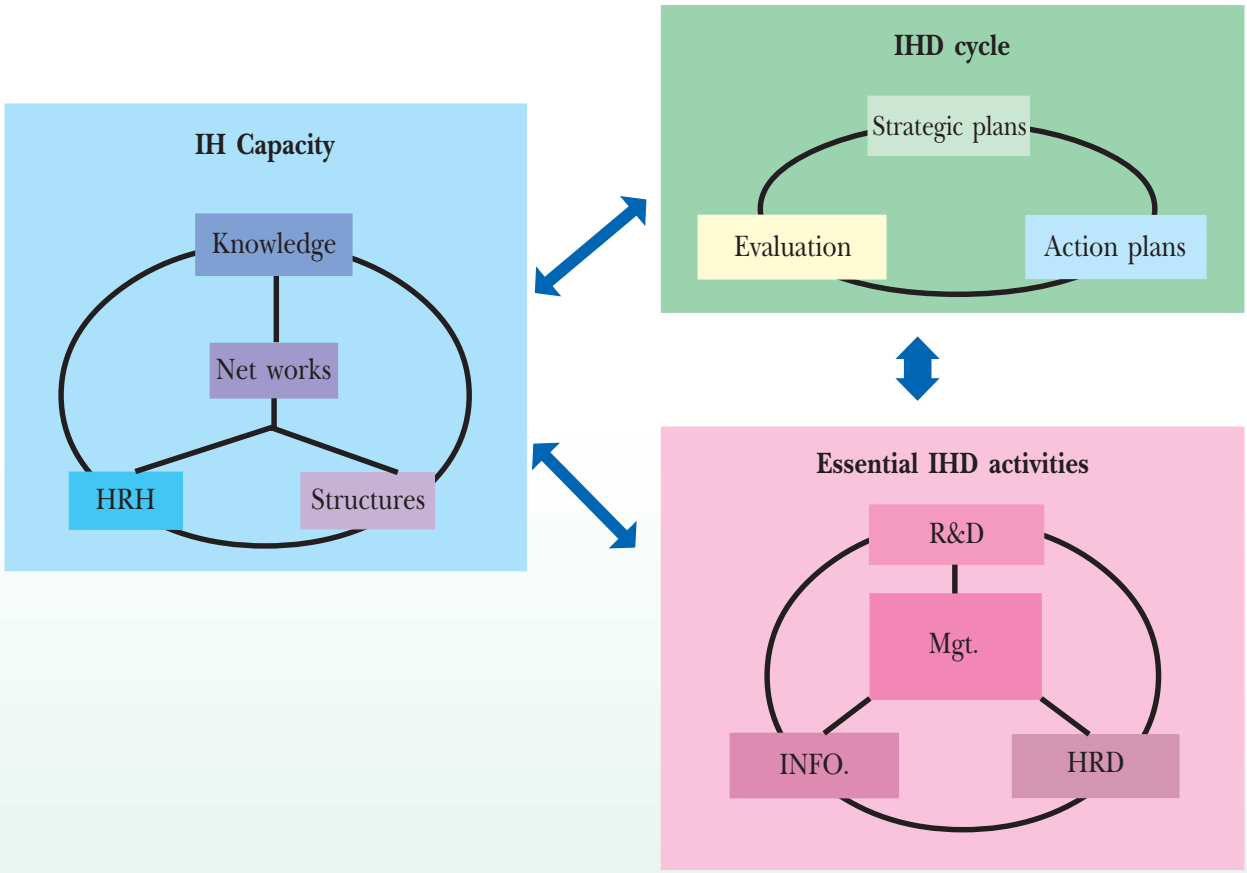


Figure 13.2 IHD systems



Mgt. = Management and networking

Figure 13.3 Framework of IHD

6 Missions	3 support measures		
	Management	Human Resource Development	Knowledge development
1. Health Surveillance			
2. Actions on Global Health Threats			
3. Global Norms/Standard			
4. Knowledge Management			
5. Health of the Vulnerable			
6. Strengthening National Health Capacity			

5.3 Strengthening and development of the new structures and mechanisms.

5.3.1 The International Health Group under the Bureau of Policy and Strategy should be strengthened through staff support and management reform. More technical staff with international public health skill and experience need to be recruited/developed.

5.3.2 The WHO roles in Thailand may also be reformed to include three main functions, i.e., the WR office, the Liaison office to ESCAP, and the office for biregional projects, e.g., the Mekong Basin Disease Surveillance Project, the Mekong Basin Project for AIDS, Tuberculosis and Malaria.

5.3.3 More active participation from non MoPH government organizations and civil society in the international health activities.

5.3.4 Strengthen the WHO collaborating centers in Thailand.

5.3.5 Development of mechanisms to build more linkages with International Health Organization to increasing sharing and transfer of wisdom.

5.4 Human resources development (HRD): HRD should aims at strengthen international health wisdom at individual and institutional level.

5.4.1 Targeted human resources development on international health in all concerned government and non-government organizations. This include the English and other international language proficiency, communications and negotiation skill, and understanding of international etiquette, norms, protocol, rules and regulations, including general and specific public health issues.

5.4.2 More longterm fellowship for junior/middle level Thai public health specialists to work as fellow with relevant department of WHO/HQ.

5.4.3 Development of clearer and definite career path for international health experts.

5.4.4 Support Thai public health expert into the international health organization, as consultants, as expert committee members, as professionals and at higher management level.

5.5 Development of knowledge-based IH system

5.5.1 IHD researches:

(1) Situation analysis of the WHO collaborating centers in Thailand and recommendation for future development.

(2) Implications of each of the several international trade agreements on health development in Thailand focus on the recommendations for capacity strengthening to prepare for most beneficial involvement.

(3) Situational analysis of all international training courses in Thailand, both long term and short term, and give recommendation for further improvement.

(4) Analysis of the potential of Thai public health experts to work in the international organizations and recommendation for strengthening.

(5) Evaluation of existing international health mechanisms at the regional and global

related to Thailand, and give recommendation on the appropriate role of Thailand.

(6) Development of guidelines and handbook for international health activities, for example, guideline for participation at the WHA.

5.5.2 IHD networks: Apart from the network of the IHD scholars, more higher level network as well as network in some specific areas to support IHD need to be developed and strengthened, e.g., HP/HSR network. Strong WHO collaborating centers in Thailand can be potential coordinators of several networks. These coordinating roles will increase the Thai strength to be accepted as center for coordination among countries in the Indochina region.

5.5.3 Support of International publications/communications

(1) Publication of research papers from Thai researchers in international journals. This should be promoted both on a compulsory and voluntary basis.

(2) Support the publication/development of International journals/webpage in Thailand, e.g., the HSRI journal/webpage. An English version of the MoPH webpage was created since June 2000.

(3) Support the publication of specific reports in English, e.g., Thailand Health Profile, and Thai Health Report.