THIRD SESSION
ROLE EXPECTED FOR INTERNATIONAL HEALTH COOPERATION

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THE ROLE OF WHO IN PROMOTING INTERNATIONAL HEALTH COOPERATION

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Introduction

It is an honor and privilege for me to address this distinguished gathering. Many of you here are high-level decision-makers at the national level, or perhaps you suffer from the various health policies of higher level decision-makers, especially as those policies relate to international cooperation.

One thing that I would like to say at the outset here is that investing in health does save money. Many countries, especially developing countries, are wrestling with severe economic problems which may constrain their ability to properly implement health policy. Each country's policy, as well as international cooperation policy, may have to be reoriented so that health problems can be addressed.

As you know, in the 1970s, many developing countries have not able to honor their debts. They have been strapped for funds. So one of the important things I would like to discuss today is how health development creates money.

But before doing so, I would to review the situation surrounding international health cooperation today. It should be remembered that when WHO was created in 1946, its founding fathers perceived that the role of international health cooperation was so important that it was listed as the first of the Organization's functions. The first paragraph of Article 2 of the Constitution states that the Organization is to act as the directing and coordinating authority on international health work. Thus, from its inception, promoting health cooperation has been seen as pre-eminent among WHO's roles.

International cooperation in health is, of course, a very broad term,

and rightly so. It involves all countries, whatever their stage of development. It is not just a matter of technical and financial support to the developing countries, important as such activities are. It implies an active and continuing partnership between all countries from which all derive benefits. The role to be played will vary, depending on national capacities, but there is a role for every country, and this is most important. Some institutions have initially built the container and, to some extent, the contents, but the contents themselves have been to be developed and reoriented by recipient countries themselves. I think this is the right approach to be used, not only in the Asian and Pacific countries but also all over the world, especially in the countries of Sub-Saharan Africa and Latin America, which suffer currently from a very difficult health and economic situation.

Situation in Developing Countries

It is, nonetheless, true that WHO has focused a great deal of its attention on the plight of developing countries and, in particular, those classified as "least developed" countries. The situation in the developing countries and, in particular, those classified as "least developed" countries, gives more than enough cause for a greater concern.

The figures themselves are shocking :

- four million children under the age of five die every year from diarrhea alone ;
- one child dies of measles every 20 seconds due to lack of immunization ;
- at least one million individuals, mainly children, die each year from malaria ;
- half a million women die each year of causes related to pregnancy and childbirth.

The underlying causes of these horrifying figures lie in the socioeconomic environment in which these women, children, and men live and die. It is estimated that one billion human beings live today in a state of malnutrition, hunger, and disease, trapped within the vicious circle of poverty. This number is equal to the combined population of Europe, the United States

of America, and the USSR.

It is estimated that 100 million individuals have no adequate shelter, and that over 50% of the population of the developing countries have no access to safe drinking water. The economic problems underlying these bare statistics are highlighted by the figures on government expenditures on health which vary from less than US $ 5 per person in the least developed countries to over US $ 1000 in the industrialized countries.

Fundamental Problems

The problems which impede effective implementation of primary health care in the developing countries fall into two main categories. On the one hand, there is undoubtedly an absolute lack of financial resources, with generally poor economic performance, often aggravated by other factors such as natural, and sometimes man-made, disasters. However, no less important are such factors as widespread weaknesses in the organization and management of health services, poor health information systems, lack of intersectoral cooperation, and weak and ineffective coordination of both internal and external resource inputs. To this must be added a lack of skills in the area of health economics, with resultant deficiencies in the rationalization of health care financing.

This morning, many of you talked about health research, and maybe we have to look at the number of medical doctors versus health economists and lawyers interested in health. In some countries the number of lawyers interested in health exceeds the number of medical doctors. There are very few health economists, and we hope that one day medical doctors will be trained not only in medical skills, but also in management skills including legal, political, and economics skills.

Gap between Rich and Poor

The Asian and Pacific regions exhibit very clearly the mixtures between deteriorating conditions in some countries and marked success stories in others. Looking at the global picture, we must remember that in 1971, 25 countries were classified by the United Nations as "least developed", where

as by 1990 this number has grown to 41. The 1980s were a lost decade. We must put a stop to this descent to disaster, wherein the gap between rich and poor is enlarging, and there is a rapid increase of least developed countries, or so-called "poor" countries. The rich become richer and the poor become poorer.

Initiatives by WHO

With the objective of halting and reversing this calamitous situation, WHO has resolutely taken a new initiative to intensify its support to those countries and peoples in greatest need, not only to the least developed countries but all countries in need. This strategy involves the closest collaboration among all levels of WHO and is based on a country-by country approach. We are seeking to develop new and active partnerships with other international development agencies and the development agencies of the industrialized world.

A pervasive and consistent underlying problem has been the economic conditions in most developing countries. The influence of global macroeconomic policies, their effects at the national level, and the implementation of structural adjustment policies are inadequately understood by many governments and, more especially, by their health ministers.

Our country-centered approach emphasizes better integration and coordination of all WHO programs of cooperation within a country, together with the close alignment of WHO activities with national health priorities. It also lays special stress on the need to support countries in developing increased capabilities for dealing with the analytical, management, economic, and financial aspects of health strategies.

Commitments by WHO

The WHO approach requires a commitment by the national authorities in each country concerned to take a fresh and realistic look at its health priorities and available resources. The government must be prepared to recast its national health plan, or to vary it, and to reallocate existing resources if the reappraisal indicates this to be necessary.

At the same time, WHO will commit itself to re-examining the allocation of its own resources, and will develop some degree of flexibility in the utilization of its funds at the country level. The outcome of this process will naturally vary from country to country. However, in most cases, it can be anticipated that it will lead to the development of better integrated, well-coordinated, and more realistic national health development plans, as well as health systems and infrastructure development that meet the realities of the availability of human and financial resources.

An important result of the approach will be an increased capability for planning, programming, and management in the health sector. This will, of course, be of direct benefit to the countries concerned. It will also provide a guarantee of a greater capacity to absorb, and to use effectively, resources provided by WHO and by other cooperating organizations.

WHO's experience to date has indicated that it will be necessary to improve the effectiveness of existing aid flows, and this will include better management and coordination. In addition, it is essential that the volume of aid to those countries in greatest need should be increased substantially, in a manner that is sustained over a number of years. Industrialized countries must recognize that developing countries will require adequate additional external financial support on a long-term basis. We need sustainable assistance. Fundamental changes in aid modalities for the health sector are required, both to limit dependence and to increase the effectiveness of aid. Experience has taught us that the basic need for the health sector of these countries is for technical and managerial inputs and for the appropriate development of human resources. Without these, even presently available funding cannot be adequately absorbed and utilized.

Creating Partnerships

WHO is seeking new forms of partnership with development agencies. It is convinced of the need to work with them from the earliest stage of identification and formulation of recipient countries' priority programs and activities. It goes without saying that this partnership will include the national health authorities of the countries concerned.

The modalities of such partnerships could, for example, include joint missions for program identification and preparation, and the establishment of technical services agreements for program execution. Mutual exchange of expertise would be invaluable for the monitoring and evaluation of program development. Arrangements could be envisaged for co-financing plans for sustained development with consultation among the cooperation agencies involved. WHO's knowledge and expertise, when matched with that of the development cooperation agencies, would benefit all parties involved at the country level.

International policies must be developed to ensure that multilateral and bilateral partners work within a common framework to strengthen governments in attaining their health sector priorities. Joint programming by donors, in full consultation with the government and in coordination with WHO, would improve the effectiveness of aid programs.

Health Economics

As part of WHO's intensified collaboration with countries, and a more integrated and sharply focused drive to overcome obstacles to the effective implementation of primary health care, it is recognized that a heightened appreciation of the importance of health economics is a vital and integral component.

I have drawn attention on several occasions to the close relationship between the state of the world economy and health development, especially as it affects the less developed countries.

In many countries the political and economic environment is changing, in some cases at a near-revolutionary rate. Countries' health objectives, and the appropriate structures and processes to achieve them, are also entering a period of fluidity and change. Even in the countries not directly affected by recent political changes, people's health care expectations and demands continue to rise, new technologies are continuously being developed and disseminated and, of course, even the demographic situation in developing countries is very rapidly changing.

Identifying and assessing economically feasible options for the

financing, delivery, and administration of health services will become one of the principal components of WHO's work in health economics. This does not mean that WHO will advocate particular policy instruments, such as compulsory health insurance or voluntary health insurance, or user charges in any particular form. WHO's concern is to cooperate in identifying changes in the organization, financing and delivery of health care that have a beneficial effect on the overall health status of that particular country.

WHO adopts a pluralistic approach. In the provision of health care, it does not advocate any preconceived ideology, whether based on a centrally planned or a free market economy.

The choice of appropriate policies for achieving the health-for-all objective is a choice that must be made according to local and changing needs and opportunities and in full consultation and involvement with the community to be served. We must never forget the central role of people. It is they who create and constitute the wealth and formulate the values of society.

WHO's role in health economics is to contribute to this process by giving technical support in the identification and appraisal of policy options and by disseminating such experiences internationally.

There is much to be done in this area. It is often the case that in the design of national plans for health development, political considerations overshadow economic realities. Careful cost assessments and realistic epidemiological projections form part of the considerations for each health development option, and fiscal realism and an understanding of the determinants of the demand for health care, including community views, are major criteria to be used in appraising alternative policy choices.

The concept of health economics must not be regarded as a theoretical exercise. Very practical applications abound throughout the development and delivery of health services. What is needed is a careful selection and effective utilization of appropriate technologies and strategies in each situation. The rational use of drugs and an integrated approach to maternal and child health programs, including family planning activities and nutrition programs and programs on immunization and acute respiratory

infection, can be utilized in increasing the effectiveness of health development activities. Other examples for achieving a rational and maximum utilization of available resources lie in the use of the school system for health education activities and community orientation for health programs in urban areas.

The tools and methods for option appraisal are available. The challenge is to ensure that they are well- and widely-used and are adapted to rapidly changing conditions. WHO's initiatives in health economics will attempt to achieve this ideal. Management by information, in addition to management by long-term planning, is essential to ensuring sustainable development in the health sector.

Role of Developed Countries

Developed countries have a crucial role to play, not only through their capacity for bilateral cooperation with developing countries, but also through the influence that they can bring to bear on multilateral development agencies, such as the international Monetary Fund and the World Bank, and also in wider spheres, such as international trade and monetary policy. New and innovative thinking is needed with regard to the intolerable burden of international debt, which hampers the development of so many countries of the Third World. Possible alternatives, such as the conversion of such debts into local currencies to be expended in the health sector, need to be given active consideration.

However, the developed countries must not be looked on merely as sources of financial support. Even more important for lasting development is the need for technical skills and expertise, together with the knowledge acquired, often painfully, through a succession of successes and failures. The transfer of appropriate technology in the health field should be taken into account together with human resources development in developing countries. It is this hard-won knowhow that is so necessary for the developing countries in their struggle towards better and more effective health services and a higher standard of health for their peoples. This knowledge needs to be adapted judiciously to the social and economic framework of each society, but it is of priceless value.

Role of WHO

Health must no longer be regarded purely on a humanitarian basis. Again and again, we must emphasize that a healthy population is essential for continuing and sustained national development, and that it is a wise investment for national development. It is the role and responsibility of WHO to continue to act as the advocate for health in all appropriate forums.

Acting in its capacity as a clearing house for information on the health status and problems of its Member States, WHO is in a position to provide very considerable assistance to the cooperation agencies of developed countries. WHO has much information available on the policies, plans and priorities of its Member States and is eager to share this information with development agencies in a cooperative effort. Moreover, WHO's regional structure and the presence in almost every developing country of a WHO country representative, together with professional staff, can allow for significant collaboration in program identification and formulation, as well as in monitoring ongoing activities.

In this opening year of the decade, we have seen dramatic changes in many countries — changes in both politics and economics. This is a period of fresh thinking with new horizons appearing for many people throughout the world. With reductions in international tensions and significant disarmament by major powers, it is time to review how the industrialized countries can best work together with the countries of the developing world to reduce the inequalities which exist in health. It is surely not unrealistic to hope that the wave of change which has produced such sweeping alterations in so many parts of the world, can be translated into the field of international economics, and that originality and innovation can be applied to the problems of international indebtedness and economic policies. If, for example, only a small proportion of the funds previously used in the armaments race could instead be devoted to developing health services in the Third World, some of the horrifying figures I quoted earlier could be significantly reduced.

Focus on People and Communities

However, governments and ministries of health cannot improve the health situation alone. There must be a focus on the needs of the community and thus the people themselves must be actively involved in planning for, and promoting, their own health and that of their children. It is at the community level also that the influence on health of other sectors, such as education, food supply, transportation, communication, and irrigation, is most clearly visible and understood. There, as a result, a closely interwoven pattern of truly effective intersectoral activities can be developed.

I remember my talk with some of the Thai Health authorities, and they told me that Thailand has successfully implemented to an extent so-called "primary health care" or "initial primary heath care" in community development, but genuine primary health care development is this decade's program. They said that only intersectoral cooperation can bring about genuine primary health care development. Health is a fundamental human right and it is for the people themselves to play an active role in ensuring the acceptance of this philosophy. It is only by involving individuals and communities that ministries of health can ensure that the services they provide are equitable in distribution, are of acceptable quality, and are delivered efficiently.

It must be emphasized again and again that a healthy population is a productive population and that no significant socioeconomic development can take place without it. We must rid ourselves of the idea that the health sector is only a consumer. It is, in fact, a productive sector——this is what I want to say——and its product is a population with the energy and will to advance a country's economy. A healthy and productive population remains the greatest guarantee of continuing peace for the nations of our world.

It is for the developed countries to take up the challenge. WHO stands ready to place its technical resources at the disposal of all who will join in active partnership to reverse the worsening worldwide health situation, and if we work together now we can ensure that, in contrast to the lost decade of the 1980s, the 1990s becomes a decade of hope.

REPORT BY RAPPORTEUR

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Opening Session

We started out by being greeted by the President of JICA and by the Minister of Foreign Affairs, Dr. Nakayama, who reiterated the commitment of Japan to its role in medical cooperation, especially in these changing times. The humanitarian concerns of Japan and the commitment to address basic human needs were emphasized by both individuals who gave their greetings to us.

We also received a letter, if you recall, from the Prime Minister of Malaysia, who also reiterated the importance of health and medical cooperation and was especially concerned about the area of technology transfer.

Following this, we moved to the keynote address, a very exciting talk by Dr. Carl Taylor, who expressed optimism about the improvements that can take place in health over the next few decades, but noted that these improvements will not occur unless we achieve equity, unless we achieve the goal of health for all by the year 2000. He set some goals for us——I think modest goals for what we can do——and they are to decrease under-5 mortality by one-third or to less than 70 per 1,000, to decrease maternal mortality by half, and to decrease under-5 malnutrition by one-half.

He noted the extreme importance of networking, particularly in schools of public health and in research areas, and gave us some examples of this from his work in China and in India.

He emphasized the need for a broad-based approach, not a simple

categorical approach, and reminded us that change can be very rapid, and I will show you a brief example of that.

This was followed by some remarks prepared by Dr. Shimao (but which were read by Dr. Ishikawa) who reviewed very briefly Japan's experience since the Second World War.

First Session

We then moved into our First Session where we looked at the health care status of a number of countries, many of whom were undergoing health transition. We heard from Dr. Prakrom of Thailand, Dr. De Leon of the Philippines, Dr. Perera of Sri Lanka, Dr. Abu Bakar of Malaysia, Dr. Basudev of Nepal, Dr. Chee of Singapore, and Dr. Soeradi of Indonesia.

The major observation that I take away from this session was the tremendous range of problems and also some of the similarities. The Asian region is a vast one, both in terms of area and in terms of population. Over one-half of the world's population lives in this region. It is tremendously varied, however, in terms of its geography and its cultures, although there is a similar thread that weaves its way through this area.

But look at the differences: infant mortality rates range from 130 to 8; maternal mortalities range from 11 to 1,000; life expectancies range from 47 to 73; per capita incomes from 150 to 8,000 dollars; physicians, from 1 per 23,000 people to 1 for every 1,300 people; (I am excluding Japan, by the way, from all of these analyses since they are our host) nurses from 1 per 9,000 population to 1 per 600. So tremendous differences exist.

Let me briefly give you some data from a particular country. The infant mortality is over 150: this is for 1925. If we went back to 1918 the infant mortality in this country would be 190. That's higher than any country in the Asian region at this moment; however, infant mortality in 1985 was less than 6. That country is Japan. So in this very country that we are in right now, not that many years ago, 70 years ago, the infant mortality was over 190. We have tremendous lessons just where we are right now.

Many of the speakers brought up examples of health problems that

are pre-transition and post-transition. Some of the countries are in the pre-transition phase, wherein children have problems with diarrhea, ARI, polio tetanus, undernutrition, malaria. Countries in the post-transition phase, such as Singapore and Malaysia, have to confront problems such as congenital defects, growth failure, micronutrient deficiency, mental development problems, and injuries.

If we look at adults and the elderly, again we see very different patterns that exist in Asia itself. In the pre-transition phase, there are tuberculosis, malaria, AIDS and STDs, chronic parasitic infections, injuries, and maternity problems.

As we get into the post-transition phase, circulatory diseases, cancer, injuries, particularly automobile accidents, AIDS, STDs, etc. become dominant.

This was certainly brought out in the First Session. For example, in Thailand there are a tremendous number of automobile accidents and heart disease.

Singapore reminded us of what they had done in terms of automobile accidents by requiring seat belts, by having mandatory car inspections and very strong rules against drunk driving. Dr. Perera suggested that maybe we ought to go to Singapore to find out what we ought to do, that right in our own backyard are the answers to some of our problems.

This is another thing that came out of this particular session, that is, the number of experiences within regions that are transferable, that many of the answers to problems that exist within these regions are found right here and that more communication of this sort is needed to go on.

There are other countries, of course, that are in a pre-transition stage. Problems in Bangladesh and Nepal were brought out: tremendous problems with just getting around the countries create real challenges for the health system.

We then moved into the session on training and human resource development, and Dr. Han gave us a very nice review in his area where he looked at the major obstacles for health improvement and saw in this the need for increasing training of personnel. He saw this as the major impediment. There are not enough nurses, there are not enough field workers,

there is mal-distribution. All of these were brought up in his talk. He warned us of being overly concerned with academic excellence.

Dr. Gani from Indonesia again reiterated the shortages that were present in his country and the need to look at the facilities and the population to determine what the manpower needs should be.

Dr. Lewis from Fiji explained the new concept for the medical school that was being developed, and the need to again determine what the people felt was necessary and the kind of practitioners that were required. He reminded us that the primary health care practitioners would still remain the cornerstone of the health system within Fiji, that services must reach the people.

Dr. Mahmud of Malaysia again reiterated the shortages that they faced, particularly in the area of specialists. The need for continuing medical education was brought out in his remarks.

Mr. Dayal of India reminded us that education does not just begin with health personnel, but is important from the beginning, and, certainly, we know that one of the strongest correlations with reduced infant mortality is the education level of women in the society.

In terms of shortages, there was a particular shortage in India of ancillary health personnel.

Dr. Chua from the Philippines again reiterated the need for training in this particular region.

During the discussion, Dr. Ansari pointed out the need for coordination amongst the donors in terms of training programs.

Mr. Robert Clay of USAID, as well as Dr. Mohamud, made a very important point regarding in-service training, that is, it is important to monitor the progress of the workers after the training end to help them use the skills they have learned.

Mr. Song from China pointed out the need for fellowships and the need for training programs and that there just were not enough fellowships to send people out for the kinds of training that could not necessarily be done in-country, and the need for training programs in-country.

Professor Ramalingaswami reminded us that in terms of manpower

development we have to bring together universities, planners, and practitioners, that we have to meld all of these together in our training program.

Dr. Habte closed this session by reminding us of the conflict that oftentimes takes place between the producers, those that train health personnel, and the consumers, who may have different needs.

We then moved on to a session which looked at some of the international cooperation that was taking place and at what some of the donors were doing.

Dr. Kondo reviewed for us some of the work that JICA was carrying out and looked at two areas, software and hardware, hardware being the building of buildings, providing of equipment and so on, whereas software includes technical cooperation and training.

There are two different kinds of aid that JICA gives grant aid and technical cooperation. I won't go into that in detail, but it is extremely well-pointed out in the booklet, which is distributed in the Symposium. It's a very very good description of the health program of JICA and what they are doing. He noted the need to review their work and to determine what programs were working and which were working less well. I view the world as varying degrees of success rather than varying degrees of failure. I think that's a far better way to look at things, the glass being half full rather than half empty.

Mr. Robert Clay of AID reviewed the work of USAID and noted that it was based on three principles : the pursuit of economic growth, the development of local strength and self-sufficiency, and the support of pluralism. The AID budget at the moment is upwards of 300 million dollars. They are working in 70 countries, with heavy emphasis on 22.

Child survival has been a cornerstone of their work. In the past, diarrhea and EPI have received most of their funds, but they are branching out more and more into acute respiratory infection, breast feeding, maternal health, AIDS, water and sanitation, and vector control. He pointed out the importance of partnerships in all of this.

Professor Jane Kusin of the Netherlands gave us, I think, a goal to

shoot for. The Netherlands gives 1 % of their GNP to international development work, and is one of the three highest donors in this area. Their amounts are small, but they do work in 23 priority countries.

Reducing maternal mortality has a very high priority, and, I noted, within this region the differences between those that have done very well and those that have not are on the order of 200 to 1. It is rather sobering to realize that the improvements in maternal mortality, in fact, have been far less significant than they have been in infant mortality and child mortality. It is a real eye sore for all of us.

After 1991, of course, there will be more cooperation and coordination in the European Community.

Dr. Wagatsuma reviewed for us some of the work at the National Medical Center which started out with six staff members in his unit but has increased to 25, of which 19 are very active, and six are now overseas. So there has been tremendous improvement and development in this area.

Second Session

We next moved on to the area of research and support for research. In this area Dr. Kaihara noted that research is really the generation of new knowledge using scientific methods to identify and deal with health problems, and there was a good deal of discussion of the book on health research which was put out by the Commission. I need not say more of that. Again, I recommend this to all of you.

Professor Demissie Habte looked at the gap between countries in the developing world and the developed world in terms of science and technology and noted that this gap was tremendous, and it was through research that this gap is going to be closed. He reviewed for us the work of the Commission and also reviewed for us some of the work of the International Center for Diarrheal Disease Research in Bangladesh, a unique institution in that it is truly an international institution in terms of health research.

Dr. Saniel of the Philippines reviewed for us the Research Institute for Tropical Medicine and mentioned its tremendous growth in the past nine years, from where they had one individual identified six months before

opening to their current staff of 300, and their budget has increased from 180,000 dollars from the Government of the Philippines to over one million dollars. They have also received funding for many other projects from a number of external donors.

She noted the tremendous input that had come from JICA, both in terms of hardware and technical cooperation, and had special praise for the sensitivity of the Japanese counter-part who was there in the early days.

She noted the importance in the future of having greater flexibility in terms of equipment and training.

Dr. Krasae of Thailand reviewed for us the primary health care training program that exists at the Asian Training Center in Salaya outside of Bangkok. Having taken part in a number of seminars and having set us some conferences at this training center, I can understand his enthusiasm. It's an excellent institution.

Dr. Gu Fang Zhou of China reviewed for us a very extensive research program in China in many different areas of China, through many different institutions. He did note the shortage of funds and the desire for continued training, both in China and outside.

And, finally, there was a summary by Mr. A. M. Alimuzzaman from Bangladesh who reminded us of the tremendous differences among countries, Bangladesh being 90th in area in the world but 9th in population, and the tremendous problems that this creates in terms of the health of this country. The need for national health research was reiterated by him.

And, lastly, Dr. Mohammad Yassin noted the need for cooperation.

The last session was on the future directions of health cooperation. We began by reviewing some of the work that was carried out here in Japan, what Japan is doing in terms of institute strengthening. Dr. Hiroshi Tanaka reviewed this by looking at some of the joint studies carried out by Kobe University and also some of the work by the Kenya Medical Research Institute based in Nairobi.

There is a small nongovernment community here funding health research. The most prominent is the Sasakawa Memorial Health Foundation which has been giving a very large amount of its funds to leprosy research.

This was followed by remarks by Professor Richard Feachem, Dean of the London School of Tropical Medicine and Hygiene, and I thought he presented for us a very nice scenario of what could be done in the area that we are discussing. He noted for us that the major objective for health research, as he saw it and with which I agree, was to develop the capacity to conduct research because once that is done the researchers can then continue to pursue grants from numerous sources.

He secondly noted that of the two types of research, biomedical and essential national research, he would give priority to essential national research, and, again, I would concur in his conclusions. Such research requires skills in epidemiology, health economics, anthropology, sociology, areas that we do not generally consider and for which there is a tremendous shortage of researchers throughout the world.

He then noted that to achieve this there must be money spent both in Japan and overseas, in Japan to strengthen the capacity of Japanese scientists and advisors to develop their skills and to develop training programs within the country and, of course, within the Asian region also. There clearly needs to be a graduate school that deals with international health activities.

Fourthly, he pointed out that we should not separate the health research problems in the developed and the developing world. This is a continuum. Just as Dr. De Leon spoke of the continuum between tertiary and primary care, there is also a continuum between the health problems of the developed and the developing world. If the AIDS epidemic has taught us anything, it has taught us about this continuum and that there is no separation in the problems that all of us face.

And, lastly, he talked about the need to strengthen local institutions in developing countries, both individually and through twinning with institutions in the donor countries.

We got into a whole discussion on how long does this take, and we arrived at 10 years. I think everybody likes to divide things by five. I want to hear someone once say : I think it needs 12 years, or 11, or something other than ten, but ten sounds like a good number. Even the United States

is now moving to the metric system, so I suppose we will be speaking in terms of ten as well.

Dr. Maureen Law from the IDRC in Canada reviewed their very extensive program and noted, which I thought was very important, that on their board of governors sit 9 individuals from developing countries, so that they have integrated into their program the ideas and thoughts of those recipient countries. She reviewed their very extensive program and noted that they were celebrating their 20-year anniversary and that they were reviewing their past activities.

Dr. Chung-Tai Kim of Korea reviewed more of the social science aspects and also pointedly asked why there was no school of public health in Japan. I should point out that there is an Institute for Public Health in Japan within the Ministry of Health and Welfare but not within the Ministry of Education, and I think this is one problem that needs to be addressed in Japan, if I may make a small editorial comment there; however, but there is public health training here. It is in another ministry, however, but the institute does see itself as a place where public health training certainly can be carried out in Japan and for international individuals. But, clearly, this is an area that needs to be built up tremendously.

She noted the tremendous problem with researchers not really being paid terribly much and that individuals in hospitals and private practice can get a great deal more.

Professor Ali Muhammad Ansari then noted for us in his review remarks that science is a search for truth. It is a continuous endeavor and we must continue to strive to improve the situation.

Review of Recommendations

Let me then, having reviewed all that was said in this short period of time, review some of the recommendations and final comments that I believe were made.

First of all, it is clear, both from my own experience here and from the remarks that I have heard, that within Japan more attention must be paid, and will be paid, to the planning of projects and to increasing the

number of professional staff. If JICA is going to increase their programs, which they are committed to doing, as Japan is committed to doing, they are going to have to increase the number of professionals, and they are going to have to increase the training of these professionals. Be it a new school or improvement of existing facilities, this will be obviously a local decision, but I would again concur in many of the comments that Professor Feachem made.

There needs to be an increasing in the building up of units like Dr. Wagatsuma's at the National Medical Center. Clearly, there must be improvements in training, and in facilities. Language continues to be a problem, but I suspect that over time this will also be dealt with as more and more young people in Japan travel abroad and get extensive experience there. I have met so many young physicians and other health professionals who are extremely enthusiastic about this area and wish to devote their careers to international health activities.

There clearly needs to be increasing follow-up on past work that JICA and other institutions have done. Clearly continuing work needs to be done on this and to link these tertiary institutions with many of the primary health care activities that are being thought about and planned. There needs to be increasing flexibility, and with this will come the need for a longer-term planning and involvement.

It is pleasing for me to note that in many of the JICA projects there has been long-term involvement, up to ten years in projects that I am aware of.

And, certainly, there is a need for evaluation, and I think this conference is an attempt to do that, to evaluate the projects, to see what has worked, what has worked better than other things. Again, everything works, to some extent. Some things just work a bit better than others, and it is important to find those things out.

Let me then conclude by saying that it is clear that Japan has made a major commitment in this area just as they made a major commitment in health when they lowered their infant mortality from 190 to 4.

This meeting is evidence, obviously, of that commitment, a clear sign

of Japan's willingness to continue to increase their efforts in this area and to learn from their experience and from the experience of so many individuals in this room and elsewhere in the world, and I commend them on it.

REMARKS

Dr. Hisao Manabe
President Emeritus,
National Cardiovascular Center,
Japan

This International Symposium on Cooperation in Health in Asia and the Pacific Region has contributed to my understanding of a number of points. I am sure that many of you share with me the same favorable evaluation of this symposium.

Our Minister of Foreign Affairs, Dr. Nakayama, who gave us an address yesterday, proposed this symposium. Since our Foreign Minister has served as a physician, he has a special appreciation for the problems that we have been discussing.

I hope that we will be able to get the cooperation of the Ministry of Foreign Affairs, the Ministry of Health and Welfare, and JICA in the future in order to get together again and discuss similar topics and issues of importance to us.

Of course, our Minister of Foreign Affairs will not always be Dr. Nakayama, but, no matter who takes his place, I hope that we can continue to have symposiums like this in the future.

During the last two days we have had in-depth discussions on international cooperation, and we have realized that it requires global, as well as bilateral, relationships and efforts. A global exchange of information will be very important in facilitating international cooperation in the area of health.

Cooperation in this area of health is going to be very important, and when we reflect on the international cooperation that Japan has been involved in over the years, we can see that JICA has been instrumental in promoting this kind of collaboration, and in doing so they have given due consideration to the priority needs in the receiving countries.

When there is a country that is in dire need of a certain project,

then that project might be taken up by JICA in their programs, but only after determining that the particular project will be very meaningful for the people in that country. It is important, therefore, to conduct proper evaluation activities in the future.

We have discussed the need to establish a system of cooperation in promoting research. The allocation of resources to build research facilities and produce researchers is going to be very important, and it is important that exchange of information be promoted to further enrich cooperation in this area.

I would like to try to relate to you what little experience I have had over the years in international exchange. Once when I was in Japan's National Cardiovascular Center, a proposal came from Bangladesh asking Japan to assist them in establishing a cardiovascular facility in their country. For six years, starting in 1979, support for establishing this Cardiovascular Center was extended ; we sent about 100 people to help in this activity. We have seen that since its opening, cardiovascular treatment has improved ; the practicing heart surgeons' skills have been elevated, and cardiotomy can be performed very smoothly.

We soon found that with the establishment of the Cardiovascular Center, people became interested in cardiovascular research. A Rheumatic Fever Control Project was also established, and we dispatched experts to study cardiovascular valvular disease and rheumatic valvular disease. But interest in researching preventive medicine and epidemiology and bacteriology was less enthusiastic there ; perhaps the importance of these areas of research was not known.

Even though Japan helped in establishing a central research facility, and even though experts were dispatched from Japan, the focus at the Cardiovascular Center still remained clinical. The research facility has been less effective than we have hoped. We need a renewed awareness of the importance of laboratory work, so that research can be conducted effectively.

In many developing countries there are greater interests in practicing clinical medicine and, of course, it's probably better for fostering the individual. Perhaps that is why many of the people in Bangladesh moved

towards a clinical practice rather than remaining in research. We need to create an awareness in people of the importance of basic and applied research in order to create an interest in the research fields.

In China there is research conducted in the area of Oriental medicine. This is a good example of a developing country using its resources to conduct practical research. Maybe China can serve a central role in promoting such a project, or Bangladesh could play a leadership role in promoting other research projects within the country for which they already have research facilities. There are other developing countries which may be able to take leadership in certain areas. I think that this kind of practical approach will be important in the future in further strengthening efforts in the area of international cooperation and research.

Of course, the leadership is assumed by the physicians in providing care for their patients. In thinking about international cooperation in the area of medicine, I think we should not forget the importance of love. I think that all kinds of cooperation should be based on love of people in both the developed and the developing countries should reflect on what they have been doing over the years, and whether it is still right and still applicable today and for the future.

In this session we are concentrating on Asia and the Pacific Region, and I think that we should be very serious in considering the theme of international cooperation in trying to upgrade and improve cooperation in our region.

DR. U KO KO
Regional Director,
Regional Office for South-East Asia (SEARO),
WHO

After two days of intensive work and speeches by the distinguished participants from the countries and agencies, and summarization by our very competent Rapporteur Dr. Cash, I think whatever needed to be said has been said. It makes my task easier. Maybe I will just emphasize points that have already been made, then I will add one or two more points. I think I will first mention two or three things which you have not discussed, but which may have some indication of the role Japan plays in international health development.

The first point I would like to mention is the important advocacy rule of the Japanese Government and the peoples of Japan. As you know, the world scene is set in many governing bodies all over the world starting from the United Nations General Assembly, UN Council, Economic and Social Council, General Assembly, Executive Board, Regional Councils, etc., and I think that Japan can be an influence for good in those important bodies so that the policy of these organizations can have a positive impact.

Governments also can be influenced, in a positive way, through government-to-government contact or through person-to-person contact, so that the technical competence of countries is improved. We may do it in the form of conferences, seminars, meetings, such as this, or by visits to the departments, and universities, or even though informal person-to-person talks with decision-makers. All of these will have influence.

The second thing I would like to say is about how to give technical support. I will mention a few of Japan's activities to make my point.

When we send experts and hold training courses and consultations, through your acceptance and support, we can have a lot of important exchanges of experience and we can learn from one another with great benefit to all of us. But I also think supplies play a very important role in the development of health or, for that matter, any developmental program.

Sometimes donors or developmental agencies, including WHO, think supplies are not very important. I disagree, because supplies and equipment form a crucial part of technical development programs.

Technology development and transfer have been talked about for at least the last ten years. I have participated in meetings in Japan and in Geneva, and in many other places. Many times the emphasis is on how to prepare the recipient countries, but I would like to submit that we have to discuss how to prepare the transferors also. The mentality and attitude of the donors is just as important as preparing the department, and training the people, of the recipient country.

We have been hearing about coordination at the country level. I think one important point that I would like to mention is management support to the countries. We have talked about health policy analysis, health policy formulation, efficient implementation, etc. The Director-General referred a few minutes ago to the need for increased capability at the country level, which I mentioned yesterday also. In the Southeast Asia region, we regard it as the most important technical support we can give. If we can increase the competency of national level coordination and planning, I think that will go a long way toward improving other things.

Areas that WHO and others can consider when offering assistance include situation analysis, priority setting, appraisal of project formulation, monitoring, and evaluation. Whether we implement a project or not does not matter——we will be very happy to be used in any way you like. Please allow us to help you in my way.

We have been talking recently about TCDC, Technical Cooperation Among the Developing Countries. By definition, technical cooperation among developing countries means that developing countries also might contribute something —— finance, resources, model support, policy analysis. But the role of the developed countries is sometimes not considered adequately. I think TCDC can be accelerated if the developed world supports TCDC activities in these countries, and here I would like to mention the role of the developed countries in support of regional collaboration, either directly or as an intermediary. For instance, in this area we have many geopolitical groupings

of countries, for example, ASEAN. We have in the Indian Subcontinent the SAARC; in the South Pacific AGENTS; and recently the G-15. I think we should be able to mobilize many resources.

Finally I would like to say a few things, at the risk of repeating what has been said, about what I have learned from the speeches of our distinguished participants. I think the priority areas that we might be able to support can be listed under three headings: first, service delivery or health system infrastructure; second, human resource development; third, health system, which includes health economic research and essential research in everything which will solve the problems of the countries. Within these three different groupings, we have mentioned the development and strengthening of national capabilities, health services infrastructure, primary health care, and planning, which is always changing so much that people can not know what we are talking about these days. You may call it "country-help programming", or "manager processes of national development", or whatever you like, but it is all planning and it is very important.

There are certain vulnerable groups of people that we have talked about: those who need primary care in the urban and rural areas to minimize the equity gap, for example, expectant mothers, and children. Specific programs for these groups are save-motherhood, family planning, and MCH, which includes nutrition.

In the field of epidemiology, we have the problems of Malaria, tuberculosis, and leprosy, which, in spite of all our efforts, are still major health problems in the region. We also have ongoing programs with very good potential, such as those aimed at eradicating tetanus. We can expect a lot of dividends in these priority areas. The new problem of AIDS, I think, should be approached cautiously, because this will be a very long battle. While we are concerned about it, I do not think we should spend all our energy on this one problem, which we might have to fight for the next two to three decades.

We have other emerging problems, such as traffic accidents, noncommunicable diseases, and tobacco and alcohol addiction.

There are new positive developmental areas such as inter-health life

styles, positive health, and promotive health. I would like to submit that we should consider these things, though we will not be stressing them now.

In the 1960s, with the economic boom all over the world, our countries were very active in developing services, and we achieved a lot, until 1970 – 1975, when we were somewhat frustrated and looked for alternative approaches to health services delivery. Then we began the primary health care approach and talked about "health for all", but unfortunately, this coincides with the economic depression of the early 1980s. We have not made much progress during the 1980s. I cannot see clearly what will happen economically in the 1990s, but with the improved political situation, I expect that it will be a good decade for international cooperation. I hope we can achieve as much, if not more, as we did in the 1960s.

Finally, I would like to thank you, Mr. Chairman, and through you, the organizers. Since my Director-General cannot be here, I would like to thank you on his behalf, and also on behalf of my colleague, Dr. Han, who had to leave early. Thank you, distinguished participants, for listening. Once again, I would like to remind you that we are all very willing to be used. Please use us, and we will be very happy to do whatever you like.

Prof. V. Ramalingaswami

I think this symposium could not have been timed better, as we are just entering the fourth UN Development Decade and are on the threshold of a new millennium.

I can see a reinforcement during this decade of the principle of human-centered development. This is clearly written into the 4th UN Development Decade document, and, as Dr. Nakajima has pointed out, health will be considered not merely as a humanitarian endeavor but also as a productive process.

We hope that through these exchanges of the last two days, actions will follow which will reduce disparities between countries and inequities within countries, and help women, and children, and the socially, economically and, culturally vulnerable groups to become stronger. Vulnerability is something that we hope to tackle in this process. We also hope to sustain what we have gained. We hope not to regress, as so many of the least developed nations have done during the past decade.

We hope eventually to be able to predict disease through modern medicine and to be able to cope with new diseases. Josh Lederberg tells us AIDS may not be the last new disease that mankind will face.

In our discussions we gave central attention to capacity building. There are many developmental agencies that regard this type of aid as a bottomless pit. You can go on sinking resources into capacity building and yet not see the results for a long time. As Dr. Maureen Law has told us, capacity building is a risky business. Notwithstanding, all of us here are agreed that it ought to be the central focus of our future efforts.

I believe that Japan's leading position in the world today gives her a great opportunity to support and strengthen this concept of building capacity, not only in medicine and health, but also in science and technology as a lever for development. I would like to see this come out as the most important thought emanating from our symposium.

We have said that training is the most important thing. H.G. Wells has said that mankind's choice is between education and training, on the one

hand, and catastrophe, on the other. We should be prepared to look at training and education in a very flexible way from a long-term point of view, and also be prepared to invest substantial sums of money. This requires courage.

This is the hour when courage is needed —— moral courage followed by insights into modalities of actualizing that courage —— and I believe that Japan and JICA are in a unique position to play a leading role.

Dr. Taylor told us one of the things we should be doing; we should look at our schools of public health not as mausoleums or structures of concrete and stone, but as idea stores, new schools that will champion the ideas of multisectorality, multidisciplinarity. These school should engage in the study of people and their behavior in addition to molecular biology and basic medicine. They would teach ways to interact effectively with leaders and with political systems in order to gain support for what needs to be accomplished.

We need this kind of new school to combine superb styles of management, financing, and all these aspects of public health, with basic medicine, because basic science provides the tools for measurement of our activities.

I think that the concept of a graduate school here in Japan is wonderful. Japan's assistance could go towards realizing this concept of new schools of public health in our region, with new visions and new goals for facing the challenges of the future.

We have also learned one other important thing. I think it is rather dangerous to have set views or very rigid conceptions based one or two examples. We should have an open strategy of learning by doing. The KBDRB has shown, for example, that building international institutes of research in health sciences is a valid goal; but the Commission warns that this may not be the only route to development. We can also build national institutes, like the one in the Philippines that was so beautifully described today. A national institute can have an international role by looking at both national and international problems. Institutions can evolve, and this kind of evolutionary approach to our institution building for the future is

something that I would commend for JICA and Japan to look at more closely in the future.

Professor Manabe told us his experiences in building an institute in one of the developing countries. I think his experience illustrates both the opportunities and the limitations of that kind of an approach.

Underlying what he has said are other concepts of international health research, such as nurturing the developing countries' scientists, in a way that is mutually beneficial. I believe that many opportunities exist today and in the immediate future.

In clinical trials and field research, existing institutions and existing hospitals can introduce new scientific methods built on clinical pharmacology and various other laboratory sciences. It is one way of building, step by step — the whole "edifice" of intervention research that Dr. Nakajima talked about. Field research, using epidemiology, measurement, and bio-statistics, is one way of increasing capabilities within countries, but we need to incorporate modern technology as well.

The last point I wish to make is that capacity building is absolutely essential for countries to be able to choose the technologies that they need for the fulfillment of the goals that they have set for themselves. The capacity building system should not be technology-driven, primarily, but rather need-driven, priority-driven, resource-driven, fitting technology in as a booster to the overall process. Technology must be usable where it is being provided.

Finally, Dr. Nakajima has said the 1980s was a lost decade for international health. It may be that we have lost paradise, but it could be paradise regained in the 1990s.

DISCUSSION

In the Discussion, the participants expressed their appreciation to JICA for its efforts in organizing the symposium ; there was agreement that the symposium was both well-run and valuable. Topics considered in the Discussion were : i) the improvement of schools of public health, ii) the importance of continuity of collaboration, iii) aspects of types of financing, especially local cost financing, and iv) the role of women in health development.

CLOSING REMARKS

Dr. Akira Oya

During the two days of the present symposium, many valuable views, criticisms, and suggestions were presented, focusing on international cooperation in the past in Asia and the Pacific Region.

The details have been summarized in the Rapporteur's report. For planning and implementation of future international cooperation, we should consider carefully what sort of cooperation is appropriate and how to implement and how to evaluate it.

International cooperation for health should stand essentially on the basis of primary health care, focusing on our final goal of health for all, which is the basic concept of the policy of WHO.

The purpose of cooperation should be carefully examined according to the situation of the recipient country, whether it is matched to its needs in public health.

To implement cooperation, we should not force our own ideas on others. Instead, considering the social background and the level of the partner country, we must proceed step by step, observing carefully its impact on the public.

Finally, I would like to stress the importance of evaluations being performed by neutral specialists, as well as specialists from the recipient side. It may be worthwhile to have a special international meeting, such as the present symposium, to discuss peoples' view from time to time.

In this sense, I am very much pleased that this symposium was successful and very profitable for donor countries and recipient countries.

Hoping our future collaboration will be more fruitful for both developed and developing countries, I would like to close this productive symposium.

I want to express my cordial thanks to all participants who helped to make this symposium very successful.

Thank you and Ihope to see you again,

APPENDIX

Appendix I

PROGRAM OF THE SYMPOSIUM

(Original)

June 25

[A] Opening Session 9:30 – 10:15

Address

Mr. Kensuke Yanagiya
President,
Japan International Cooperation Agency (JICA),
Japan
(representing the organizers of the Symposium)

Address

Dr. Taro Nakayama
Minister for Foreign Affairs,
Japan

Key-note Address

"Health Problems in Developing Countries and the Role of International Cooperation"
25 minutes

Dr. Carl E. Taylor
Professor Emeritus,
Johns Hopkins University,
School of Hygiene and Public Health,
U.S.A.

Introductory Remarks **10 minutes**

Dr. Tadao Shimao
Managing Director,
Japan Anti-Tuberculosis Association,
Japan

[B] First Session "Health Care in Transition **10:15 – 17:00**

Part 1. Present Status and New Issues in Health Care

10:15 – 12:00

Cochaired by : **Dr. Saiichi Mishima**
Vice-President,
The Japan Medical Association,
Japan

– and –

Dr. Azrul Azwar
President,
Confederation of Medical Associations
in Asia and Oceania (CMAAO),
Indonesia

1) Case of Thailand **15 minutes**

Dr. Prakrom Vuthipongse
Deputy Director General,
Department of Health,
Ministry of Public Health,
Thailand

2) Case of the Philippines **15 minutes**

Dr. Alejandro S. De Leon
Assistant Secretary,
Office for Hospitals and Facilities Services,
Department of Health,
Philippines

3) Case of Sri Lanka — 15 minutes

Dr. M. A. L. R. Perera
Deputy Director General of
Health Services,
Ministry of Health and Women's Affaires,
Sri Lanka

4) Case of Malaysia — 15 minutes

Dato' Dr. Abu Bakar bin Suleiman
Deputy Director General of Health,
Ministry of Health,
Malaysia

Discussion — 45 minutes

Remarks by ***Mr. Basudev Pradhan*** — *5 minutes*
Acting Secretary,
Ministry of Health,
Nepal

and by **Dr. Chee Yam Cheng** — *5 minutes*
Director (Medical and Nursing Manpower),
Hospital Division,
Ministry of Health,
Singapore

Part 2. Human Resources Development in Health — 13:30 – 15:00

Cochaired by : **Dr. Kenzo Kiikuni**
Professor,
Institute of Community Medicine,

Tsukuba University,
Japan

– and –

Dr. Robert Quentin Reilly
Secretary for Health,
Ministry of Health,
Papua New Guinea

1) Overview **15 minutes**

– Human Resource Development in Health –

Dr. Sang Tae Han
Regional Director,
Western Pacific Regional Office (WPRO),
World Health Organization (WHO)

2) Case of Indonesia **10 minutes**

Dr. Ascobat Gani
Professor,
Department of Public Health and Hygiene,
University of Indonesia,
Indonesia

3) Case of South Pacific Countries **10 minutes**

Prof. Ian C. Lewis
Head of School,
Fuji School of Medicine,
Fiji

4) Case of Malaysia **10 minutes**

Dato' Dr. Haji Mahmud bin Mohd. Noor
Consultant Pediatiric Surgeon,
General Hospital, Kuala Lumpur,
Malaysia

Discussion **45 minutes**

Remarks by **Mr. Madhu Sudan Dayal**

5 minutes

Additional Secretary,
Ministry of Health and Family Welfare,
India

and by **Dr. Primitivo D. Chua**
Secretary Treasurer, CMAAO
Philippines

Coffee Break **15:00 – 15:30**

Part 3. International Cooperation in Health by Developed Countries

15:30 – 17:00

Cochaired by : **Dr. Takashi Wagatsuma**
Director,
Department of International Cooperation,
National Medical Center Hospital,
Japan

– and –

Dr. M. Harly Soeradi, S.K.M.
Secretary General,
Ministry of Health,
Indonesia

1) Case of Japan — **20 minutes**

Dr. Takefumi Kondo
Managing Director,
Medical Cooperation Department, JICA,
Japan

2) Case of U.S.A. — **15 minutes**

Mr. Robert M. Clay
Cheif
Health Service Division,
Office of Health,
Bereau for Science and Technology, USAID,
U.S.A.

3) Case of the Netherlands — **15 minutes**

Prof. Jane A. Kusin
Head,
Department of Nutrition,
Royal Tropical Institute,
Netherlands

Discussion — **40 minutes**

Remarks by **Prof. V. Ramalingaswami** — **5 minutes**
Special Adviser to the Executive Director
on Child Survival and Development,
United Nations Children's Fund (UNICEF)

June 26

[C] Second Session "International Cooperation in Health Research"

9:00 – 12:30

Part 1. Health Research in Developing Countries **9:00 – 10:30**

Cochaired by : **Dr. Shigekoto Kaihara**
Professor,
Faculty of Medicine,
Tokyo University,
Japan

– and –

Pengiran Dato Mohammad Yassin
Permanent Secretary,
Ministry of Health,
Brunei

1) Overview **15 minutes**

Prof. Demissie Habte
Director,
International Centre for
Diarrheal Disease Research, Bangladesh
(ICDDR, B)

2) Case of Research Institute for Tropical Medicine(RITM) in the Philippines
15 minutes

Dr. Mediadora C. Saniel
Director, RITM,
Philippines

3) Case of Primary Health Care (PHC) Centre in Thailand

15 minutes

Dr. Krasae Chanawongse
Director,
Research Development Institute (RDI),
Khon Kaen University,
Thailand

4) Case of China — 15 minutes

Dr. Gu Fang Zhou
Dean,
Shieh-ho Medical College,
China

Discussion — 30 minutes

Remarks by **Mr. A. M. Alimuzzaman** — 5 minutes
Joint Secretary,
Ministry of Health and
Family Planning,
Bangladesh

Coffee Break — 10:30 – 11:00

Part 2. Future Direction of Cooperation in Health Research

11:00 – 12:30

Cochaired by : **Dr. Akira Oya**
Director General,
National Institute of Health,
Japan

– and –

Prof. Ali Muhammad Ansari
Director General Health/
Additional Secretary,
Ministry of Health,
Pakistan

1) Review of Heatlh Research Cooperation by Japan **15 minutes**

Dr. Hiroshi Tanaka
Professor Emeritus,
Faculty of Medicine,
Tokyo University,
Japan

2) Technology Transfer in Health Research **15 minutes**

Prof. Richard G. A. Feachem
Dean,
London School of Hygiene and Tropical Medicine,
United Kingdom

3) Case of the International Development Research Centre(IDRC)
15 minutes

Dr. Maureen M. Law
Senior Fellow, IDRC,
Canada

4) Training of Research Scientists **15 minutes**

Dr. Chung Tai Kim
Vice President,
Korea Institute for Health and Social Affairs,

Korea

Discussion **30 minutes**

[D] Third Session "Role Expected to International Health Cooperation"

14:00 – 17:00

Cochaired by : **Dr.Tadao Shimao**

– and –

Mr. Song Yun Fu
Director,
Department of Foreign Affairs,
Ministry of Public Health,
China

1) Special Address "The Role of WHO in Promoting International Health Cooperation" **30 minutes**

Dr. Hiroshi Nakajima
Director General,
WHO

2) Report by Rapporteur **20 minutes**

Dr. Richard A. Cash
Director,
Education Programs in International Health,
Harvard School of Public Health,
Fellow,
Harvard Institute for International Development
U.S.A.

Coffee Break **14:50 – 15:20**

Remarks by **Dr. Hisao Manabe** **10 minutes**
President Emeritus,
National Cardiovascular Center,
Japan

by **Dr. U Ko Ko** **10 minutes**
Regional Director,
Regional Office for South-East Asia (SEARO),
WHO

and by **Prof. V. Ramalingaswami**
10 minutes

Discussion

3) Closing Remarks: Dr. Tadao Shimao

Appendix II

PARTICIPANTS LIST OF THE SYMPOSIUM

[Bangladesh]

Mr. A. M. Alimuzzaman

Joint Secretary,
Ministry of Health and Family Planning

[Brunei]

Pengiran Dato Mohammad Yassin

Permanent Secretary,
Ministry of Health

[Canada]

Dr. Maureen M. Law

Senior Fellow,
International Development
Research Centre (IDRC)

[China]

Dr. Gu Fang Zhou

Dean,
Shieh-ho Medical Collage

Mr. Song Yun Fu

Director,
Department of Foreign Affairs,
Ministry of Public Health

[Fiji]

Prof. Ian C. Lewis

Head of School,
Fiji School of Medicine

[India]

Mr. Madhu Sudan Dayal

Additional Secretary,
Ministry of Health and Family Welfare

[Indonesia]

Dr. M. Harly Soeradi. S. K. M.
Secretary General,
Ministry of Health

Dr. Azrul Azwar
President,
Confederation of Medical Associations
in Asia and Oceania (CMAAO)

Dr. Ascobat Gani
Professor,
Department of Public Health and Hygiene,
University of Indonesia

[Japan]

Dr. Akira Oya
Director General,
National Institute of Health

Dr. Shigekoto Kaihara
Professor,
Faculty of Medicine,
Tokyo University

Dr. Kenzo Kiikuni
Professor,
Institute of Community Medicine,
Tsukuba University

Dr. Hisao Manabe

President Emeritus,
National Cardiovascular Center

Dr. Saiichi Mishima

Vice-President,
The Japan Medical Association,

Dr. Takashi Wagatsuma

Director,
Department of International Cooperation,
National Medical Center Hospital

Mr. Masao Kawai

Managing Director,
Planning Department,
Japan International Cooperation Agency (JICA)

Dr. Takefumi Kondo

Managing Director,
Medical Cooperation Department,
Japan International Cooperation Agency (JICA)

Dr. Nobukatsu Ishikawa

Head,
International Cooperation Department,
Research Institute of Tuberculosis

Dr. Shigetaka Katow

Chief Researcher,
Department of Measles Virus,
National Institute of Health

Dr. Koyo Kojima

Head,
International Cooperation Office,
The Institute of Public Health,

Dr. Yuichiro Hirano

Head,
Planning & Information Division,
Department of International Cooperation,
National Medical Center

Dr. Nobuyuki Hyoi

Staff,
Division of International Cooperation,
The Institute of Public Health

Dr. Masami Matsuda

Assistant Course Director,
Japan Anti-Tuberculosis Association,
The Research Institute of Tuberculosis

Dr. Eiji Marui

Assistant Professor,
Faculty of Medicine,
Tokyo University

Ms. Keiko Yamazaki

Chief,
Office of Secretary General's Staff,
The Japan Medical Association

Dr. Hiroshi Tanaka

Professor Emeritus,

Faculty of Medicine,
Tokyo University

[Korea]

Dr. Chung Tai Kim

Vice President,
Korea Institute for
Health and Social Affairs

[Malaysia]

Dato' Dr. Abu Bakar bin Suleiman

Deputy Director General of Health,
Ministry of Health

Dato' Dr. Haji Mahmud bin Mohd. Noor

Consultant Pediatric Surgeon,
General Hospital,
Kuala Lumpur

[Nepal]

Mr. Basudev Pradhan

Acting Secretary,
Ministry of Health

[Netherland]

Prof. Jane A. Kusin

Head,
Department of Nutrition,
Royal Tropical Institute

[Pakistan]

Prof. Ali Muhammad Ansari

Director General Health/

Additional Secretary,
Ministry of Health

[Papua New Guinea]

Dr. Robert Quentin Reilly

Secretary for Health,
Department of Health

[Philippines]

Dr. Alejandro S. De Leon

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Office for Hospitals and Facilities Services,
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Prof. Richard G. A. Feachem

Dean,
London School of
Hygiene and Tropical Medicine

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