



Original article

Human Resources Development as Part of the Response to the Changing Paradigm of International Health Functions: The Case of Thailand

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Abstract

Several changes in the world situation necessitate the reform of existing international health mechanisms. New paradigms of international health functions have gradually evolved. To avail itself with necessary and efficient mechanisms and resources to cope up with these changing paradigms, a developing country like Thailand needs to be well prepared. This paper analyses in detail the changing international health paradigms and the situations that challenge international mechanisms existing globally and in Thailand. Human resources development on international health and negotiation skills constitute the core responses. The initial success of the recent development in Thailand is also reviewed. Finally, the conceptual framework, possible strategies and priority activities are proposed to be carried out for future international health development.

Key words: *Human Resource Development, International Health, WHO, negotiation.*

Introduction

The initial attempts at international health cooperation were started as a result of some important epidemics that affected countries all over the world, dating back to the middle decades of the last century. International health organizations, namely the Pan American Sanitary Bureau (1902), OIHP (1907), Health Organization of the League of Nations (1919), and finally the World Health Organization (WHO-1948) (Table 1)⁽¹⁾ were established mainly based on the purpose of controlling infectious diseases spreading through international trade/travel. Today, a number of different UN organizations, the development banks and the World Trade Organization (WTO), have effective mandates in health (Table 2)⁽²⁾.

Several changes in the world situation necessitate the reform of existing international health organizations and mechanisms, i.e.,⁽³⁾

1. Increasingly Complex Health Challenges from Epidemiological and Demographic Transitions.

- 1.1 Preventable health problems affecting the poor and vulnerable populations.
- 1.2 Health problems associated with development and ageing.
- 1.3 New and emerging diseases, environment-caused risks, and behavior-associated problems.

2. The Impact of Globalization

- 2.1 International health risks from travel, trade and environmental risks.
- 2.2 International and regional trade agreements such as those under the WTO Asia Pacific Economic Cooperation (APEC), North Atlantic Free Trade Area (NAFTA) and ASEAN Free Trade Area (AFTA).



3. Altered Institutional Landscape

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

3.1 UN agencies (stable or declining)

3.2 Bilateral agencies (declining)

3.3 Development banks (increasing)

3.4 Civil society (increasing)

3.5 Business (increasing)

4. Outmoded Structures of Existing International Organizations

4.1 Confined only to government sectors

4.2 Outmoded regional structures

Table 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 Health 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.
1919	The League of Nations is created and is charged, among other tasks, with taking steps in matters of international concern for the prevention and control of disease. The Health Organization of the League of Nations is set up in Geneva, in parallel with the OIHP.
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.
1995	WTO was established with several health related agreements.

Source: Adapted from the World Health Report 1998.⁽¹⁾

Table 2 Health Related International Organizations and Comparative Advantage

World Bank (+ Regional development bank)	<ul style="list-style-type: none"> * financial resources, policy advice, and technical assistance * links to ministries of finance and planning 	<ul style="list-style-type: none"> * centralized, weak country offices (staff in Washington) * narrow economic approach to health * perceived as Western dominated and ideologically driven
UNICEF	<ul style="list-style-type: none"> * effective at operational level * resources at country level * strong country offices (85% staff at country level) * advocacy role 	<ul style="list-style-type: none"> * too driven by New York and narrow goals * sustainability of initiatives * vertical approach to health
UNFPA	<ul style="list-style-type: none"> * resources * strong advocacy role (family planning) * limited technical capacity * effective procurement service 	<ul style="list-style-type: none"> * small, undergoing paradigm change from rigid population control to reproductive health * subject still vulnerable to political differences
UNDP	<ul style="list-style-type: none"> * broad development orientation * close ties to government * coordination role 	<ul style="list-style-type: none"> * diverse competence at country level * poor on advocacy because of ties to government
WHO	<ul style="list-style-type: none"> * technical and scientific knowledge * network of experts * links with ministries of health 	<ul style="list-style-type: none"> * weak at country level * two-thirds staff (of 5700) at central or regional level
WTO	<ul style="list-style-type: none"> * legal binding to all member states 	<ul style="list-style-type: none"> * may focus on trade issue which is detrimental to health.

Source: Adapted from Michaels B. **Report on the Conference on Global Health Cooperation Beyond 2000, April 1998, Mexican Health Foundation, Mexico City.** Washington DC: ODC, 1998.⁽³⁾

4.3 Strong bureaucratic infrastructures

5. Inadequate Partnerships with other Actors

6. Lack of Mechanisms for Sharing Experiences between Countries.

This paper aims at analysing the changing scope, functions, organization, and mechanisms of international health. It then analyses the situation and proposes the future development of **International Health Capacities and Roles** particularly Human Resources Development, for a developing country like Thailand, in order to benefit and contribute most to the health development at the country, regional, and international levels.

The Changing Scope, Functions, Organization and Mechanisms of International Health

1. The Scope of international health encompasses:-

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

The scope of International Health is moving from mere cooperation on control of epidemics to broader areas of health development.

2. The Functions

2.1 Criteria for International Health Functions

There are two types of international public health functions⁽³⁾, i.e.,

2.1.1 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;

2.1.2 Those that are specific to individual countries or populations, but that justify international collective action due to shortcomings in national performance or because of moral imperatives.

2.2 Essential International Health Functions

2.2.1 The constitution of WHO, one of the main international health actors, defines 22 functions of the organization⁽⁴⁾.

2.2.2 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.,⁽³⁾

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

(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.

(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.

(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.

(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.

(6) Strengthening National Capacity and Performance: building on national efforts to improve health outcomes and strengthen the foundation for global health systems.

2.3 Proposal for reform

The Conference for World Health Cooperation Beyond 2000⁽³⁾ also offers three proposals for revitalizing the cooperation between key actors in international health cooperation.

2.3.1 Strategic development: 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 More focus on International Health: International organizations which are active in health should reemphasize that international health functions are central to their roles.

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

Situation Analysis of the International Health Development (IHD) System in Thailand

1. Problems of the Existing Systems^(5,6)

1.1 Unclear direction: The clear vision and strategies of IHD have never been developed at the national level.

1.2 Inadequate structures: The existing structures narrowly confine themselves in the government sector, particularly the Ministry of Public Health (MoPH). The **International Health Division** in the MoPH mainly provides international relations services and possesses inadequate public health capacity for efficient technical cooperation.

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

1.4 Weak institutional capacity: There are **no international health experts** in Thailand, and there is no definite plan to develop them. Those that used to work in this area usually depended on their personal capacity without continuity of wisdom. Most international health information is scattered and can not be retrieved easily.

2. Need for reform

Apart from several changes at the global level as mentioned above, there are also changes at the country level, during the past decade, which push for the reform of the existing system.⁽⁵⁻⁷⁾

2.1 Level of development of the country: Thailand has become a middle income country since the last decade. Despite the economic crisis, the GDP/capita is still at the level of US\$ 2,000 (or US\$ 7,000 - purchasing power parity). This resulted in a great reduction of international and bilateral grant aid to the country. Most bilateral health aid has been terminated. The WHO country budget, at the level of US\$ 6.4 million (the 7th rank of the global WHO country budget) is going to be reduced. The Thai Government initiated the “Thai International Cooperation Program” in 1961. This programme aims at providing bilateral assistance to least developed neighbouring countries. In 1992, the budget of this program was increased from US\$2.5 m. to US\$8.5 m. and to US\$16 m. in 1997 as a result of the economic boom. This fund was greatly reduced (down to US\$3.5 m. in 1999) after the

economic crisis.

2.2 The economic crisis: The current economic crisis greatly reduced the public health budget as well as the Thai aid fund. Thus, international health cooperation is becoming more important to health development. The increasing role of the development banks in various structural adjustment programs, including health, are clearly evident⁽⁸⁾. The Asian Development Bank’s (ADB) social investment loan to Thailand in 1998-1999 provided technical supports and identified certain conditions for Thai health system development, e.g., Hospital Autonomy. The coming WB Public Sector Reform loan will definitely propose additional health systems reforms. These may be threats as well as opportunities for the Thai health system. Good international health negotiation skills are definitely needed to achieve the best reform package for the country.

2.3 Increasing health development capacity: The past success in several aspects of health development in Thailand resulted in the accumulation of great social assets in health, both at the institutional and individual levels. For example, the success in Family Planning, Primary Health Care development, Maternal and Child Health, Immunization, Tobacco Control, Health Economics and Health Care Financing, and Food and Drug Control can be considered as part of this success.

These can be shared and used to strengthen the Thai role in international health cooperation and even help improve the foreign exchange situation. One evidence of such capacity is the number of WHO fellows placed in Thailand (339 in 1997, and 225 in 1998), which is at the level comparable to the USA (Table 3)⁽⁹⁾. The difference is that most fellowships to Thailand are short term in nature. Another evidence is the abundance of WHO collaborating centres in Thailand, numbering 26 centres in 1998.

2.4 Increasing regional and bilateral collaborating mechanisms: Recently many new regional and bilateral health related collaborations

Table 3 Top ten host countries for WHO fellowships, 1992-1996.

Country	Region					Total for top 10 countries	Remarks
	Americas	South-East Asia	Europe	Eastern Mediteranean	Western Pacific		
1. United States of America	10.0						Africa has no countries represented among the top ten 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 ten 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/HQ.

have been developed, e.g., the Intercountry Cooperation for Health Development in the 21st Century (ICHCD), the Mekong Basin health projects, ASEAN subcommittee on health and nutrition, the bilateral cooperation agreements with neighboring countries, and the south-south collaboration. To benefit and contribute most to these collaborations, there is a need to rapidly strengthen international health capacity, particularly in human resources.

2.5 Increasing international health politics: Issues related to resource allocation, vested interests in international trade, and politics in international organizations are affecting and maneuvering all developing countries including Thailand. International politics and vested interests have intruded more and more into the international health arena/fora. The serious negotiations on WHO's regular budget during the 51st and 52nd World Health Assembly (WHA), and negotiations regarding the General Agreement on Trade in Services (GATS) and

Trade Related Intellectual Property Rights (TRIPS) in the WTO are good examples.

2.6 Inefficiency and non-transparent management of international health activities: Particularly the management of international health resources allocated to Thailand, e.g., past practices involving the **WHO country budget**, as well as the government budget for international business negotiation. Information on collaborations between international organizations and Thai organizations are scattered and fragmented. No one in the MoPH knows the overall picture of MoPH and UNICEF collaboration.

3. Movements in the Last 24 Months⁽¹⁰⁾

3.1 Development of Clear Vision and Strategies

The strategic plan for International Health Development (IHD) was developed and debated in several multidisciplinary and multisectoral fora. Then, it was finally proposed to and

approved by the International Health Development Policy Committee of the MoPH in July 1998.

3.1.1 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”.

3.1.2 The strategies:

(1) Development of effective international structures and mechanisms to address common health issues, especially these transcending national borders.

(2) Human resource development.

(3) Development of Knowledge-based IH systems for mutual benefit.

3.2 Outcome achievements :-

3.2.1 Development of effective structures and mechanisms

(1) Many **cooperating mechanisms for IHD** were developed (Figure 1)⁽⁶⁾. These mechanisms aim at facilitating joint programming and exchange of information. They are not aimed to be managerial bottle necks.

(2) **Reform of the secretariat office.** A proposal to establish a **“Bureau of International Health”** to replace the existing **“International Health Division”** is being developed. This new structure will provide both technical and managerial support for IHD activities. It will be the technical secretariate to all international cooperating mechanisms. The personnel will be drawn from the existing International Health Division, as well as public health specialists from other organizations on both full time and part time bases.

(3) **Reform of the Royal Thai Government (RTG)-WHO collaborating mechanism⁽¹¹⁾.** This is aimed at improving efficiency, transparency, and institutional collaboration, in order that limited WHO resources can be best used to support national priority health needs. A

Figure 1 Structure and mechanisms of international health collaboration

decentralized management system under Senior National Consultants/National Consultants (SNCs/NCs), supported by experienced reviewers and supervised by the Joint Committee was developed (Figure 2). Clear and transparent guidelines for submission of project proposals and extensive announcements through both official letter and the Internet were accomplished. The efficiency of the upstream process was much improved with the obligation rate of more than 80% of the 1998-1999 biennial activity budget by the end of 1998, as compared to 15% and 30% in the previous two biennia. Out of the total of 349 projects proposed and reviewed, only 226 were approved, with an approval rate of 64.76%. The total proposed budget for all submitted projects was US\$5,541,321 and only US\$ 2,881,934, or 52.01%⁽¹²⁾, was approved.

(4) Reform of the mechanisms to prepare for high level international health meetings, i.e., WHA, Health Ministers meeting, Health Secretaries meeting, and Regional Committee (RC) meetings. Active and progressive preparation, with involvement of concerned organizations both public and private, has been

implemented.

(5) Reform of other bilateral and multilateral health cooperation

A Working Group (WG) for each type of bilateral and multilateral health cooperation was set up. These WGs were chaired by appropriate senior health officials with strong secretariat support from different technical divisions, which have highest number of relevant cooperation activities. The aim of these WGs is coordination. Management bottle necks are strongly avoided.

3.2.2 Human Resources Development

These are the core activities which will support long term and sustainable development.

(1) International Health Scholars (IH scholars)

A project to recruit and develop international health scholars was proposed jointly by the Bureau of Health Policy and Plan (BHPP), Praboromrajchanok Institute for Health Manpower Development (PBRI), and the International Health Division, and approved by the MoPH. The aim is to develop a critical mass

Figure 2 Structure for RTG-WHO collaboration in Thailand, 1998-1999.

IHD = International Health Division
BHPP = Bureau of Health Policy and Plan.

(at least 50) of high capacity IH scholars to support future IHD. More than 200 applications, on a voluntary basis, from different departments of the MoPH, universities, and other organizations were received. Only 48 candidates were selected based on age group (30-45), English proficiency (TOEFL more than 500, IELTS more than 6.0, or local language testing score more than 70%), and distribution among different organizations. The second batch of scholars will be recruited after an evaluation of the first year of implementation.

These candidates will be considered as International Health Scholars. They will be the priority group in the development of human resources for IHD.

(2) Systematic Training

• Short course.

A three week training course on international health was developed and carried out by the College of Public Health, Chulalongkorn University (CPH-Chula), with the support of the MoPH, WHO/Thailand, and WHO/ SEARO. The first two weeks were for course work at the CPH-Chula focusing on international health functions, international organizations and mechanisms related to health, and international negotiation skills. The final consisted of field study to attend the World Health Assembly including visits to international organizations in Geneva. The selected trainees had to participate actively in the WHA. WHO/ SEARO provided financial support for one participant from each SEAR country. Participants from other regions or additional participants from SEAR countries had to find their own financial support. This course may be held again once (before the WHA) or twice (before the RC meeting) depending on the success and demand. Active international health scholars were selected to be the priority trainees.

• Long term training

A master degree on IHD is being developed by the CPH-Chula with financial support from WHO/SEARO. This should be available in the

year 2000. This course aims at longer term IH human resource development.

The Asian Institute for Health Development (AIHD), Mahidol University, has also expressed interest in developing this kind of long term course. It may develop a master degree course on IHD specifically for rural hospital doctors.

• Regular meetings of the IH scholars

The first meeting was held in December 1998. Monthly or Bimonthly meetings among the 48 IH scholars were agreed upon. The meetings will be full day and comprise external resource persons on several topics, e.g., negotiation techniques, WHO-its function, structures, and work processes, and presentation by the IH scholars themselves, e.g., Border health in real action, clearing house of information on IH, Health Systems in various countries, etc.

In their last meeting in June 1999, four scholars presented the health systems of four countries where they have had experience.

This is a process to strengthen their international and public health knowledge, to promote stronger networks, as well as to evaluate their commitment to IHD.

• Participation in IH forum.

IH scholars will be selected, according to their active involvement, to participate in different IH fora both in Thailand and overseas, for example, participation in the Regional and National workshops for IHD, and in the technical review meetings for RTG-WHO collaboration. Some of them will also participate in IH fora outside Thailand, e.g., meetings of WG to evaluate efficiency of WHO Regional and Country Offices, Joint Programming Initiative meeting, Consultative Committee for Program Development and Management (CCPDM), Regional Committee (RC) meetings, and the World Health Assembly (WHA). To participate in the international health forum, e.g., the WHA or the RC meeting, they have to meet three requirements. First, they need to prepare at least one technical paper on the issue that is going to

be discussed. Second, they have to intervene at least once during the meeting. Third, they have to finalise their report before they return home.

During the 52nd WHA, five IH scholars successfully intervened in several meetings of Committee A, and Committee B. They were very proud and felt more confident in attending international meetings.

3.2.3 Development of Knowledge-based IH systems

(1) IH information clearing house:

This is in progress and the detailed work plan was presented to and approved by the meeting of IH scholars in March 1999. It is under the responsibility of Health Statistics Division, BHPP with WHO financial support.

This information database will include the organizations and persons responsible for international health, and the funded projects of each organizations. A webpage will be created with regular updates to facilitate easy access, and to allow access to other IH related websites

(2) English language publications:

English language publications were supported, for example, Health in Thailand 1995-1996. The 1997-1998 issue is now in progress.

(3) IH research:

Only one proposal to analyse the previous RTG/WHO collaboration and suggest future forms of collaboration was proposed and implemented. The final report is pending.

Future plan

International Health development has to be linked and closely related to overall national health system development and the dynamics of globalization (Figure 3). The IHD systems should be comprehensive and focus on essential IHD activities to strengthen national IHD capacities (Figure 4). The three main horizontal supportive activities, i.e., Human Resource Development, Management Structure and Mechanism, and Knowledge Development, should be interwoven with the six international public health functions

Figure 3 Conceptual framework for IHD

as described (Figure 5).

Three main future actions are proposed:

1. Further Strengthening and Development of the New Structures and Mechanisms.

1.1 The new Bureau of International Health will be strengthened through staff support and management reform.

1.2 The WHO role in Thailand may also be reformed to include two main functions, i.e.,

the WR Country Office activities, the Liaison Office to the Economic and Social Commission for Asia Pacific (ESCAP), and coordination of biregional (WPR/SEAR) projects, e.g., the Mekong Basin Disease Surveillance Project, the ACT Malaria Project, the ICHD mechanism, etc.

1.3 More active participation will be sought from non MoPH government organizations and civil society in the IHD activities.

1.4 The WHO Collaborating Centers in

Figure 4 IHD systems

Figure 5 Framework of IHD

Thailand will be strengthened.

1.5 Mechanisms to build more linkages with International Health Organizations to increase sharing and transferring of wisdom will be developed.

2 Human Resources Development (HRD)

HRD aims at strengthening international health wisdom at the individual and institutional levels.

2.1 Targeted human resources development on international health in all concerned government and non-government organizations will be the main focus. This includes English and other international language proficiency, communications and negotiations skill, cross cultural sensitivity, and understanding of international etiquette, norms, protocol, rules and regulations, including general and specific public health issues. The three-week short training course on international health and the master degree course on international health will be further developed and strengthened.

2.2 Long term fellowships for junior Thai public health specialists to work as fellows with relevant departments of WHO/SEARO, and WHO/HQ will be supported to gain more indepth skills in international health issues.

2.3 Long term development of Health Policy/Health Systems Research (HP/HSR) researchers and analysts to support international health development. A project to develop at least 50 Ph.D. graduates on HP/HSR has been developed by the Health Systems Research Institute (HSRI) and approved by the MoPH, and the RTG-WHO board⁽¹³⁾.

This is a 10-year project. Each trainee has to work as an apprentice with a senior researcher in the first year. After that she/he will be evaluated on the basis of commitment, attitude, and English proficiency. If approved, she/he will be supported to attend a 3-4 year Ph.D. course at selected international institutes in USA, Canada, or Europe. After graduation, she/he will have to return and work as a fellow with a senior

researcher for another year before being placed at an appropriate institute. Their dissertation also needs to be done in Thailand.

These 50 HP/HSR Ph.D. graduates, if successful, will be important core international health experts for Thailand in the future. They will also be resources for further internal production of Ph.Ds. in HP/HSR.

2.4 Clearer and more definite career paths for international health experts will be developed.

2.5 Evaluation of the existing activities will be carried out in order to improve future implementation.

2.6 Support will be provided to place Thai public health experts into international health organizations, as consultants, expert committee members, professionals and at higher management levels.

3. Development of Knowledge-Based IH System

3.1 IHD research: Several areas of research to support IHD will be supported as follows:

(1) Situation analysis of the WHO Collaborating Centers in Thailand and recommendations for future development.

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

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

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

(5) Evaluation of existing international health mechanisms at the regional and global levels as related to Thailand, and recommendations on the appropriate role of Thailand in

such arrangements.

(6) Development of guidelines and handbook for international health activities.

3.2 IHD networks: Apart from the network of IHD scholars, higher level networks as well as networks in some specific areas to support IHD, need to be developed and strengthened, e.g., HP/HSR network, and all other six areas under ICHD^(14,15). Strong WHO Collaborating Centers in Thailand can be potential coordinators of several networks. These coordinating roles will increase the Thai capacity to serve as a center for coordination among countries in the Indochina region. Several health development projects related to international level activities could also be linked and mutually supported. These projects should focus on the mutual benefits to be obtained through effective international health coordination.

3.3 Support of International Publications/Communications

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

(2) Support should be provided for the publication/development of International journals/webpages in Thailand, e.g., the HSRI journal, Human Resources for Health Development Journal (HRDJ), and Journal of The Medical Association of Thailand (JMAT).

(c) The publication of specific reports in English, e.g., Health in Thailand, should be supported.

Conclusion

A developing country like Thailand needs to expand its international health capacity in order to cope with rapid changes in the world environment. The success of such an endeavour depends on systematic planning and serious implementation with adequate policy support. During the past two years, several components of the international health development system

were successfully created and strengthened, focusing on short-term and long-term human resource development. Further developments will be based on the real reform of the international health structures and mechanisms, long term human resources development and the development of knowledge-based international health systems.

These lessons can be good lessons to share with other developing countries. It is the network of strong international health experts from developing countries that will allow these countries to benefit most and lose least from the changing world power.

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