ROLE OF WHO IN THE DEVELOPMENT OF INTERNATIONAL HEALTH IN THAILAND

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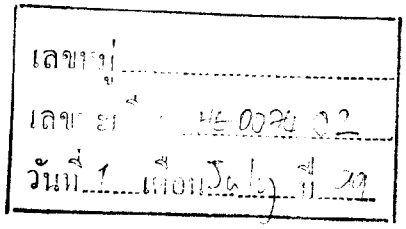


TABLE OF CONTENT

1. INTRODUCTION

In the long history of the Kingdom of Thailand dated back since Ayudhya Era there had been accounts of foreign relations which bore influence upon health. Apart from the establishment of a hospital in the ancient capital of Ayudhya and inception of modern medicine among the missionaries, foreign traders and countries, there were evidences that Italian and French missionaries had initiated sanitation and water works in Lopburi province through mobilisation of natural water sources.

Only after the year 1828 during the **Reign of King Rama III of the Chakri Dynasty** that Western medicine became more popular and gradually gained its stancds in the Thai healthcare system which was basically based upon indigenous medicine. An American Missionary, **Dr.Dan Beach Bradley**, had introduced **small pox vaccination** in the Kingdom after which court doctors were assigned to learn the art and began their practises in 1838.

In the **Reign of King Rama IV** an American Missionary, **Dr.Sanruel Raynolds House** offerred his services in prevention and treatment of **cholera.** Foreign influence in provincial health services was initiated in 1861 under the initiatives of Presbitarian Missionaries, **Dr. S.G. McFarland** and **Daniel McGilvary** who assisted the people in Petchaburi and Chiang Mai in controlling and treatment of **malaria** and **small-pox**. **Dr.Hames W. Mckean** helped set up the first **Leprosy Control Center** in the Kingdom. In the field of medical education many foreign professors had been key resource persons in the Kingdom's first medical school, Siriraj which was established under Royal initiative of **King Rama V** in 1888.

International relations in health development have therefore been evolved for several hundred years in Thai history and have born considerable impact upon health and quality of life of the Thai people. About 50 years ago in **1947 Thailand became a member country of WHO** and this has marked a new era of progressive development of international health and national capacity in health development, an extremely valuable experience to be documented for future references.

This paper intends to present a brief history and background of collaboration between the **Royal Thai Government** and **WHO**, problems inherant in current RTG-WHO country programme management system and recommendations for new approaches in international health in the globalization era.

2.THAILAND'S RELATIONSHIP WITH NEIGHBOURING COUNTRIES AND DONOR AGENCIES

The first international convention on health was held in Paris in the year 1851 in cognizance that communicable diseases had no boundary and countries should undertake joint effort in controlling such diseases along their borderline. This had resulted in the establishment of an **International Organization for Controlling Communicable Diseases** in 1907 which later joint WHO in 1947.

International organizations which had been major sources of technical assistance and other support in terms of supplies, equipment and health manpower development were **WHO** and **UNICEF.** Through these organizations international collaboration in health development and technology transfer began to take shape and Thailand has benefitted considerably in the field of communicable disease control, maternal and child health, environmental sanitation and rural health. Bilateral relations among developed and developing countries had also been established based upon mutual interests and friendship.

In the past 20 years there has been a marked changes in the world's economic order and political circumstances. With the termination of major military conflicts and the **"cold war"** coupled with the sustained economic development, changes of Thailand's relationships with donor agencies and neighbouring countries became most notable over this period. Several bilateral (e.g. USAID, Government of the Netherlands, etc.) and multilateral agencies (WHO, UNICEF, World Bank, etc.) have substantially reduced their development assistance to Thailand eventhough the Kingdom remained a major location for regional assistance programmes. Some agencies like UNICEF are reappraising their level of direct support to the Kingdom and there is a tendency that they will phase out the country assistance programme over the next few years.

These changes have coincided with the decision of the **Royal Thai Government** to establish its bilateral assistance programme known as **"Thai Aid"** for providing financial and technical assistance under TCDC (Technical Cooperation among Developing Countries) concept to the immediately adjacent neighbouring countries whereby health is an essential integral part. In March 1994 the **Thai Government Department of Economic and Technical Cooperation (DTEC)** hosted a 3-days meeting with major donor agencies' participation, proposing that **Bangkok** be used as a base for "tripartite" efforts to assist countries in **Indo-China** in human resources development and technical cooperation whereby health will be an important component. It was agreed that the **Thai Government** will cooperate with bilateral as well as multilateral donors in providing assistance in the field of healthcare and overall health development to neighbouring countries namely **Burma** (now **Myannar), Cambodia, Laos, Vietnam** as well as other developing countries as may be requested. However the assistance has been based upon mutual interests and **TCDC** concept.

There have also been frequent international meetings, seminars and study tours in health development both at regional and country levels as well as exchanged visits among health ministers and policy makers. **Thailand** has also hosted a number of international meetings and seminars as well as meetings of Health Ministers in **Southeast Asian** and even **Eastern Mediterranean Region**. All the international health development endeavours have contributed greatly in enhancing the friendly ties and constructive relationships between **Thailand** and **WHO** member countries particularly those in **Southeast Asia Region.**

3. HISTORY AND BACKGROUND OF COLLABORATION WITH WHO

Relationship between the Royal Thai **Government** and **WHO** has been established since the year 1947 when Thailand became a member country of **WHO. Office of WHO Representative to Thailand** was later set up at the **Ministry of Public Health** in Devaves Palace in the building which used to be heritage home of **Somdetch Krom Phraya Devawongse Varoprakarn** (now moved to the new home of the Health Ministry in Nonthaburi province.

Chronological development of **RTG-WHO** relationship could be highlighted as follows :

3.1 CHRONOLOGY OF RTG-WHO COLLABORATIONS

1. Conventional Technical Assistance (1949-1975)

After **Thailand** became member of **WHO** in 1947 the **Kingdom** had entered into an agreement with **WHO** for receiving technical assistance and consultation for the first time in 1949. WHO assistances comprised :

1.1 Technical consultants

1.2 Seminar, training, assignment of WHO Expert Group in specific fields as requested by individual country

1.3 Fellowships for overseas training

1.4 Preparation and implementation of pilot project, field experimentation or research

1.5 Other technical supports

1.6 Supplies and equipment

During 1949-1970 **RTG-WHO** collaboration was based upon general programme on control of communicable diseases, eradication of small-pox, maternal and child health, basic health services and health manpower development. Originally request for **WHO** assistances was submitted through **WR Office** to be considered by **WHO/SEAR** except where extra-regional resources from **WHO/HQ** were required. The latter needed to be considered in light of the resolution and judgement of the **World Health Assembly**.

The years 1970-1975 saw the commencement of technical-collaboration between **MOPH** and **WR Office** in planning and managing **WHO** resources for health development in response of emerging needs in the areas of research and training in human reproduction (HRP) and tropical diseases (TDR). This system had been maintained during successive periods to ensure best use of **WHO** resources for health development.

2. Country Health Programming (1975-1981)

In 1975 **Thailand** and **WHO** joined in initiating the **Country Health Programming (CHP)** exercise which coincided with the preparation of the **4th Five-Year National Economic and Social Development Plan** whereby health planning was an essential integral part. This had resulted in reorganization and strenthening of the role of the **Health Planning Division.**

In 1976 joint management of **WHO Country Programme Budget** was initiated by the establishment of **RTG-WHO Coordinating Committee** comprising senior officials from **MOPH,** 3 senior officials from concerned universities, **WR to Thailand** and chaired by **MOPH's Permanent Secretary.** The Committee's function was to guide and WHO supervise the development and management of the programme using WHO resources. During this period primary health care has become the key strategy for Health for All in the **National Health Development Plan** and **WHO** has contributed immensely in the development of innovative activities at the peripheral levels.

In October 1981 **Dr. H Mahler** the then **WHO Director-General** (DG) and **Dr. U Ko Ko, Regional Director** (RD) for **WHO/SEAR,** visited Thailand to attend the Joint Policy Review Meeting. Recognizing the capability and strong commitment of the MOPH policy makers towards HFA goals with primary health care as the key strategy coupled with the vision and application of complimentary strategies for national health development, the **DG** and **RD** agreed to suspend **WHO** rules and regulations governing the use of **WHO** regular budget at the country level for the years 1983 and 1984-85. Under the **"Bangkok Declaration" WHO** country programme resources were to be planned and made use of under the **Decentralized Management System** with **RTG-WHO Coordinating Committee** assumed all decision-making authorities.

3. Programme Budgeting Exercise (1981-1984)

Under the principle designated in the **Bangkok Declaration** on October 26, 1981, **RTG-WHO Coordinating Committee** had set up a **Secretariat Office** comprising middle level managers of **MOPH** and **WR**

Office to facilitate overall programme management. Technical Sub-Committees were appointed for detailed progamming and considering project proposals. The programme areas designated as complementary strategies for national health development comprised :

3.1 Programme on the role, responsibility and empowerment of the community

3.2 programme on mechanism for intra and intersectoral collaborations

3.3 Programme on financial system management

3.4 Reorientation of health manpower

3.5 Technology transfer to the people

3.6 Policy and operational research

3.7 Increase community capability in planning and management

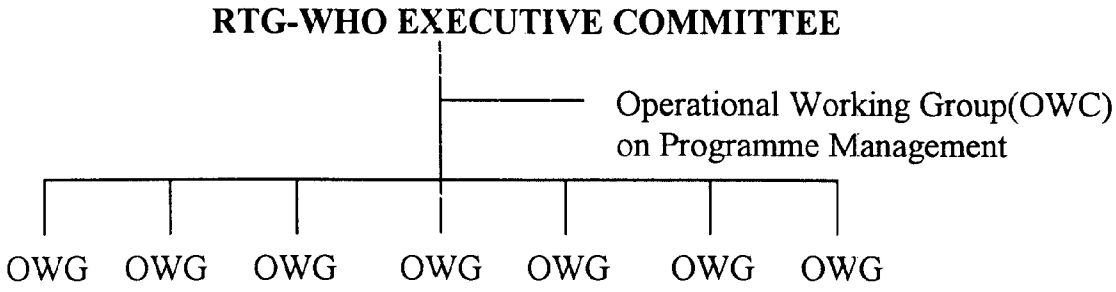
3.8 Programme on mobilizing essential social resources (concept, practise, technology, culture, manpower, finance, institution) for health development

Of the 27 detailed plan of actions, there had been dramatic shift from **LTS, STC** and **S&E** budget components to more flexible area of **LCS** and fellowships/study tours and other people participation PHC oriented projects.

In June 1984, **WHO DG** and **RD** revisited **Thailand** for **Joint Evaluation Meeting** of the **Programme Budgeting Exeicese** and found it practical and useful for the Thai situation and agreed to maintain it under the **Decentralized Management System** (DMS's).

4. Evolution of the Decentralized Management System (1984-1986)

Based on the recommendations made in the 2nd Evaluation Meeting, mechanism for **RTG-WHO** Collaboration was revised for more systematic and adequate for a sound programme planning, implementation and evaluation. In order to build up technical competency and experience in intemational health among middle level health administrators in the **MOPH,** 8 **Operational Working Groups** were set up to assume more comprehensive role in programme coordination and operation. The **RTG-WHO Coordination Committee** was assisted by the **Operational Working Group** on programme management which was represented by WR Office manager, Director and staff of International Health Division.



Operational Working Group
each responsible for specific programme areas

During this period the 13 detailed programmes reflected the **MOPH's** major **programme** on **self-manage PHC villages** and the **Mini-Thailand** demonstration project whereby the **TCDV** (Technical Cooperation among Developing Villages) was applied and made possible by the decentralized management.

1986 - 1987 : During this biennium the number of programmes was reduced considerably in order to yield more tangible impact on specific areas of urgent need. **RTG-WHO Executive Committee** (known as **EXCOM**) and 7 **Programme Implementation Coordinating Teams** (PICT's) replaced the **RTG-WHO Coordinating Committee** and the **Operational Working Groups**. **WHO DG** and **RD** participated in reviewing the **DMS** and it was mutually concluded that the system successfully demonstrated effective use of **WHO** resources.

1988 - 1989 : During this biennium 6 programmes (HST, MPN, PHC, HMD, IEH and RPD) were implemented under the management of the **EXCOM** and 7 **PICTs** (2 PICTs for PHC which remained in focus).

1990 - 1991 : Human resource development was in the forefront during this biennium which was reflected in an increase to 25 programmes with more provision on long-term international fellowships.

1992 - 1993 : In continuation of the 1990-1991 biennium there had been further increase in programmes under the management of the **EXCOM** totalling 28. Concurrently the number of **PICTs** increased to 10

thus allowing considerable number of **"new wave"** middle level health administrators receiving on-the-job training in international health.

1994 - 1995 : Based upon ongoing evaluation of programme implementation and restructuring the 23 programmes were under the management of the **EXCOM,** a **WHO/MOPH Working Group on Programme Management** and 4 **PICTs.**

1996 - 1997 : During this period 22 programmes were implemented by the **EXCOM** chaired by the **MOPH Permanent Secretary** with **WR** in an ex-officio capacity. **RTG-WHO Programme Coordinator** was recruited and acted as one of the 3 secretaries of the **EXCOM.**

3.2 CURRENT ARRANGEMENTS FOR RTG-WHO COLLABORATIONS

The **RTG-WHO** collaboration is being administered through a collaborative mechanism between **MOPH** and **WR Office.** Major components of this mechanism comprise the **EXCOM, MOPH-WHO Working Group on Programme Management** and **PICTs.** The system is backed up by International health Division (IHD) and **Office of WHO Representative (WR).**

The detailed arrangements and responsibilities vested in the sub-systems appear as follows :

3.2.1 Executive Committee (EXCOM)

EXCOM is composed of senior executives of the **MOPH,** concerned national health institutes and universities. The **MOPH Permanent Secretary** acts as the **Chairman of EXCOM** with the **Deputy Permanent Secretary** responsible for international affairs as **Vice Chairman. WR to Thailand** represents in an ex-officio capacity. Other members who are representatives from concerned institutions are selected and appointed by consensus on a biennial basis. The term of reference of the **EXCOM** is to provide policy direction and guidance on **RTG-WHO** collaboration based upon **WHO** policies as stated by the **World Health Assembly, Executive Board** and **Regional Committee** as well as **Thai** national health development policy.

3.2.2 MOPH-WHO Working Group on Programme Management

This Working Group is co-chaired by the **MOPH Deputy Permanent Secretary** responsible for international affairs and **WHO Representative to Thailand.** Its members comprise senior **MOPH** officials nominated by the **Permanent Secretary, Director of IHD, Public Health Administrators** (PHAs) of the **RTG-WHO** collaborative programmes and the professional staff of the **WR Office.** The main functions of the Working Group are to act as a technical and managerial secretariat to the **EXCOM** while providing ongoing technical and administrative support to the **PICTs.**

3.2.3 Programme Implementation Coordination Teams (PICTs)

Chairmen of the PICTs are appointed by the **MOPH Permanent Secretary** in his capacity as **EXCOM's** chairperson. **PICTs'** chairmen are senior health administrators or experts in particular programme area. They select their respective **PICTs** members from individuals nominated by **EXCOM,** concerned institutions and universities as well as **WHO** to be further appointed by the Chairman of **EXCOM.**

The PICTs are charged with the responsibility to plan, coordinate implementation, monitor, evaluate and report on specific collaborative programme areas as assigned by the **EXCOM** and appeared in the **Detailed Plan of Action.** Their activities also include screening and prioritizing project proposals from all concerned agencies both within and outside **MOPH** and assuring that high standard technical and financial accountability is maintained by the institutions, agencies and individuals implementing the programme budget activities. The **PICTs** are fairly independent in developing their own management style as appropriate to their programme areas and available resources based upon **Management By Objectives (MBO)** principles. They could call upon support from the **MOPH-WHO Working Group on Programme Management** whenever the deemed essential. The substantial work of the **PICTs** requires regular meetings, twice a month or monthly.

3.2.4 Public Health Administrators (PHAs)

Recognizing that international health will inevitably become more important in the globalization era the **MOPH** supports the development of middle level technical or administrative staff (up to PC 8 or Division Director

level) who are active, capable and willing to be involved in **RTG-WHO** collaborative programme planning and implementation in accordance with stipulated terms of references. Candidates are recruited, screened and nominated by the **EXCOM** in consultation with the **WR Office.** The **PHAs** serve under a Contractual Services Agreement (CSA) arrangement with the **WR Office.** They assume roles as technical and administrative secretaries of the **PICTs** and facilitate overall programme management through liaising between the **PICTs** and the **MOPH-WHO Working Group.** Their number and assignments are designated by the **EXCOM.**

3.2.5 International Health Division (IHD)

IHD is a Division under direct jurisdiction of the **MOPH Office of Permanent Secretary.** It is responsible for all international affairs particularly bilateral and multilateral transactions involving both the public and private sectors concerning health. **IHD Director** serves in an ex-officio capacity as secretary to the **EXCOM** and the **Working Group.** It is the focal point within **MOPH** for support under RTG-WHO collaborative programme.

3.2.6 Office of WR to Thailand

The **WR** represents the **World Health Organization in Thailand** and supports the **RTG** in planning and managing the **RTG-WHO** collaborative for national health development including the organization of appropriate supportive health information systems, identification and coordination of available or potential external resources for the implementation of overall national health development programme.

Under close collaboration and policy guidance from **WHO/HQ** and **WHO/SEARO, WR** assumes authority to discuss programme activities and release the funds to **MOPH** accordingly. As part of its accountability to **WHO,** the **WR** must assure that all collaborative activities are in line with national policies and priorities and in accordance with **WHO** guiding principle and administrative regulations.

3.3 ANALYSIS OF RTG-WHO COLLABORATIVE SYSTEM

For roughly 4 decades that **WHO** has collaborated closely with the **Royal Thai Government** in direct support of the **Kingdom's** continuing endeavours for national health development.

In the first two decades up to the 1970's **RTG-WHO** collaboration programme was not country specific but based basically upon needs of all developing countries in the areas of communicable disease control including eradication of small-pox, development of health manpower, maternal and child health services and basic health services at the peripheral level. During 1970-1975 when population problem became an issue of global concern, special programme for research and training in human reproduction **(HRP)** and tropical diseases **(TDR)** were highlighted. **WHO** assistance had contributed greatly in the eradication of communicable diseases like small-pox and cholera and sizeable reduction in maternal and infant mortality rates. Many health policy makers had been benefited from the health manpower development programme which concurrently bore impact upon progressive development of the healthcare system and national capacity in country health programming.

It should be noted that many **Thai** high level officials both within **MOPH** and in the universities e.g. **Prof. Dr.Prapont Piyaratn, Dr.Amorn Nondasuta, Prof. Dr.Natth Bhamarapravati, Dr.Uthai Sudsukh, Dr.Paichit Pawabuta, Dr.Damrong Boonyoen** and many of their junior colleagues were among pioneers in introducing changes to the conventional RTG-WHO collaborative system.

During the **Programme Budgeting Exercise** in 1981 there was high level agreement between **MOPH** and **WHO** on the innovative complementary strategies **WHO** could offer to priority areas of national health development policy and plan. In practise these strategies required a reallocation of both technical and financial resources from the top to the periphery. Based upon mutual agreement there was a profound shift from support to the traditional budget components of international long-term staff and short-term consultants, long-term fellowships and supplies and equipment to the more flexible budget components of local cost subsidies and short-term fellowships/study tours. This decision has brought about more active

involvement of **MOPH** middle level personnel in international health, country health programming and in the managerial process for national health development under **WHO** catalytic and supportive roles.

One of the unique feature of **RTG-WHO** collaboration which had evolved after the **Programme Budgeting Exercise** was the **Decentralized Management System** which allowed ample opportunity for development of national technical and managerial capabilities. It could be said that the **Decentralized Management System** was initiated in **Thailand** because of increased self-reliance and capability in local management of **WHO** collaborative activities that included the development of a **RTG-WHO** coordinating body, the country health programming exercise, formulation and implementation of national primary health care policy and programme as well as the strong political support for the **WHO HFA/2000 Goal.** One of the outstanding success of the **DMS's** was the generation of active intra and intersectoral collaboration both at the national and peripheral level in health policy formulation, health planning and the overall managerial process for national health development based on primary health care - a lesson whereby missions from **WHO/HQ, Regional Offices** and study teams from member countries had made site visits through technical collaboration programmes, meetings and study tours.

The person most actively involved in the development and implementation of the **Decentralized Management System in Thailand** was **Dr.Amorn Nondasuta**, the then **Permanent Secretary of Public Health from 1983 to 1986.** Following his retirement there was a gradual shift back to the traditional methods of programme implementation. Stakeholders from the medical schools of the **Ministry of University Affairs** viewed **DMS** as a system which focused primarily on the needs of the **MOPH** and should be reorientated to meet new challenges at the macro level with provisions for fellowships and health sciences research and development.

MOPH's Permanent Secretaries appointed after **Dr.Amorn** had not been actively involved in the decision making process on the use of **WHO** resources nor had they been involved in the programme budgeting exercise. Although they were considered to be part of the critical mass of key stakeholders, they were not part of the principle group that reached consensus on how to make best use of **WHO** resources under the **DMS's** principles. As

a result they were not committed fully to the previously agreed upon course of action.

This had led to changes in operational policies such as an increase in collaborative programmes and a return to the provision of long-term fellowships. With the appointment of new WHO Representative in 1988, there was a return to **WHO/SEAR** guidelines of **WHO** resource allocation to specific programmes rather than to broad programming. Such changes came into effect during the 1990-1991 biennium.

Although the structure and focus of the **RTG/WHO** collaborative mechanism has undergone modifications over the years, the principle of having a large policy maker group for formulating policy, strategy, programming and budgeting and some smaller groups for managing programme implementation have remained as the integral functional element of **RTG-WHO** collaboration.

One of the most notable outputs of **RTG-WHO** collaboration is the development of a critical mass of young and talented doctors and middle level technical personnel of **MOPH** and other related agencies whose apprenticeship in managing and participating in **RTG-WHO** collaboration has helped built up their confidence and competency to meet new challenges of the globalization era particularly in the field of international health.

4. PROBLEMS INHERANT IN CURRENT RTG-WHO COUNTRY PROGRAMME MANAGEMENT SYSTEM

During past decade there has been considerable concern about the appropriateness and effectiveness of multilateral agencies at the country level. The agencies themselves have paid continuing interest in following up the output and impact of their programmes on national development. As for **WHO** one of the six development teams appointed in pursuant of resolution **WHA 46.16** for reviewing **"WHO's Response to Global Change"** directed their effort towards reassessing the role of **WHO Country Offices** to ensure their success in furthering the organization's goals in assisting countries to improve and attain equitable levels of health (see, for examples, **DANIDA,** 1991, Effectiveness of Multilateral Agencies at Country Level. **WHO** in **Kenya, Nepal, Sudan** and **Thailand. Copenhagen ; Daes EA, Daoudy A,**

1993. Decentralization of Organizations within the **United Nations System.** Part III : the **World Health Organization. Geneva, Joint Inspection Unit ; Godlee F,** 1994. **WHO** at country level-a little impact, no strategy. **British Medical Journal** ; 309 : 1636 - 1639).

There has also been internal criticism of **RTG-WHO Country Programme Management System** as reflected in some working papers (see, for example, **Chakradharm, Chawalit, Chamaiparn** et al., **Study on WHO Program Management in Thailand 1990 - 1991, Bangkok, RTG/WHO, 1992).**

Limitations and problems of current RTG/WHO country programme management were generally discussed at 2 essential levels : **Priority or Content Level and at the Procedural or Organizational Level.**

4.1 PRIORITY OR CONTENT LEVEL

Current **RTG-WHO** collaborative system seemed to have its shortcomings in identifying issues of high priority to be supported under the Country Programme. Unlike past approaches during country health programming or programme budgetting exercises whereby policy makers joint in setting scenario for national health development and complementary strategies whereby **WHO** catalytic role could contribute, Current system was found to be fairly inadequate in spelling out policy directions or guiding principles for broad programming and detailed programming. Conflicts of interest did exist internally among concerned departments and externally between **MOPH's** and other technical counterparts particularly the medical schools which would like to see international health development in a broader context, not just vested under MOPH's administration.

In the past decade, health development has become a high priority in the national development agenda with a corresponding increase of annual budget. With the establishment of **THAI AID Programme** under the **Department of Technical and Economic Cooperation Thailand** began to assume the role of donor under the principle of **Technical Cooperation Among Developing Countries.** There has also been a downward trend of external assistance both for bilateral and multilateral cooperation. It is thus

understandable that management of **RTG-WHO** collaboration has not been high on the agenda as it used to be because of the limited resources and the necessity to share this with all major stakeholders under the principle of intersectoral collaboration in health and quality of life development.

It was noted that topics for support were often decided upon in a rather arbitrary and pragmatic way and based primarily upon technical group consensus. Guiding principles or criteria for screening and selecting proposals may be available but ample flexibilities were allowed in the selection process. In some cases no explicit nor precise selection criteria were set for deciding exactly what could be support. The limited resources available to the programme were then dissipated over a wide range of loosely connected activities like workshops, meetings, preparation of technical documents, etc.

Eventhough comments were made that the topics included in the WHO country programme support were relatively insignificant and did not bear any tangible results towards reducing disease burden, reducing inequity, improving quality of care, nor were they of public health importance. Their outcomes still contributed towards national health development programmes in the areas which were not adequately or could not possibly be covered by the regular government budget.

The **WHO 9th General Programme of Work (GPOW)** covering the period 1996 - 2001 did provide guidance for setting goals, objectives and targets of the individual country programme. Its 4 major policy orientations provided framework for actions to be undertaken at the country level. According to **WHO's 9th GPOW,**

> " Four interrelated policy orientations are proposed as a focus for action by the international health community to reach goals and targets as well as to support countries in reaching the goals and targets they set in light of particular situations :
>
> (A) integrated health and human development in public policies ;
> (B) ensuring equitable access to health services ;
> (C) promoting and protecting health ;
> (D) preventing and controlling specific health problems."

For each of the four policy orientations, the **9th GPOW** gave a listing of major results of world action during this programme of work. However they were deemed inadequate as guidelines for setting specific and quantifiable priorities for the country programme. Similar comments also applied to the ten **"Goals and Targets"** designated in the 9th GPOW as an expression of commitment of the international health community in supporting countries in achieving improvements of health status and greater equity in health. The ten goals and targets were expressed as **"minimum requirements"** to be achieved by the end of the period in order to control or eliminate major health problems. Most of the minimal set of goals had already been achieved in Thailand.

While the **Office of the WR to Thailand** has attempted to selectively translate the 4 interrelated policy orientations of the **9th GPOW** to be relevant and specific to **the Kingdom,** it would probably be more useful if there were a set of global or regional explicit criteria and procedures for setting specific country priorities. This could help ensured that the country programme proceed along the desirable direction while making it relatively easier to monitor and evaluate the effectiveness of the country programme.

However, it could be argued that the **9th GPOW** was drafted at a macro level and could not possibly be country or regional specific. Formulation of the country programme depends upon vision and capacity of concerned key personnel of each individual country. In **Thailand** with ample experiences in country health programming and decentralized management this exercise could probably be done with least difficulties.

4.2 Procedural or Organizational Level

The biennial **Detailed Plan of Action (DPOA)** of the **RTG-WHO Country Programme** was said to be largely decided through essential negotiations and renegotiations among the various departments within the **MOPH's** with minimal participation by representatives from other concerned institutions including the universities. It appeared that an overriding concern was principally made as inclusive as possible and often resulted in a wide range of topics supported and involved large number of departments and divisions within the **MOPH.**

The draft **DPOA** was eventually considered by the **Working Group for Detailed Programming** and then submitted through the **EXCOM** to be approved by **WHO/SEAR.** At each stage of this process the tendency was that the successive committees often suggested additional activities to be supported rather than screening out inappropriate activities.

Unlike conventional RTG-WHO collaborations whereby specific objectives and priorities of WHO country programme were set from the very beginning and all activities should be geared towards the desired directions, current DPOA's of specific programme areas were often considered separately by the 4 **Programme Implementative and Coordination Teams (PICT's)** and resulted in a large number of programme components. The **PICT's** were primarily involved in overall programme implementation from the process of proposal screening to monitoring and following up of each individual project up to the submission of final reports. However it was noted that for some projects no report was ever submitted and the results remained doubtful. Lack of overall programme monitoring and assessment against pre-set objectives resulted in some dissatisfaction of current mechanism in which **WHO** country programme was decided upon and implemented.

However experiences from the **WHO Decentralized Management System** have created keen interest in international health among the "New Wave" public health administrators who visualize international health development as a tool for building up
friendship among neighbouring countries as well as promoting regional solidarity and security in health.

5. PROPOSAL FOR FUTURE INTERNATIONAL HEALTH DEVELOPMENT IN THAILAND

Professor Dr.Natth Bhamarapravati once expressed that health should be part and parcel of **Thailand's** foreign relations policy as in comparing it with other mojor areas be it military, political or economic relations, Health is seemingly free from unfavorable side effects which may occur as a result of other type of intercountry transactions. The **Department of Technical and Economic Corporation's TCDC** or **Thai AID programme** was initiated along this line and has been quite successful in

establishing constructive relations with neighbouring countries with health as an essential programme component.

In the **Ministry of Public Health** the **Health System Research Institute** has realized the need for promoting international health in the so-called globalization ara, using the experience gained from **RTG-WHO Decentralizing Management System** as entry point with the intention to reorientate the system to be more effective and contribute towards strengthening **Thailand's** role in the subregional, regional and global level in health development.

A working group comprising senior consultants and expert in international health joint with the **HSRI** in making the proposal for future international health development in Thailand which appeared as follows :

1. RATIONALE

1.1 Communication technology and social development have brought the world into an era of **'globalization'** and **'world without border'.** Countries in various regions especially those with adjacent borders, are actively grouped together often for their political and economical interests. **Thailand** is no exception. Apart from being a member in **ASEAN,** we also actively participate in new regional groupings, e.g., **APEC,** and **BITS.** At the same time movements for establishing bilateral and regional collaboration among countries in the **Indochina Penninsula** are also being observed.

1.2 Collaboration in health development among countries in the region, especially those with adjacent borders, would yield positive results in communicable disease control with a more **"regionally secured"** health environment. Furthermore, networks of personal and institutional friendships built up from collaboration in health development would be long term assets facilitating efficient and flexible international collaboration not only for health issues, but also for economic, social, and political relations.

1.3 **Thailand** has achieved an acceptable level of health through several decades of comprehensive health development activities. The improvement in health and human development index, the extensive health

services including the PHC network, the success in MCH/FP, communicable diseases control the active movement in health promotion especially tobacco consumption control and physical exercise as well as the developments in health science and technology are valuable regional specific experiences which can be, and should be, shared with our neighbours. Meanwhile, other countries in this region and elsewhere in the world have broad experiences that we could learn from them. Although some of the neighbouring countries are in different regions of **WHO,** health development network could be established on a bilateral and regional basis under other arrangements. The **WHO** is also in the process of creating new mechanisms for inter-regional collaboration as reflected in the **ICHD** (International Collaboration for Health Development) workshop held in **Chiang Mai,** between 12-15 December, 1997 ; and the **WHO-ASEAN MOU on health Development.**

1.4 Economic development in **Thailand,** discounting the recent economic crisis, has transformed the country from the status of a **"recipient"** to more of a **"non-recipient"** country. Furthermore, active collaboration in health sciences and technology within the region will allow for more **"economies of scale"** in the production and marketing of health services and health products which will reduce import and further strengthen regional export and market share of health products.

1.5 Current International health development activities in Thailand are scattered among institutions in the **Ministry of Public Health,** the universities, the **Prime Minister's Offices (DTEC),** other concerned ministries and the private sector (both for profit and not for profit). Inadequate cooperation and coordination among these institutes have mostly resulted in passive movements, lack of unity of command and inefficient use of resources. Above all, there is a severe shortage of human resources in the international health field that could build up the country's image and support it's role in international political forum.

Based upon changing conditions and new challenges as reiterated, there is an urgent need to strengthen the country's international health management system to be more efficient and flexible for timely and progressive movements. This system armed with highly experienced human resources, will not only allow us to play leading roles in international health forum, but also support regional collaboration to achieve **"regional health**

security" and foster other constructive socio-economic and political relationships. However, these activities must take into account the current economic crisis, and its impact on financial support for such development.

2. OBJECTIVES

2.1 General objectives

To create an efficient, flexible, and progressive international health management mechanism which facilitates and enhances Thailand's role and position in international
health forum, support regional health security, and foster overall international socio-economic and political relations.

2.2 Specific objectives :-

2.2.1 To create an efficient, flexible, non-bureaucratic, and participatory infrastructure for international health development.

2.2.2 To build up sufficient human resources for health capable of managing international transactions at subregional, regional, and global levels.

2.2.3 To strengthen regional collaboration in health development to achieve **"regional health security"** especially among neighbouring countries.

3. STRATEGIES

3.1 Reorientation of resources

International and national resources (through **WHO,** and other concerned agencies) will be mobilized to support specific priority areas of health development at regional level in order to build up mutual understanding and partnerships in health development as well as international health capacity.

3.2 Institutional strengthening and networking

This is to create efficient network and focal points for mobilization of technical and financial cooperation among international health development institutions. These focal points require capable human resources and up to

date retrievable information. Such human resources would be recruited in the international health infrastructure to enhance the Thai leadership role in international health in the long run.

3.3 International Partnership building

Networking with international/regional technical institutions will be promoted to strengthen **Thailand's** role in the subregional, regional and global level.

4. DIRECTION OF THE IMPLEMENTATION

Implementation of this proposal should start with an initial phase of development for 3 years. After this period lessons learned through systematic evaluation will lead to long term programme to achieve sustainable international health development.

5. ORGANIZATIONAL FRAMEWORK FOR IMPLEMENTATION

5.1 **Forum for International Health Development**

In order to achieve a participatory management mechanism under the situation of the current economic crisis, it is proposed that a **"Committee for International Health Development"** be set up.

This committee will report directly to the **Executive Committee for RTG/WHO Collaborative Program.** Its main responsibility is to formulate policy and strategies for international health development. It will also determine priority issues that need to be addressed and then assign potential institutes for further development and implementation.

This committee will therefore, play a coordination role rather than being involved in direct implementation.

There will be an **Office of the Committee for International Health Development** to work as its secretariat.

Members of the committee will comprise technical personnel with ample experience in international health in the **Ministry of Public Health,** universities, other ministries including the private sector. The **Director of the Office of the Committee for International Health Development** will serve as secretary of this committee.

A highly experienced senior international health leader may be selected as the chairman of the committee.

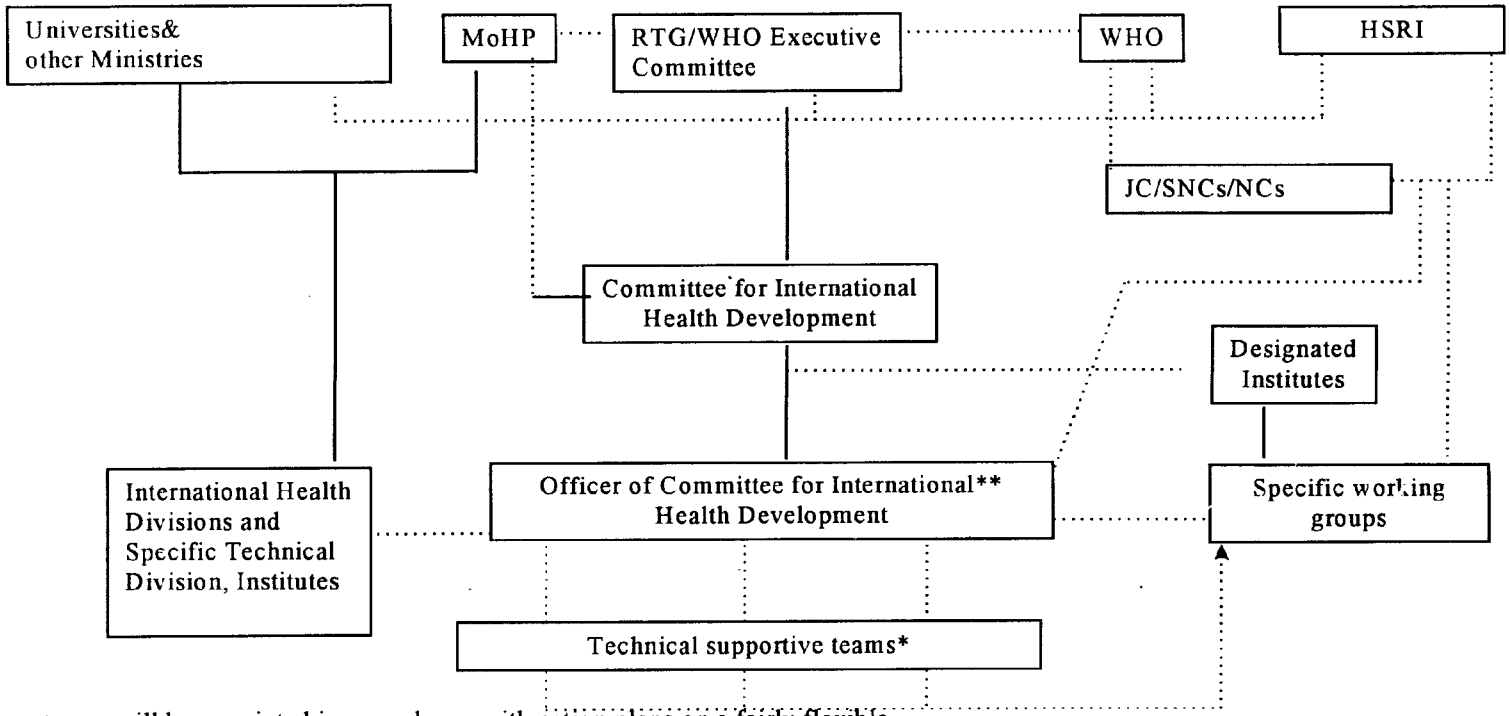
5.2 Office of the Committee for International Health Development

This will be a small, flexible and non-bureaucratic office, headed by a director with many years of international health experience and expertise and with proven capability in fostering international cooperation and mobilization of resources. The director will serve as the secretary of the committee and coordinate the activities of specific working groups responsible for priority issues of international health development. This office will work closely with the international health divisions/sections of all related departments and institutes. It will also collaborate closely with the **Joint Committee** (JC), **Senior National Consultants** (SNCs), and **National Consultants** (NCs) under the **RTG/WHO Collaborative Program,** as well as other bilateral or international agencies.

5.3 Specific working groups

A number of specific working groups will be set up to analyse and develop action plans for dealing with specific priority issues of international health development as determined by the committee. Members of the working groups should be proposed by the institutes designated by the committee to be responsible for the specific development and implementation issue. The action plans developed by the working groups, after being approved by the committee, will be supported by all relevant institutes during implementation. **WHO** support will be established through, the **JC, SNCs** and **NCs** mechanisms.

Infrastructure for International Health Development



* These teams will be appointed in accordence with action plans on a fairly flexible basis and serve as secretariat technnocally supervised by special workoing groups.
= supervisory, technical and financial support
= line of command

** This office may be set up on a temporary basic under a special project for I international health development. After a few years, when the model and the system becomes satisfactorily settled, a more permanent, small, flexible and non bureaucratic office may be set up

6. PRIORITY ISSUES FOR DEVELOPMENT

Three priority areas are proposed for the **initial phase** of development, i.e.,

6.1 Control and eradication of regional communicable diseases.

This is aimed at promoting **"Regional Health Collaboration to achieve Health Security"**, with initial focus on the control and eradication of regional communicable diseases, e.g., Malaria, Poliomyelitis, Measles, Filariasis and DHF.

This collaborative endeavors may be expanded to include other communicable and non-communicable regional health problems, e.g, Thalassemia.

6.2 Human Resources Development

This is to build up capable human resources to fill appropriate roles at the subregional, regional and international levels. These human resources should be allocated among all participating institutes. Opportunities to support **Associate Professional Officers** (APO) to work with international organizations should be explored and developed.

6.3 Regional networking for health development

This is aimed at creating regional health development training programs and seminars including networks of research and development on specific areas, e.g., Health Policy and Health Systems, Pharmaceuticals, Medical Technologies and Gerontology...etc.

Studies on health impact from current economic crisis in this region may be a good starting point.

7. BUDGET

Various sources of budgetary support will be mobilized, i.e.,

7.1 Government budget

7.1.1 Regular budget from DTEC

7.1.2 MOPH and other ministries regular budget

7.1.3 HSRI/TRF

7.2 Private organizations

7.2.1 For profit pharmaceutical and medical equipment industries

7.2.2 Not for profit organizations

7.3 International

7.3.1 WHO (country, intercountry and global budget)

7.3.2 Other international agencies

7.3.3 Other bilateral or multilateral cooperation

8. CONDITIONS FOR MAKING THE PROPOSAL FEASIBLE ;

8.1 strong political support for essential reorientation of the system and budgetary support ;

8.2 mutual understanding and commitment among all concerned **Ministries** and key personnel ;

8.3 effective mobilization of experienced well-trained and high calibered personnel to be recruited at the initial stage.

8.4 existing bilateral or multilateral assistance in health development should be redirected to support and promote international health.

6. EXECUTIVE SUMMARY

This paper aimed at documenting the chronological development of international health in Thailand with particular emphasis on the role and contribution of the **World Health Organization** in health development and international health. The study was made primarily through literary review and written records in the **Ministry of Public Health** since the time when Western medicine was introduced to the **Kingdom** during the **Region of King Rama III.** A brief review of **Thailand's** relationship with neighbouring countries and donor agencies was also made.

The history and background of the collaboration between Royal Thai Government and the World Health Organization was the highlight of this paper. Apart from presenting a comprehensive account of the relationship dated back since 1949 up to 1997 and the trend of changes in its management

mechanism, attempts have been made to analyse current collaborative system and problems inherant in actual system functions.

Proposal for future international health development was also recommended to be considered by policy makers with a view to create an efficient, flexible and progressive international health management system that is capable for enhancing the **Kingdom's** role and position in international forum, supporting regional health security and fostering constructive international socio-economic and political relations.