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WORLD HEALTH ORGANIZATION AND UNIVERSITY OF CALIFORNIA, LOS ANGELES (UCLA) COLLABORATIVE SUPPORT FOR HEALTH DEVELOPMENT

WHO/UCLA Collaborative Meeting
Los Angeles, USA, 13-14 November 1996

Report

WORLD HEALTH ORGANIZATION
GENEVA, 1997

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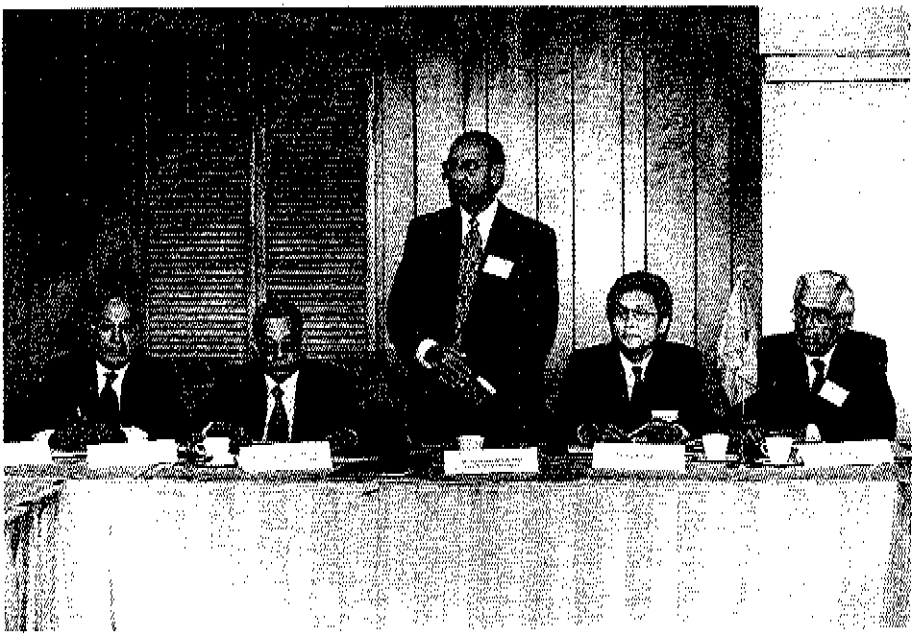

From left to right: **Dr A. Amini**, Consultant, Division of Interagency Affairs, WHO, Geneva; **H.E. Professor Ismail Sallam**, Minister of Health and Population, Egypt; **Dr Abdelmonem A. Afifi**, Dean, School of Public Health, Center for Health Sciences, UCLA; **Dr Yuji Kawaguchi**, Director, Division of Interagency Affairs, WHO, Geneva; **Dr Osman Galal**, Director, International Health Programs, School of Public Health, UCLA.

PREFACE

Since the spring of 1995 a number of discussions between the World Health Organization and the University of California, Los Angeles (UCLA) have been held. These discussions focused on the gap between available resources and needs faced by developing countries, and sought to identify possible ways for WHO and universities to work together to bridge this gap. As a result of several meetings and consultations, the WHO/UCLA Collaborative Meeting took place in Los Angeles, California, USA, on 13 and 14 November 1996. Senior government and university officials from Egypt, Indonesia and South Africa attended the meeting. Representatives of six US universities discussed how to bring together the intellectual capital of a group of universities and the technical capabilities of WHO in order to effectively provide joint assistance to countries. The meeting concluded its work with a pledge to establish an alliance between WHO, UCLA and participating governments with an active membership of selected bilateral and multilateral agencies, other universities, NGOs and the private sector.

This document contains the summary of the discussions of the WHO/UCLA Collaborative Meeting. It focuses on selected priority needs and appropriate strategies for governments, WHO, Egypt, Indonesia, South Africa, and the international community, universities, NGOs and the private sector, to collaborate on a partnership basis to ensure sustainable improvement in people's health and social well-being.

On behalf of the World Health Organization and the University of California, Los Angeles, we would like to take this opportunity to thank and

acknowledge the valuable contributions made to the success of the meeting by the attending government and university representatives, providing the basis for the establishment of a collaborative framework to support further health development in developing countries.

Abdelmonem A. Afifi, Ph.D.
Dean
School of Public Health
University of California at Los Angeles
USA

Yuji Kawaguchi, M.D., Ph.D.
Director
Division of Interagency Affairs
World Health Organization
Geneva, Switzerland

1. INTRODUCTION

The WHO/UCLA Collaborative Meeting was held at the School of Public Health, University of California, Los Angeles, USA, 13-14 November 1996. This meeting, organized by the UCLA School of Public Health and the World Health Organization, brought together high-level government representatives and representatives of academia from developing countries of three WHO regions, namely, Egypt, Indonesia and South Africa, as well as Deans of other Schools of Public Health in the United States, and representatives of the World Bank, other academic institutions and foundations.

2. OBJECTIVES OF THE MEETING

- Establish a joint WHO/UCLA collaborative framework with other partners in support of health development in countries of Africa and Asia-Pacific.

- Identify the priority health needs of selected African and Asia-Pacific countries and to establish a mechanism to provide support for institutional capacity-building at the national level.

- Review priority areas for technical cooperation, starting with the areas of health sector reform, family health, training, research and technology transfer.

- Establish a mechanism to mobilize the community, private sector, national, international and university resources to strengthen health development programmes in countries of Africa and Asia-Pacific. Egypt, Indonesia and South Africa are the preliminary sites for action.

3. OPENING SESSION

The meeting was opened by Dr A.A. Afifi, Dean of the School of Public Health, UCLA, who expressed his hope that the meeting would chart new territories of collaboration between university, international organizations and service delivery organizations in various countries around the world. Though the goals were rather lofty, Dr Afifi expressed his hope that the meeting would get somewhere further than the situation of today. He recalled that the idea had started about one and a half years earlier, when Dr Kawaguchi had visited some Schools of Public Health in the USA, including UCLA. Given the history of UCLA, it was quite appropriate to work with WHO within the new concept of collaborative relationships.

4. INTERNATIONAL HEALTH AT UCLA

Dr Milton Roemer, Professor Emeritus, Department of Health Services, recalled that the School of Public Health at UCLA was established as an independent school, with its own dean and faculty, in July 1961. In January 1962, a Committee on International Health was set up which he had had the privilege of chairing.

At present, 23 courses offered in the School have a definite international health orientation. Of these, 17 are in the Department of Community Health Sciences, five in the Department of Epidemiology, and one in the Department of Health Services. Virtually all instruction in all five departments (the above 3 plus Biostatistics and Environmental Health) of the School of Public Health has some international orientation. These were somewhat greater for the developing countries, where communicable diseases were still rampant. With respect to the organization and financing of personal health services, the policies and practices in Europe were especially relevant for the United States. Students come from all over the world and, upon return home, extend

their acquired knowledge far and wide. Faculty research and consultation was carried out in some 70 countries on all the continents.

5. INTERNATIONAL STUDIES AT UCLA

Dr John N. Hawkins, Dean, UCLA International Studies and Overseas Programmes, referred to the health care work he had done in China and his responsibility for overseeing and putting together one of the more unique structures in American education, namely that of international university studies. This experience, which had ranged from a scattered approach compared with a central approach, lent itself very well to the objectives of the Meeting. Twelve years ago there had been international programmes in a variety of places, e.g. the more conventional topic-oriented projects in countries such as China, Japan and Korea, as well as studies looking across regional problems, such as migration in the Pacific Rim. These had been pulled together under the present International Studies and Overseas' Programmes. Professional studies were certainly not ignored, linking political sciences, economics, linguistic skills with health professional skills. This had taken various forms and it was possible to offer joint degrees to graduates with, for example, linguistic and health professional skills. Joint research and joint faculty appointments were other types of working models of strategic alliances which Dr Hawkins considered to be the future of higher education.

6. IMPLICATIONS OF INTERNATIONAL HEALTH FOR DOMESTIC HEALTH POLICY

Dr E. Richard Brown, Director, UCLA Center for Health Policy, and President of the American Public Health Association, stated that various

situations impacted heavily on international health, e.g. infectious disease control, as such diseases knew no geographical borders and made it imperative for all partners to collaborate closely. In environmental health and occupational health there should be a similar interaction, e.g. regarding the use of certain goods which may be banned in one country but nevertheless exported to another; water pollution and air pollution across borders were other examples. With regard to behavioural patterns, lessons could be learned from others; and the impact of public policies and marketing should be reckoned with. All such situations compelled the sharing of information and experiences, learning from the results of research in other countries, and contributing to the study of different approaches to deal with the problems. At UCLA there were many opportunities for engaging in collaborative research, as there was no way one institute could do it alone. In addition, there was a great deal to be learned from others. Dr Brown therefore looked forward to increased opportunities through the proposed WHO/UCLA collaborative programme.

7. WHO GLOBAL STRATEGIES AND PARTNERSHIP INITIATIVES FOR HEALTH DEVELOPMENT

Dr Yuji Kawaguchi, Director, Division of Interagency Affairs, WHO, expressed his appreciation to all present for their participation in the meeting which represented an important milestone in the pursuit of mechanisms to address health priority areas and issues in developing countries through global partnership initiatives. A summary of Dr Kawaguchi's full presentation is provided in Annex 1.

8. NATIONAL AND INTERNATIONAL COLLABORATIVE ACTIVITIES: COUNTRY SITUATIONS AND EXPERIENCE

Professor Ismail Sallam, Minister of Health and Population, Cairo, Egypt, provided an overview of the current constraints faced by the health sector in Egypt (high population growth rate, deterioration of the physical infrastructure facilities, quality of personnel, low salaries, lack of confidence) the steps taken for health sector reform, the priorities for the country and the proposed areas for collaboration. A more detailed summary of the presentation is provided in Annex 2.

Dr Agus Suwandono, Head, Center for System Health Services, Research and Development, National Institute of Health Research Development, Surabaya, Indonesia, described the major issues and challenges in health development in Indonesia. While there had been substantial improvement in the health sector in Indonesia in the last 25 years, several health indicators were behind those of neighbouring countries and several major reforms were being undertaken to respond appropriately to them. A more complete summary is provided in Annex 4.

Dr Yogan Pillay, Director, National Health Services, Department of Health, Cape Town, South Africa, described the major disparities in the health sector which in fact mirrored the disparities in the South African society, as well as the opportunities and challenges to collaborative activities with South Africa in the areas of health sector reform, family health, training, research and technology transfer. A summary of the presentation is in Annex 5.

Mr J. Baudouy, Chief, Human Resources Division, Middle East Department and North Africa Region, World Bank, said that the

meeting represented the importance of **collaboration**, the achievement of which depended on institutions and individuals knowing each other. The Bank was organized by geographical region and by sector and provided the largest source of funding for health, nutrition and population activities, based on the premise that healthy and educated people provide the necessary basis for enhanced welfare, reduced poverty and sustainable growth. As the world was still in a state of recession, the expectations should be realistic. There was "polarization of development": equity had not improved in recent years (with the exception of China), the differences were still very wide, and there were great variations in the burden of disease. With the increasing burden of disease in the coming decades, the rising total costs were going to be mostly for noncommunicable diseases. In conclusion, Mr Baudouy reported that the World Bank was increasing its collaboration with WHO, particularly in the area of policy advice, in order to achieve consistency.

9. REVIEW OF TRAINING INSTITUTIONS/THE UCLA RESPONSE TO THE PRIORITY HEALTH NEEDS OF DEVELOPING COUNTRIES

In addressing the *health needs in developing countries*, **Dr Gail Harrison, Professor and Chair, Department of Community Health Sciences,** referred to the mix of health needs faced by most countries in the world as the twenty-first century approached. These were heterogeneous, rapidly changing, and enormously challenging. Urbanization is among the greatest forces contributing to this challenge, accompanied by demographic and epidemiological transitions with direct impacts on health care priorities. Populations were ageing; the middle-aged and elderly contributed an increasing proportion to morbidity and health care costs; chronic diseases were assuming greater importance; injuries, violence and substance abuse

emerged as significant health threats; and new diseases such as AIDS threatened to consume health care budgets. At the same time, there was a large "unfinished agenda" of excessive maternal mortality, malnutrition, vaccine-preventable diseases, and the traditional contributors to child mortality - low birth weight, diarrhoea, pneumonia, and malaria. Since the latter set of problems afflicts disproportionately children, women, the rural and the poor, they were in danger of being ignored in the pressure to deal with the emerging and potentially very expensive problems. Basic minimum needs - adequate nutrition, safe childbearing, effective immunization programmes, good sanitation - were not an "agenda" to be finished, but rather had to be a continuous priority in planning for health care, even while new and emerging problems were being confronted. The costs of not doing so were great in terms of health care costs and economic development.

Health sector reform in developing countries. **Dr Paul Torrens, Professor, Department of Health Services,** stated that previous health sector activity in developing countries was (a) mainly initiated by governmental efforts, and (b) focused on specific individual public health problems such as water supply, sanitation, TB control, basic maternal and child health issues, and the like. Now that these individual problems were beginning to be solved, attention was turning to health care infrastructure development. The focus was changing from individual disease-focused projects to infrastructure building and development.

As economic progress proceeds in developing countries, the private sector begins to develop, particularly around hospitals, medical practice, and medical technology, and governments strive with the issue of public/private cooperation and integration. As the private sector and technology base grows, costs begin to increase and governments worry about how to finance the growing medical care system solely (or primarily) with government funds. A great interest in the economics of health care begins to develop and economic issues tend to dominate all discussions about health care. Eventually, the economic pressure and discussions focus on health insurance as a means of financing the growing costs of medical care. Contributory

private health insurance is seen as a way to relieve government of the sole burden of financing the country's growing medical care establishment by itself.

This pattern of events suggests that developing countries need to concentrate on certain areas and subjects in order to handle health sector reform: (a) health planning; (b) health policy process; (c) health system design and management; (d) health economics; (e) health insurance.

Key elements in public health training and training of health professionals in developing countries. **Dr Roger Detels, Professor, Department of Epidemiology**, emphasized that training in public health for health professionals in developing countries must be relevant to the health problems and issues confronting these countries. The challenge for educational institutions in developed countries wishing to assist developing countries is to train their health professionals in the principles, methods and strategies which are applicable under the circumstances and constraints that exist in the developing countries. The objective of these training programmes must be to train health professionals to contribute to the generation of health knowledge essential to the development of informed decision-making and policy formulation and to effective implementation of these policies.

A relevant, effective training programme must include academic expertise, knowledge of the public health problems occurring in the countries from which trainees are drawn, and opportunities for implementation of the newly acquired principles, methods, and strategies in these countries.

Priority areas of transfer of technology in developing countries. **Dr Ralph Frerichs, Chair, Department of Epidemiology**, said that technology to gather and disseminate information essential for education, service and management was frequently lacking in less developed regions of the world. New information continues to accumulate at an ever-expanding pace on disease process, patterns of occurrence, methods for control, and approaches to treatment and care. However, due to shortages of knowledgeable educators, adequate facilities, computers, and professional

books and journals, the information needed in developing countries remained unfulfilled. To address this need, technology was being developed to enable worldwide access to information on the Internet and to facilitate long distance learning, bringing audiences and educators together in time but not space. At the local level, portable computers were being used to conduct rapid surveys, offering information on the health of populations in weeks rather than years. Finally, new approaches were being developed for obtaining data on individuals using saliva rather than blood to measure for the presence of antibodies to disease-causing antigens (including HIV/AIDS, rubella, rubeola, schistosomiasis and leptospirosis) and therapeutic and harmful drugs. Such varied technologies are especially useful in developing countries, and represent priority areas for transfer from UCLA and other universities to local public health professionals often working in remote regions.

Impact of programme implementation through joint collaboration. **Dr Donald Morisky, Vice-Chair, Department of Community Health Sciences**, pointed to the numerous international, national and local health organizations which were increasingly interested in joint collaborative research/training opportunities between community-based health service organizations and university-based professionals. It was through these collaborative affiliations that national programmes had soon become international leaders in smallpox, malaria, and polio eradication programmes. Local health services' research programmes had also gained international recognition, such as the North Karelia Cardiovascular Risk Reduction Project and the Stanford Heart Health Programme. The conceptualization and implementation of three collaborative efforts in the area of HIV/AIDS prevention, cardiovascular risk reduction, and tuberculosis control were discussed, along with the opportunities which broadened and expanded their impact and outcome results. The key concept in each was the active involvement of all participants in the conceptualization, planning and implementation of the programme at the onset. Opportunities for organizational development, capacity building and coalition building became important adjuncts providing reinforcement, continuity and creativity for expanded programmatic efforts.

10. ROUND TABLE PRESENTATIONS AND DISCUSSIONS BY REPRESENTATIVES OF UNIVERSITIES

Dr Mohammad El-Amin Abdel-Fattah, Dean, High Institute of Public Health, University of Alexandria, Egypt, briefly reviewed the history and role of the Institute. Many of the faculty were used in support of health sector reform with the Ministry of Health, Egypt, as well as in several countries of the Arab world and the Middle East area. Among other areas presented, as included in the summary in Annex 3, Dr Abdel-Fattah considered that, for community health development, it would be useful to conduct surveys to have sound base-line data on how health centres were being used, as currently there was no complete information on this. Another area which would be particularly useful to discuss would be the MPH programme supported by distance learning.

Dr Ascobat Gani, Dean, Faculty of Public Health, University of Indonesia, Depok, Indonesia, pointed to the changes which had already taken place in the health system in Indonesia. He saw three roles which universities could play: (a) education and training to produce needed human resources, (b) research, and (c) provision of technical assistance. The critical issue was to link and match the curricula of health professionals with the dynamic changes required in the health care system. A more complete summary is provided in Annex 4.

Professor W. Pick, Medical School, University of Witwatersrand, Johannesburg, South Africa, referred to the historical determinants of the current transitional situation in South Africa and how training institutions were grappling with this. There were very few institutes to carry out ground work, e.g. there was no human resource planning and thus there was enormous potential for cooperation in this and other areas. It was also necessary to

broaden the concept of transfer of technology and to be able to turn the know-how into improvements for the people. A more complete summary is in Annex 6.

Dr Robert Bailey, Professor, Department of Epidemiology and Biostatistics, School of Public Health, University of Illinois at Chicago (UIC), referred to the diversity of communities, of socioeconomics, and of access to health care. There was a need to train in leadership skills to collaborate across professions and to form partnerships with the government, business community, schools, religious groups, universities, etc., for health prevention strategies. UIC had a lot of expertise in fostering strong relationships with various groups and in working with communities in defining their problems, e.g. UIC had a strong involvement to develop a collaborative project in South Africa.

Mr Joseph Hafey, Executive Director, Western Consortium for Public Health, Sacramento, California, pointed to the funds that were required to increase collaboration between developing countries and universities. There was a need to look at the incentives for doing this as well as ways to influence donors to be more involved. The academic community needed to recognize what they did well, and what was done less well, e.g. they were generally not as good at continuing education as basic education. Likewise there were too few collaborative university-to-university project areas.

Dr Allen Rosenfield, Dean, School of Public Health, Columbia University, pointed to the importance of cultural sensitivity; all too often courses were geared to problems in the USA and not to problems of the countries of the international students. He suggested that one priority would be to come up with projects for preventing maternal mortality. The only way to deal with this was through the promotion of women at the first level referral centres in rural areas. In this regard, how in fact did countries implement the recommendations of the International Conference on Population and Development (ICPD), Cairo, 1994, when they had limited resources? The

American Association of Schools of Public Health had an international committee whose objective was to work more effectively with such schools in other countries, and the Association was interested to give more focus to strengthening these schools; the present initiative presented a vehicle for facilitating this.

Dr Reed Tuckson, President, Charles Drew University, confirmed the close collaboration it enjoyed with UCLA. He pointed to the trauma, violence and disgraceful parade of unnecessary deaths which the university hospital witnessed daily. Drew's fundamental aim was to train the next generation to serve the underserved population. Dr Tuckson, in addressing the main objectives of the meeting, suggested that the case should be made to those with resources that if there was not action beyond goodwill there was a definite risk of a growing inequity and social injustice. Human development called for shared expertise. Another important factor would be to understand the role of the private sector and to discuss public/private partnerships in the countries involved, the incentives, and what could be enforced through legislation to be incentives. It was important to have community-based planning that was culturally relevant, and the "patience to listen" was paramount.

Dr Julia Walsh, Adjunct Professor, Maternal and Child Health and International Health, School of Public Health, UC Berkeley, said that the objectives of the proposed collaboration provided a challenge across a broad range of issues. She pledged her University's interest in responding to some of these challenges, and was interested in doing more than hitherto in international health in these areas. In this regard it was important to look at some models for community involvement.

Dr A. Amini, WHO consultant, briefly outlined a type of network that could be developed whereby the transfer of technology and learning opportunities could be enhanced so that these would be more closely matched to the real health needs of the developing countries. He also briefly described the proposed new "WHO/universities' Collaboration in Professional Career

Development" whereby professional graduates in health and health-related fields will be assigned to the host countries, under the direct supervision of the WHO representatives, for a period of a minimum of six months and a maximum of two years. This programme will provide the graduates with real life experiences, an opportunity to observe health problems first-hand, and the developing countries with technical expertise in the field of health. This collaborative initiative will help to build a bridge between the resources of universities and the real health needs of Member States.

11. WORKING GROUP TO OUTLINE MECHANISMS FOR COLLABORATION BETWEEN WHO AND UCLA

Outline of mechanisms for collaboration between WHO and UCLA. **Dr Osman Galal, Chair, International Health Committee**, outlined the possible mechanisms to establish an effective collaboration between WHO and UCLA that would accelerate the involvement of multilateral and bilateral institutions, other universities, foundations, NGOs, and private sector, in this collaborative effort. This collaboration will bring together training, education, research, new skills, and access to funds and deal with country-specific priorities. He presented a potential funding model whereby both WHO and UCLA will act as facilitators to achieve these goals.

In discussing the approach for establishing a new model for a higher level of collaboration, the Group focused on the principle of partnership to meet common objectives. The following were some of the areas considered in this regard: why there was a need to change; strengthening of institutions and sustainability of the partnership; capacity building; health services research to support health sector reform, including public/private partnerships and the broader issue concerning health insurance; technical cooperation; mobilization of expertise and resources; transfer of technology; etc. As a

result of an exchange of views on these issues, the Group concluded as follows:

Conclusion

(1) All participants agreed with the concept of establishing a collaborative framework to support health development in developing countries.

(2) The partnership/alliance would be among:

(a) WHO
(b) Universities
(c) Governments
(d) Other bilateral/multilateral agencies
(e) Private sector
(f) NGOs

(3) During a two-month period, a working group would develop terms of reference for establishing:

(a) priority areas/issues to be addressed through the collaborative activities;
(b) mechanism for the collaboration.

(4) Dr A. Amini, WHO Consultant, and Dr Osman Galal, Chair of the International Health Committee, UCLA, will constitute the alliance secretariat to follow up the agreement/consensus reached at the meeting.

12. CLOSURE

Dr Kawaguchi, on behalf of WHO, expressed his thanks to all participants, stressing the importance of the process of consultation and sharing of experiences with all partners. Shortage of resources might continue, but this initiative should have a positive outcome, as partnership collaboration becomes increasingly effective. Particular thanks were expressed to representatives of governments and institutions of the three countries and to Dean Afifi and his colleagues of the UCLA School of Public Health for hosting the joint meeting. It was WHO's sincere hope that, through working together, it would be possible to see a significant improvement in the health status of people by the turn of the century.

Dean Afifi also expressed appreciation to all who attended the meeting, in particular to Dr Kawaguchi for having come up with the original idea of the project. His idea had been crystallized - and it was now the collective task to make the germ come to fruition. He extended his appreciation to all participants, knowing how difficult it was for them to take time out of their busy schedules. A warm thanks was also extended to UCLA faculty and a number of graduate students for their input to ensure the smooth running of the meeting.

ANNEX 1

WHO GLOBAL PARTNERSHIP INITIATIVES FOR HEALTH DEVELOPMENT

Dr Yuji Kawaguchi, Director, Division of Interagency Affairs, WHO, Geneva

SUMMARY OF PRESENTATION

In the last two years in particular, the World Health Organization has been forging stronger partnerships with intergovernmental organizations within and outside the United Nations system, as well as with nongovernmental organizations and other elements of "civil society". The Division of Interagency Affairs, as the central focal point of the Organization for collaboration with external partners, has led and developed these actions. The objectives of this policy direction are:

- to place and maintain health at the centre of national development and regional and global cooperation;
- to ensure complementarity and cost-effectiveness in the allocation and use of resources for health by all parties concerned;
- to promote the development of strategic alliances with intergovernmental organizations and other important institutions to meet the health needs of Member States;
- to contribute to the capacity-building of developing countries.

The Forty-ninth World Health Assembly in May 1996 welcomed these forward-looking measures taken by WHO to revitalize existing relations and to form new ones with intergovernmental organizations and other partners concerned with health and health-related fields, particularly the significant

steps taken to develop WHO's new partnership with the World Bank and to agree on action to combine the two organizations' complementary technical expertise and financial resources.

The World Health Assembly, made up of high-level representatives of 190 Member States, also commended "the progress made at global, regional and country level to implement the WHO policy of forming and strengthening partnerships within a United Nations system currently under reform and with different elements of "civil society" to place health at the centre of development".

The Assembly urged Member States, together with WHO, to play a strong coordinating role in working with external partners in health development, to establish health as a central component of national development, and to ensure capacity-building for health and overall development.

In the same resolution the Assembly called on the international community, including development agencies and "civil society", to join forces in pursuing the WHO policy on collaboration with partners for health development and to mobilize further necessary technical and financial resources.

Considerable financial allocations, mainly in the form of loans, were being expended globally by the multilateral development banks on an annual basis for the social sectors (education, health, nutrition and population), as well as water supply and sanitation and urban development. In 1994 this amounted to some US$ 7 300 million. Despite this, the gaps in the state of health of the people of developing countries were increasing, with wide variations across regions. Whilst a significant level of economic development and improvement in peoples' lives could be seen in parts of Asia and the Pacific, with similar trends also apparent in Latin America, development had, to a large extent, evaded many countries, particularly in Africa. Dr Kawaguchi stressed that there was full recognition that "more of the same" was not sufficient and that new mechanisms needed to be put in place whereby all relevant partners agreed on the priorities, shared the same objectives, and worked together on

a full partnership basis to bring the level of health of the people of the nations up to an acceptable level and one that could be considered worthy for the turn of the twenty-first century.

To this end, the present meeting represented a significant milestone: based on the participants' experiences concerning national and international health programmes, proposals would be made for a collaborative framework among governments, academia, bilateral and multilateral organizations, nongovernmental organizations, and the private sector to guide effective, complementary action among all partners. For this, the World Health Organization, with its global, regional and country network, would play an important facilitating role, guided by the international health policies emulated by the governing bodies of the Organization.

ANNEX 2

COUNTRY SITUATION AND EXPERIENCE OF NATIONAL AND INTERNATIONAL COLLABORATIVE ACTIVITIES - EGYPT

H.E. Professor Ismail Sallam, Minister of Health and Population (MOHP), Cairo, Egypt

SUMMARY

Professor Sallam underlined the importance of joint cooperation among different development agencies and universities, to get the maximum benefit from the available resources. The situation in Egypt was as follows:

1. CURRENT CONSTRAINTS FOR THE HEALTH SERVICES IN EGYPT:

High population growth rate; quality of personnel; deterioration of the physical facilities infrastructure; low salaries; lack of confidence in public health services; poor management systems; shortage of finance.

2. HEALTH SECTOR REFORM:

Focus on:

2.1 Policy level

Advocacy for reform; subsidy only for the poor; expanded health insurance; continuous quality improvement; privatization is the key; new role for the MOHP.

2.2 Health care delivery system

Public-private partnership; stop unnecessary construction of new hospitals; emphasis on primary health care; community participation; cost containment; social equity; customer orientation (current services are not reaching the people in the villages).

2.3 New programmes to support the reform process

Human resources development; system research - research at the community level is required, i.e. to carry out and implement the results of research at the level where PHC is delivered; redistribution of human resources; quality assurance; planning from below.

2.4 Organizational development

System approach; management by information; new central administration for quality management; improving efficiency and effectiveness; decentralization strategy (currently very difficult to decentralize because of lack of services at the local level. Efforts were therefore being made to involve leaders who were sensitive to the needs of the community and the importance of community involvement); strategic planning versus implementation planning; intersectoral coordination; institutional development; capacity building at the central as well as the governorate levels.

2.5 Priorities in health sector reform

Building the institutional capabilities of the Ministry of Health and Population; restructuring the health insurance system; begin the journey of total quality management; start the privatization process; improve the quality and increase accessibility for primary health care.

3. Proposed priorities of collaboration

3.1 Preventive health services

- Support and utilization of health information systems
- Establishment of surveillance system
- Human resources development
- Research support
- Primary health care (water supply was considered to be priority number 1)

- Integration of health services
- Community involvement in health education programmes
- Supporting laboratory services for public health

3.2 Curative health services

- Improve the health care system
- Revitalize existing institutions
  - Financial support
  - Technical assistance
  - Project development
  - Training

In conclusion, Professor Sallam pointed to the importance of enriching the sciences and obtaining the cooperation of all relevant institutes to carry out research and implement those results that will improve the life of everyone. Also, in Egypt, incentives (e.g. improved salaries, housing) were being put in place to encourage health workers to work in the rural areas.

ANNEX 3

HIGH INSTITUTE OF PUBLIC HEALTH (HIPH), UNIVERSITY OF ALEXANDRIA, EGYPT

Dr Mohammad El-Amin Abdel-Fattah, Dean, High Institute of Public Health, Alexandria, Egypt

SUMMARY

The Institute, which was founded in 1956, is the only School of Public Health in Egypt and the main P.H. School in the Arab world and Middle East area. Its purpose is to support the health development process in Egypt, the Arab world and Middle East area through a tripartite role which includes:

- development of Human Resources for Health (HRH) - degree programmes, and non-degree programmes;
- undertaking applied action-oriented epidemiology and health systems research;
- implementing community health development programmes.

Education and training programmes

HIPH offers degree programmes in P.H.

- Diploma, Master and Doctorate;
- 23 specialization areas, as well as special degree and non-degree programmes.

Between 1991 and 1996 there were 208 non-Egyptian trainees.

Since 1958, there have been an average of 92 graduates per year as indicated below:

Department	Diploma P.H.	Master P.H.	Doct. P.H.	Total
Epidemiology	191	23	24	238
Biostatistics	125	52	20	197
Health admin. & Behav. Sc.	358	75	22	455
Family health	546	98	56	700
Nutrition	248	106	20	374
Tropical health	306	103	48	457
Microbiology	296	118	28	442
Environ. health	239	74	28	341
Occup. health	118	48	14	180
Total	**2427**	**697**	**260**	**3384**

Relations with national organizations:

- Ministry of Health and Population (MOHP): originally, the Institute was founded by the Ministry of Health to support the process of national health development. More than 50% of the Institute's students are MOHP fellows. MOHP facilities are intensively used for field training. Many HIPH staff participate in MOHP activities as members of standing and temporary committees. At the same time, many of the senior MOHP staff participate in the training and research activities of HIPH. In addition, MOHP is represented on the HIPH Board by one of its undersecretaries. The MOHP has also provided adequate financial support to help the HIPH in establishing its central public health laboratory and is recognizing it as a reference laboratory. Recently, two new educational programmes have been developed as a result of fruitful cooperation between HIPH and MOHP:

  - the Leadership Development Programme (LDP) in collaboration with WHO Regional Office for the Eastern Mediterranean (EMRO).

- the Field Epidemiology Training Programme (FETP) in collaboration with USAID and CDC Atlanta, USA.

- Other organizations include: Health Insurance Organization; Academy of Scientific Research and Technology; Egyptian Medical Syndicate; Industry; Ministry of Education; Social Fund for Development; Egyptian Environmental Affairs Agency; Water Purification Organization; Sanitary Draining Organization.

Relations with international organizations:

- WHO: the relationship between the HIPH and WHO began as early as 1956 when WHO provided several fellowships to help in qualifying the Institute's faculty. These fellowships continued for several years. Currently, WHO sponsors some short-term fellowships for junior HIPH staff. WHO also offers some postgraduate fellowships each year for candidates from Eastern Mediterranean countries to study at the Institute. It also sponsors fellowships for short-term training courses. In addition, WHO and HIPH are collaborating in the areas of research and community health development. The new Leadership Development Diploma programme has developed as a result of the collaborative efforts of the HIPH and WHO.

- UNICEF: HIPH has also developed a strong professional relationship with UNICEF. Areas of cooperation include health systems action-oriented research and community development programmes.

- Other organizations include: UNDP; USAID; Fulbright Commission; Namro 3; Canadian IDRC; USNIOSH.

ANNEX 4

COLLABORATION BETWEEN GOVERNMENT, WHO AND UNIVERSITIES - EXPERIENCES IN INDONESIA

Dr Agus Suwandono, Head, Center for Health Services/System, Research and Development, National Institute of Health Research Development, Surabaya, Indonesia and Dr Ascobat Gani, Dean, Faculty of Public Health, University of Indonesia, Depok, Indonesia

SUMMARY

1. MAJOR ISSUES AND CHALLENGES IN HEALTH DEVELOPMENT IN INDONESIA

Substantial improvement in the health sector has been accomplished in Indonesia during the last 25 years. This is demonstrated through establishment of a massive health service infrastructure, improved coverage of public health programmes and significant reduction in morbidity and mortality. Nevertheless, health indicators in Indonesia are still far behind those of neighbouring countries in South-East Asia, specifically Thailand, Malaysia and the Philippines. For example, the current infant mortality rate (IMR) in Indonesia is comparable to those in Malaysia in 1964, Thailand in 1975 and the Philippines in 1978. The following is a description of several important issues and major reforms being undertaken in the health system.

One important issue in health development in Indonesia is the evidence of the epidemiological transition. Disease patterns as well as causes of death have been shifting from predominantly infectious diseases (related to poverty and poor hygiene) to non-infectious diseases, including degenerative and cardiovascular diseases, and accidents. During the transition, a double burden in health development and health financing is faced. On one hand, infectious diseases which affect a large number of people (generally poor and

living in rural areas) require a large scale health infrastructure. On the other hand, cases of chronic degenerative and cardiovascular diseases have been increasing substantially. Although their number is still relatively low, this requires treatment in hospital and medical specialists with a cost much higher than that of infectious diseases. Tuberculosis has emerged as the second main cause of death after cardiovascular disease. More exploration is needed to explain this phenomenon as the assumption that tuberculosis is related to the HIV/AIDS epidemic apparently is not valid for Indonesia since the prevalence and incidence of HIV/AIDS is still relatively low.

The transition together with limited health resources has created the need for a sharper prioritization and optimum mix of interventions. Priority setting is commonly done using certain criteria such as magnitude and severity of the problems and availability of technology. In other cases the selection of health problems to be given priority is based on the availability of resources or sometimes even based on "drive" from donors.

2. Partnership between universities, government and international organizations

Given the issues, and the challenges to the health system in Indonesia to respond appropriately to them, basically there are three main functions for a university: (1) education and training to produce needed human resources, (2) research, and, (3) provision of technical assistance. The critical issue in medical education is to link and match the curriculum with the dynamic change in the health system. A Consortium of Health Sciences (CHS) has been established to assure relevant medical education.

There are five government-owned Schools of Public Health (SPH) in Indonesia. One example of international collaboration is the six-year project starting in 1982 and supported by one US university, a development aid agency and WHO, to develop modules to be used to train provincial as well as district health personnel in comprehensive health planning.

With regard to strengthening of district administration, incentives have been created, as well as an executive master degree programme for District Health Officers and their staff. A "distance learning" programme is also under consideration.

Research capacity building and health system research have also been emphasized. Another main role of the university is to provide technical assistance to government and WHO intercountry activities.

2.1 Support for national capacity building

The prevailing central issue is human resources development. Various ongoing reforms in the form of priority assessment, financing, decentralization, promotion of the private sector, etc., would require more professionals at all levels of the health system to adopt the reform. The Indonesian experience has also demonstrated that WHO can play an important role in establishing mutual collaboration or partnership between university and government, and the collaboration can also be extended to universities in other countries. Support to the association of Schools of Public Health for example, would enable the schools to have a regular meeting to review and adjust their curriculum to make it more relevant to the country needs. Similar support could be given to health professional organizations, such as the Medical, Public Health and Nurse Associations, etc.

2.2 Support for regional collaboration

WHO could also contribute to the establishment of a networking of universities at the regional level. As for the Asia and Pacific regions, there is an Asia Pacific Consortium of Public Health (APACPH) with members representing SPHs from Australia, China, Indonesia, Japan, Laos, Malaysia, Nepal, the Philippines, Sri Lanka, Thailand, USA, and Viet Nam, etc. The APACPH provides a good forum for dialogue between countries in the region to address current and common issues.

2.3 Provision of technical assistance

Experts in health sector development are becoming more important. Experts from one country in areas such as health trend analysis, quality improvement, decentralization, health sector financing reform, policy in public-private mix, etc., could facilitate health sector development and reform in other countries.

Similar technical cooperation could also be useful in reforming medical and public health education. Such technical assistance should not be limited within one country; intercountry collaboration of universities should also be encouraged.

ANNEX 5

SOUTH AFRICAN HEALTH PRIORITIES

Dr Yogan Pillay, Director, National Health Services, Department of Health, Cape Town, South Africa

SUMMARY

1. INHERITED PROBLEMS

The present Government inherited a multitude of health systems. Beside the private and public sectors they include: Departments of Health of each of the homelands and self-governing territories and the three houses of the Tricameral Parliamentary system. This resulted in 14 Departments of Health (each with its own Minister of Health). In addition, many municipalities provide health services of some type. This resulted in significant fragmentation and duplication of services - some of which continues to date.

The disparities in the health sector mirror the disparities in South African society. South Africa is classified as a middle income country by the World Bank with an estimated per capita gross national product of US$ 2670. However, this index of wealth is misleading as the distribution of wealth (and therefore poverty) is racially skewed. White households earn on average 5.2 times more than African households. It was also estimated that half of all households in the country live below the poverty line - composed of 67% of African, 38% of coloured, 18% Indian and 6,7% of white households. Finally, there is more poverty in rural areas than in the urban areas, e.g. 73% of African households in rural areas live in poverty.

The existence of a two-tiered health system in South Africa is well known, viz., the public sector and the private sector. While 75.7% of Africans (this figure increases to 82.4% in rural areas) rely on the public health sector, 83.9% of whites and 84.1% of Indians use the private health sector. The private health sector also contains a significant percentage of the health personnel, especially

general medical practitioners (62%), medical specialists (66%), dentists (93%) and pharmacists (89%). Given that the public health sector provides care for the majority of the population (approximately 77%) and that the majority of health providers in the above-mentioned categories are in the private sector, it is not surprising that the public sector is significantly underresourced. This in turn increases the work levels of the relatively few health professionals (besides nurses) that work in the public health sector.

The public health sector is beset with other problems as well. The service has been biased towards the provision of curative and hospital-based care. It has been estimated that 76% of total recurrent expenditure in 1992/3 was spent on acute care hospitals. While tertiary (including academic) hospitals accounted for 44% of total recurrent expenditure, 11% was spent on primary health care services.

Given the historic underfunding of primary health care it is not surprising that health care is not accessible to all South Africans. About 33% of Africans in rural areas live more than one hour travelling time from the nearest health care facility, while about 24% live within 15 minutes away from a health facility. In addition, 70.3% of African (73.8% in rural areas) wait for an hour or more to see a health care provider. About 18% wait for between 4 and 5 hours.

2. KEY STRATEGIES THAT HAVE BEEN ADOPTED TO ADDRESS PROBLEMS IN THE HEALTH SECTOR

Given the structural inequities that characterize South African society in general and the health sector in particular it is clear that quick fixes or the so-called "magic bullet" do not exist. Much is wrong with the existing health system and attempts to address these have to be carefully thought out, implemented and evaluated. In its effort to address the problem, the Department of Health has based many of its strategies on the Government of National Unity's Reconstruction and Development Programme (RDP). This was considered necessary as improvement in the health status of South Africans will depend on improvement of socioeconomic conditions as much

as in improvements in the health system *per se*. The vision of the Department of Health is therefore based on the principles of the RDP and include:

- the health sector must play a role in promoting equity by developing a single, unified health system;
- the health system will be restructured on the district health system and emphasize the primary health care approach;
- the national, provincial and district levels will play distinct but complementary roles;
- the third tier of government, the private health sector and nongovernment and community-based organizations must work with the public sector in the promotion of common goals; and,
- an integrated package of essential PHC services will be available to all at the first point of care.

In order to improve access to primary health care, a major clinic building and upgrading programme was initiated in 1994. A total of 186 new clinics have been built, a further 217 are in the process of being built, 100 clinics were extended, 73 non-functioning clinics were equipped and a further 2500 clinics were given minor upgrading or equipment. In addition, 4750 new primary health care posts have been created. A focus has been on the creation of the district health system; shifting of resources to primary health care; the implementation of an essential drug list; the improvement of management of health facilities especially hospitals; and a human resource development strategy.

3. Possibilities for collaboration

The nature and extent of the problems noted above give some indication of the challenges facing the Department of Health in South Africa. This is compounded by the number of health professionals, especially doctors, occupational therapists, radiographers, etc., that are leaving the country. The brain drain is significant.

The areas of possible collaboration include:

- health care financing;
- health promotion and prevention;
- communication, information systems;
- health personnel education and training (curriculum development especially for PHC);
- appropriate models of service delivery (of various programmes but within a comprehensive and integrated framework; development of community-based programmes); and,
- development of norms and standards (and quality of care) and monitoring.

The collaboration needs to be well-defined in terms of who, what, where, how (with a clear indication of the resources available), entry points and exit points. Finally, Dr Pillay also pointed out that not only north-south collaboration but south-south collaboration was important.

ANNEX 6

THE ROLE OF TRAINING INSTITUTIONS IN MEETING THE PRIORITY HEALTH NEEDS IN SOUTH AFRICA

Professor William M. Pick, Medical School, University of the Witwatersrand, Johannesburg, South Africa

SUMMARY

1. INTRODUCTION

In discussing the role of training institutions in addressing priority health needs in an interagency framework in South Africa one has to recognize the historical determinants of the current relationship between training institutions and the health care system.

In 1992 South Africa spent 1.7% of its GDP on higher education, the same as the mean average for OECD countries. South Africa is blessed with a number of training institutions of high quality but apartheid and colonialism have skewed the South African society, the economy and mental attitudes, leading to crippling inequality which is a major challenge for the new democracy. This is reflected in the nature of training institutions in the country. Currently, there are 21 universities, 15 technikons and 140 colleges. Eight of the universities have medical schools, four have schools of pharmacy, and five have dental faculties. A total of 683 776 students (5.33% of total in education system) were enrolled in institutions for higher/tertiary education in 1994. There are also gross gender and racial inequalities in South Africa's tertiary education institutions.

Given these stark inequalities the training institutions are grappling with the process of transformation in a society which is transitional. This has given training institutions the unique and historic opportunity to be part of the process that will shape the nature of health in South Africa for many decades to come. There has been a national movement towards making training

institutions more accountable to society. This includes the harnessing of South Africa's not inconsiderable intellectual resources in improving the quality of life (and health) of all the people in the country. Training institutions have enormous potential in contributing to health development in South Africa in three major areas of endeavour. These are (1) consultancy services, (2) research, and, (3) human resources development. The division into three broad areas is one of convenience as there are clearly areas of overlap between the three.

2. Health sector reform

South Africa is engaged in a vigorous programme of health sector reform driven by certain priorities: greater efficiency and effectiveness in the use of existing resources; improvement in access and quality of health services, particularly at the primary level; distribution of resources between levels of care in the public sector; redistribution of private sector resources in order to make them accessible to a broader section of the population; and, cost-containment in the private sector.

■ Consultancy

As part of this process the incoming Minister of Health appointed 10 technical committees to assist the new government in shaping national health policy for the country.

■ Research

Through research the training institutions in South Africa continue to make a major contribution to the process of reform in health. These units are generally quite small and are handicapped by a lack of skilled research staff and financial resources.

■ Training

Training institutions are also involved in health systems research and have a major responsibility for producing the personnel who would man a reformed

health care system. The skills required for the new district-based, primary health care-driven health system are very different from the skills which prevail in the health care system overall. It is the ability of training institutions to respond to the needs of a new South Africa that will have a major impact on health development in the country.

3. Family health

Family health is recognized as a critical component of PHC in South Africa and there are a number of family health departments in the medical schools. However, unless these departments are supported by health science faculties, and unless they become major departments in medical faculties, they are destined to remain fairly marginal in shaping the health development in South Africa.

4. Research

Resources will be allocated to research on the basis of the quality, relevance and the extent to which it redresses the historical imbalances in resource allocation for research in South Africa. This is a new way of obtaining research funds and education and training institutions will have to reexamine their research priorities such that they are in line with the national vision. Partnership between the private sector, education and training institutions and the nongovernmental sector in research is encouraged.

5. Technology transfer

Despite the many technological advances in modern society, many of the technologies that can have a major impact on health development do not find themselves translated into practical interventions Similarly, the transfer of technology from industrialized to less industrialized countries and from less industrialized to more industrialized countries needs to be better understood so that technology in the global population can be optimized. Universities again have a critical role to play in this intellectual endeavour. South Africa has much to learn from the world, but, given its unique combination of extreme

opulence in some sections of its population in the presence of extreme deprivation in other sections of its populations (South Africa has the largest recorded Gini Coefficient (0.55) of any country in the world), it provides an opportunity to learn much about the transfer of technology across diverse groups of people.

ANNEX 7

LIST OF PARTICIPANTS

COUNTRIES

Egypt

H.E. Professor Ismail Sallam, Minister of Health and Population, Ministry of Health and Population, Cairo.
Tel: 20 2 355 1821; Fax: 20 2 355 3966;
E-mail: isalam@idsc.gov.eg

Professor Wagida Anwar, Adviser to the Minister for Scientific Research and Director General of Foreign Health Relations, Ministry of Health and Population, Cairo.
Tel: 20 2 353 4462; Fax: 20 2 355 9422;
E-mail: paems_md@frcu.eun.eg

Dr Mohammed El-Amin Abdel-Fattah, Dean, High Institute of Public Health, 165 El-Horreya Avenue, El-Hadara, Alexandria.
Tel: 203 421 5499; Fax: 20 3 421 8436

Indonesia

Dr Agus Suwandono, Head, Center for Health Services/System, Research and Development, National Institute of Health Research Development, Jl. Indrapura 17, Surabaya 60176.
Tel: 62 31 352 8748/22952 (direct); Fax: 62 31 352 8749;
E-mail: p4k@peter.petra.ac.id

Dr Ascobat Gani, MPH, Dean, Faculty of Public Health, University of Indonesia, Kampus Baru Universitas Indonesia, Depok.
Tel: 62 21 786 3471; Fax: 62 21 786 3472

South Africa

Dr Yogan Pillay, Director, National Health Services, Department of Health, Cape Town 8000.
Tel: 27 12 312 0696; Fax: 27 12 325 8721;
E-mail: pillay@hltrsa2.pwr.gov.za

Professor W. Pick, Medical School, University of the Witwatersrand, 7 York Road, Parktown, Johannesburg 2000.
Tel: 27 11 647 2051; Fax: 27 11 647 2084; Telefax: 27 11 646 1661;
E-mail: 081pick@chiron.wits.ac.za

INTERGOVERNMENTAL ORGANIZATIONS

World Bank

Mr Jacques Baudouy, Chief, Human Resources Division, Middle East Department and North Africa Region, World Bank Headquarters, 1818 H Street, N.W., Washington, D.C. 20433, USA.
Tel: 1 202 473 2525; Fax: 1 202 477 0036

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Dr Abdelmonem A. Afifi, Dean, School of Public Health, Centre for Health Sciences, UCLA, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 6381; Fax: 1 310 825 8440

International Health Committee

Dr Osman Galal- Chair, Director, International Health Programs, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 206 9639; Fax: 1 310 794 1805;
E-mail: ogalal@ucla.edu

Dr Roger Detels, Professor, Department of Epidemiology, Director of UCLA/Fogarty International Training Programme in Epidemiology Related to HIV/AIDS, UCLA School of Public Health, Los Angeles, CA 90095-1772, USA. Tel: 1 310 206 6039; E-mail:detels@admin.ph.ucla.edu

Dr Ralph Frerichs, Chair, Department of Epidemiology, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 206 6039; Fax: 1 310 825 8440; E-mail: frerichs@ucla.edu

Dr Dean Jamison (unable to attend), Professor, Department of Community Health Sciences, UCLA School of Public Health, Director, UCLA Pacific Rim Studies Centre, Los Angeles, CA 90095-1772, USA. Tel: 1 310 206 0223

Dr Charlotte Neumann, Department of Community Health Sciences, UCLA School of Public Health,Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 2051; Fax: 1 310 794 1805; E-mail: cneuman@ucla.edu

Dr Milton Roemer, Professor Emeritus, Department of Health Services, UCLA School of Public Health, Box 951772, Los Angeles, CA90095-1772, USA. Tel: 1 310 825 6957; Fax: 1 310 825 8440

Other faculty

Dr Robert Bailey,Professor, Department of Epidemiology and Biostatistics, School of Public Health,University of Illinois at Chicago, Chicago, USA. Tel: 1 312 996 6620; E-mail: rcbailey@uic.edu

Dr E. Richard Brown,President, American Public Health Association, Director, UCLA Center for Health Policy Research, Professor, Department of Community Health Sciences, UCLA School of Public Health, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 5491; Fax: 1 310 794 1805; E-mail: erbrown@ucla.edu

Dr Michel Eicher, Interim Vice Chancellor for Development, 1147 Murphy Hall, 405 Hilgard Avenue, UCLA, Los Angeles, CA 90095, USA. Tel: 1 310 794 2300

Dr Gail Harrison, Chair, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 3738; Fax: 1 310 794 1805; E-mail: gailh@ucla.edu

Dr John N. Hawkins, Dean, UCLA International Studies and Overseas Programmes, 310 Murphy Hall, 405 Hilgard Avenue, UCLA, Los Angeles, CA 90095, USA. Tel: 1 310 825 4921

Dr Donald Morisky, Vice Chair, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 8508; Fax: 1 310 794 1805; E-mail: dmorsky@ucla.edu

Dr Paul Torrens, Professor, Department of Health Services, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 7640; Fax: 1 310 825 8440

Other participants

Dr Emil Berkanovic, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 6063; Fax: 1 310 794 1805; E-mail: berkanovic@admin.ph.ucla.edu

Dr Linda Bourque, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 4053; Fax: 1 310 794 1805; E-mail: lbourque@ucla.edu

Dr John Froines, Department of Environmental Health Sciences, UCLA School of Public Health

Dr Vay Liang Go, Professor, Department of Medicine, UCLA Center for Human Nutrition, Tel: 1310 794 7848; Fax: 1 310 824 5990

Dr Deborah Glik, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 206 9548; Fax: 1 310 794 1805; E-mail: dglik@ucla.edu

Dr Ron J. Halbert, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 5081; Fax: 1 310 794 1805; E-mail: halbert@ucla.edu

Dr S. Kar, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 5156; Fax: 1 310 794 1805; E-mail: kar@ucla.edu

Dr Joanne Leslie, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 794 7690; Fax: 1 310 794 1805

Dr Virginia Li, Department of Community Health Sciences, UCLA School of Public Health, Tel: 1 310 825 8132; Fax: 1 310 794 1805

Dr Alfred Neumann, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 5081; Fax: 1 310 794 1805

Dr Ruth Roemer, Department of Community Health Sciences, UCLA School of Public Health, Box 951772, Los Angeles, CA 90095-1772, USA. Tel: 1 310 825 6958; Fax: 1 310 825 8440

Dr Steve Rottman, Director, UCLA Prehospital Care, 924 Westwood Blvd., Los Angeles, CA 90095, USA. Tel: 1 310 794 0577; Fax: 1 310 794 0599; E-mail: rottman@ucla.edu

OTHER UNIVERSITIES

Mr Joseph Hafey, Executive Director, Western Consortium for Public Health, Sacramento, California, USA. Tel: 1 510 644 9300; Fax: 1 510 644 9319

Dr Donald Mattison, Dean, School of Public Health, University of Pittsburgh, Pittsburgh, Pennsylvania, USA. Tel: 1 412 624 3001; E-mail: mattison@vms.cis.pitt.edu

Dr Allen Rosenfield, Dean, School of Public Health, Columbia University, USA. Tel: 1 212 305 3929

Mr Robert Minnis, Director, International Health Programs, Western Consortium for Public Health Santa Cruz, California, USA. Tel: 1 408 427 4965

Dr Reed Tuckson, President, Charles Drew University, Los Angeles, California, USA. Tel: 1 213 563 5969

Dr Julia Walsh, Adjunct Professor, Maternal and Child Health and International Health, School of Public Health, UC Berkeley, CA 94720-7360, USA. Tel: 1 510 642 1629; Fax: 1 510 643 8236; E-mail: jwalsh@uclink4.berkeley.edu

Dr Roy Wilson, Dean, School of Medicine, Charles Drew University, Los Angeles, California, USA. Tel: 1 213 563 5969

FOUNDATIONS

Dr William D. Sawyer, President, China Medical Board of New York, 750 Third Avenue, 23rd Floor, New York, N.Y. 10017, USA. Tel: 1 212 682 8000; Fax: 1 212 949 8726; E-mail: 75460.452@compuserve.com

WORLD HEALTH ORGANIZATION

Secretariat of the meeting

Dr Yuji Kawaguchi, Director, Division of Interagency Affairs, World Health Organization, Avenue Appia 20, CH-1211 Geneva 27, Switzerland. Tel: 41 22 791 2739; Fax: 41 22 791 4843; E-mail: kawaguchiy@who.ch

Dr A. Amini, Consultant, Division of Interagency Affairs

Mrs D. Halvorsen, Division of Interagency Affairs

Ms A. Prodham, Division of Interagency Affairs

Group photograph taken at the official residence of the Chancellor the University of California, Los Angeles (UCLA)

ANNEX 8

Programme

Wednesday, 13 November

08:30 - 09:00	Registration
09:00 - 09:10	*Welcome* **Dr Abdelmonem A. Afifi, Dean,** UCLA School of Public Health
09:10 - 09:20	*International health at UCLA* **Dr Milton Roemer,** Professor Emeritus and Founder of the International Health Program, UCLA School of Public Health
09:20 - 09:30	*International studies at UCLA* **Dr John N. Hawkins, Dean,** UCLA International Studies and Overseas Programs
09:30 - 09:40	*Implication of international health for domestic health policy* **Dr E. Richard Brown,** President, American Public Health Association, Professor of Community Health Sciences and Director, UCLA Center for Health Policy Research
09:40 - 10:00	*WHO global strategies and partnership initiatives for health development through interagency collaboration* **Dr Yuji Kawaguchi,** Director, Division of Interagency Affairs, WHO

10:00 - 10:20 BREAK

10:20 - 12:20 *Country experience of national and international collaborative activities*

His Excellency Professor Ismail Sallam
Minister of Health and Population
Ministry of Health and Population, Egypt
Dr Agus Suwandono
Head, Center for Community Health Services
Ministry of Health, Indonesia
Dr Yogan Pillay
Director, National Health Services
Department of Health, South Africa
Mr Jacques Baudouy
Chief, Human Resources Division
Middle East Department and North Africa Region,
World Bank

12:00 - 13:20 LUNCH

Review of training institutions/the UCLA response to the priority health needs of developing countries:

13:20 - 13:40 *Addressing health needs in developing countries*
Dr Gail Harrison, Chair, Department of Community Health Sciences, UCLA School of Public Health

13:40 - 14:00 *Needs for health sector reform in developing countries*
Dr Paul Torrens, Professor of Health Services, UCLA School of Public Health

14:00 - 14:20	*Key elements in research and training of health professionals for developing countries* **Dr Roger Detels,** Professor of Epidemiology and Director of UCLA/Fogarty International Training Program in Epidemiology Related to HIV/AIDS
14:20 - 14:40	Discussion
14:40 - 15:00	BREAK
15:00 - 15:20	*Prority areas of transfer of technology in developing countries* **Dr Ralph Frerichs,** Chairman, Dept of Epidemiology, UCLA School of Public Health
15:20 - 15:40	*Impact of programme implementation through joint collaboration* **Dr Donald Morisky,** Professor, Community Health Sciences, UCLA School of Public Health
15:40 - 17:00	*Round table discussions and presentations* Representatives of participating organizations and universities
17:30 - 19:00	*Light Reception*

Thursday, 14 November

09:00 - 10:30	*Working groups to outline outcome of meeting* Representatives of participating organizations and universities
10:30 - 11:00	BREAK
11:00 - 11:30	*Outline of mechanisms for collaboration between WHO and UCLA* **Dr Osman Galal,** Professor of Community Health Sciences and Director, International Health Program, UCLA School of Public Health
11:30 - 12:00	*Discussion to clarify conclusions of the meeting*
12:00 - 12:30	*Outcome and recommendations* **Dr Ata Amini,** Consultant, Division of Interagency Affairs, WHO
12:30 - 13:00	*Word of thanks* - **Dr Yuji Kawaguchi** *Closing remarks* - **Dean Abdelmonem Afifi**

Further information on the meeting and follow-up activities available from:

Division of Interagency Affairs (INA)
World Health Organization
CH-1211 Geneva 27
Facsimile No. (41-22) 791 48 43
Telephone No. (41-22) 791 27 39/27 41