Final Evaluation of the
WHO Country Cooperation Strategy
Thailand
2012-2016
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Thailand
2012–2016
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Acronyms and Abbreviations

AC Assessed Contribution
AEC ASEAN Economic Community
AIDS Acquired Immunodeficiency Syndrome
AMR Antimicrobial resistance
APW Agreement for Performance of Work
ASEAN Association of Southeast Asian Nations
BMA Bangkok Metropolitan Administration
BMH Border and Migrant Health
BNCD Bureau for Noncommunicable Disease
BOE/BoE Bureau of Epidemiology
BPER Bureau of Public Health Emergency Response
BPS Bureaus of Policy and Strategy
BTC Bureau of Tuberculosis Control
CCS Country Cooperation Strategy
CH Community Health
CIC Coordination and Integration Committee
CSO Civil Society Organization
DDC Department of Disease Control
DFC Direct Financial Cooperation
DM/DRM Disaster Management/Disaster and Relief Management
DOT/DOTS Directly Observed Therapy/Directly Observed Therapy Short Course
DTN Department of Trade Negotiations
EID Emerging Infectious Disease
EOC Emergency Operation Centre
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FAO</td>
<td>Food and Agricultural Organization of the United Nations</td>
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<td>FDA</td>
<td>Food and Drug Administration</td>
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<tr>
<td>FTX</td>
<td>Field Training Exercise</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GHSA</td>
<td>Global Health Security Agenda</td>
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<tr>
<td>GOARN</td>
<td>Global Outbreak and Response Network</td>
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<td>GPO</td>
<td>Government Pharmaceutical Organization</td>
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<td>GPW</td>
<td>General Programme of Work</td>
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<td>HSI</td>
<td>Hospital Safety Indexes</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HSRI</td>
<td>Health Systems Research Institute</td>
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<td>IHPP</td>
<td>International Health Policy Programme</td>
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<tr>
<td>IHR</td>
<td>International Health Regulations</td>
</tr>
<tr>
<td>IO</td>
<td>International Organization</td>
</tr>
<tr>
<td>ITH</td>
<td>International Trade and Health</td>
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<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
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<tr>
<td>JIMM</td>
<td>Joint International Monitoring Mission</td>
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<tr>
<td>JUNIMA</td>
<td>Joint United Nations Initiative on Migration, Health and HIV in Asia</td>
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<tr>
<td>MDR TB</td>
<td>Multidrug resistant TB</td>
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<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>MTR</td>
<td>Midterm Review</td>
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<tr>
<td>NCD</td>
<td>Noncommunicable Disease</td>
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<tr>
<td>NESDB</td>
<td>National Economic and Social Development Board</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
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<tr>
<td>NHA</td>
<td>National Health Assembly</td>
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<tr>
<td>NHCO</td>
<td>National Health Commission Office</td>
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<td>NHSO</td>
<td>National Health Security Office</td>
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<td>NIEM</td>
<td>National Institute for Emergency Medicine</td>
</tr>
<tr>
<td>NTP</td>
<td>National Tuberculosis Programme</td>
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<tr>
<td>ODPC</td>
<td>Office of Disease Prevention and Control</td>
</tr>
<tr>
<td>OIE</td>
<td>World Organisation for Animal Health</td>
</tr>
<tr>
<td>OSC/OST</td>
<td>Oversight Committee or Oversight Team</td>
</tr>
<tr>
<td>PHEM</td>
<td>Public Health Emergency Management</td>
</tr>
<tr>
<td>PHEOC</td>
<td>Public Health Emergency Operation Centre</td>
</tr>
</tbody>
</table>
PMDT  Programme Management of Drug-resistant TB
PoE   Point of Entry
PP    Priority Programme
RS    Road Safety
RSOC  Road Safety Operation Centre
RTG   Royal Government of Thailand
RTI   Road Traffic Injury
SEARO South-East Asia Regional Office
SEZ   Special Economic Zone
SOP   Standard Operating Procedure
SRRT  Surveillance and Rapid Response Team
SSS   Social Security System
TB    Tuberculosis
TB HBC TB High Burden Country
ThaiHealth Thai Health Promotion Foundation
THLSP Thai Healthy Lifestyle Strategic Plan
UC    Universal Coverage
UN    United Nations
UNCT  United Nations Country Team
UNFPA United Nations Population Fund
US CDC United States Centers for Disease Control
VC    Voluntary Contribution
WCO/CO WHO Country Office
WHO   World Health Organization
WHO CC WHO Collaborating Centre
WPRO Western Pacific Regional Office
WR    WHO Representative
XDR TB Extensively drug resistant TB
Executive summary

A final evaluation of the World Health Organization (WHO) Country Cooperation Strategy Thailand 2012–2016 was conducted in June 2016 as called for in the WHO Country Cooperation Strategy (CCS) 2016 Guide. A four-member team conducted the evaluation using key informant interviews and document review as evaluation methods.

The WHO CCS originally had five priority programmes: community health systems, multisectoral networking for Noncommunicable Disease (NCD) control, disaster management, international trade and health, and road safety. In addition, the normative functions of WHO, the unfinished agenda of major public health challenges, and Thailand’s role outside its own borders were part of the CCS. At midterm, community health was dropped from the CCS and two priority programmes were added – border and migrant health and ageing. The working methods of the CCS involved the selection of a lead agency and a management structure that included an overall steering committee, subcommittees for each programme, peer review, annual audits and midterm and final evaluations. The lead agencies were all in the health sector but outside the Ministry of Public Health (MoPH) and the subcommittees were all designed to have multisectoral and multistakeholder representation.

At midterm, community health was dropped and the implementation arrangements changed with the steering committee being replaced by an executive committee (EC). Also, an oversight committee was formed to monitor CCS implementation and service the EC.

The CCS was considered to be relevant to the health needs of Thailand, and WHO is acknowledged as a valuable partner. Design and implementation of the CCS is viewed as a heavy process, particularly in relation to size of the programme. WHO Thailand channels about 48% of its total funds into the CCS programmes and 69% of WHO programme funds to the CCS. The CCS was consistent with the UN Partnership Framework in Thailand. The current CCS was designed to foster multisectoral and multiagency cooperation in the complex health sector of Thailand, mainly through having lead agencies from outside the MoPH. This was successful in some programmes
and less so in others. Multiple personnel changes in both the MoPH and WHO Thailand may have hampered implementation of the innovative design of the CCS.

The role of WHO in a middle-income, high-capacity country was of great interest. The normative functions are well recognized and generally appreciated. The convening and brokering roles are also widely recognized with some reservations. An increasing need for the use of WHO’s advocacy role was often expressed. It was a widely held view that to be more effective in brokering and advocacy, WHO would need to increase its technical assistance capacity in both numbers and skill set.

Recommendations include: (1) have a clear development process for the next CCS, (2) have clear criteria for lead agency selection, (3) continue to foster multisectoral work but perhaps involve the MoPH more, (4) recognize that multisectoral work requires specific technical skills, (5) explore lighter management processes, (6) move the oversight committee towards more sustainable funding over time, (7) slow down the rate of turnover of key personnel, and (8) continue pushing multisectoral working methods in spite of obstacles.

In conclusion, the WHO CCS is well aligned with Thailand’s health priorities. It has oriented most of WHO’s resources towards the priority programmes. Most of the activities have been implemented and have contributed to the stated objectives. The method of working through lead agencies and multisectoral committees has been a partial success and holds promise for the future.
Introduction

“The World Health Organization (WHO) Country Cooperation Strategy (CCS) is WHO’s medium term strategic vision to guide its work in and with a country in support of the country’s national health policy, strategy or plan (NHPSP). It is the strategic basis for the elaboration of the biennial country workplan. It is the main instrument for harmonizing WHO’s cooperation in countries with that of other United Nations (UN) system organizations and development partners. The time frame is flexible to align with national planning cycles. It is generally 4–6 years.” The recommended CCS process is outlined in a set of guidelines issued by WHO. The guidelines are meant to be adapted to the local country situation.1

Key documents to inform the process from the WHO perspective include the WHO General Programme of Work (11th GPW from 2009–20152 and the 12th GPW 2014–20193). Key planning documents of the Royal Thai Government are the 11th National Socioeconomic Development Plan 2012–20164 and the 11th National Health Development Plan 2012–2016.5

The Royal Government of Thailand and the World Health Organization issued the fourth country cooperation strategy for Thailand in 2011 for the years 2012–2016.6 The process includes a final evaluation of the CCS.

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Background

The WHO Country Cooperation Strategy Thailand 2012–2016 was developed through a consultative process involving a participatory, multistakeholder and multisectoral approach. Multiple Thai agencies and organizations, international partners, all three levels of WHO and external consultants were involved. The process was broadly participatory although concerns were openly expressed that the result was heavily influenced by a core group of influential stakeholders.

The process had 17 key government public health agencies identify possible priority areas for WHO and government of Thailand collaboration in the CCS. Twenty-one proposed areas of cooperation were prioritized to five using preset criteria. Four were selected through this process and the fifth was selected by the Regional Director, WHO South-East Asia Region, to break a tie in the scoring system. Five priority programmes (PPs) chosen were:

- Community health systems
- Multisectoral networking for NCD control (NCD network)
- Disaster management
- International trade and health
- Road safety

In addition to the five priority programmes, three additional items were included in the CCS. These were:

- The normative function – dealing with knowledge management in its multiple aspects
- The unfinished agenda – major public health challenges that still required attention including TB control, HIV prevention and care, malaria control, reducing teenage pregnancy, preventing unsafe abortion, iodine intake, health services among migrants and mobile populations, and environmental and occupational health
Thailand’s role beyond its own borders

The management structure of the CCS priority programmes was to include:

- Steering committee for all five programmes to be chaired by the Permanent Secretary of the MoPH and co-chaired by the WHO Representative
- Subcommittees for each priority programme
- Internal and external peer review of plans
- Annual programme/financial audits
- Midterm and final reviews

Terms of reference for the steering committee and the subcommittees were part of the CCS. All of the committees were multistakeholder and multisectoral in nature, with both WHO and MoPH representation.

The five priority areas each had objectives, a main focus area, an approach and a lead agency identified and endorsed by the steering committee as documented in the CCS. The management of the three nonpriority programme areas remained in the more traditional mode of the WHO programme being done through the WHO Thailand Country Office and the Ministry of Public Health.

The CCS was a point of significant departure from tradition in that all five of the lead agencies for the CCS priority programme and the chairs of the subcommittees were in the health sector but outside the MoPH. This was a conscious decision taken at the time of formulation of the CCS. The health sector in Thailand is complex with many points of influence and action outside the MoPH. Health itself was seen as being heavily influenced by factors outside the health sector, the social determinants of health argument. The CCS was aimed at fostering multistakeholder and multisectoral collaboration and action, something that could be described as an ‘all of health’ or even a ‘health in all policies’ type initiative.

At approximately midterm of the CCS period, significant parts of the CCS and its processes changed. The steering committee mechanism was disbanded and replaced by an Executive Committee (EC) that was also chaired by the Permanent Secretary of the MoPH. The EC was responsible for overseeing the CCS priority programmes as well as other activities of WHO. The Health Services Research Institute (HSRI) withdrew from being the lead agency for community health and from being the umbrella organization to serve as the Secretariat for the now disbanded steering committee. Community health was dropped from the CCS when HSRI withdrew.

The Executive Committee appointed an Oversight Team, now renamed the Oversight Committee, within the Bureau of Policy and Strategy of the MoPH in June 2014. This team served most of the functions that HSRI was to perform previously. The responsibilities included:
Review all five priority programmes based on the original principles of the CCS

Develop new programmes in accordance with the changed context

Closely oversee and support the implementation of all programmes throughout the remaining period of the CCS and continuously report to the EC

Financial support came from WHO and required exceptional approval from the Regional Director as salary supplements were included, which were obtained in October 2014.

Community health was dropped as a priority programme when HSRI withdrew as the lead agency. Ageing and Border and Migrant Health (BMH) were added as two additional priority programmes with the lead agencies for both being in the MoPH. Neither of the two later priority programmes had a subcommittee to guide the work.

Many governmental changes occurred in Thailand during the period of the CCS, both in the health sector and in the broader government, including personnel changes. Within the MoPH, there have been three ministers, two Permanent Secretaries and three Deputy Permanent Secretaries – the post that holds the portfolio of being WHO’s direct counterpart. During the period of the current CCS, WHO has had three WHO Representatives (WR) and a total period of 1½ years when the WR post was filled on an acting basis by three different individuals.
Methods

A four-person external final evaluation team consisting of Dr Sawat Ramaboot, Dr Kumnuan Ungchusak, Mr Stéphane Rousseau and Dr Dean Shuey was contracted by WHO with Executive Committee approval. The evaluation methods included a review of documents and key informant interviews that were conducted from 13–24 June 2016. The terms of reference included review of the six priority programmes plus three additional areas of work that had received significant attention from WHO. These areas were: Tuberculosis control, IHR – International Health Regulations, and AMR – antimicrobial resistance.
Findings

Each of the priority programmes was independently assessed and those individual assessments make up Annexes 3–11.

The general findings relevant to all of the programmes are listed in the following sections using headings defined in the CCS guide for evaluations.

4.1 Relevance and Achievement

Thai and international partners acknowledge WHO as a valued partner within the Thai health sector. All key informants felt that the programmes selected to be part of the CCS were highly relevant to Thai priorities, and that they linked to national health policies, strategies and plans, which was confirmed when they reviewed the relevant documents.4, 5

Some expressed concern that the selection of programmes and lead agencies could have been done in a more transparent manner that is more easily understood by all involved. They recognized that there is always some dissatisfaction when programmes or projects are not selected and even a feeling that certain areas of work are being devalued. It is important to inform partners, both past and present, that not being a part of the CCS does not imply that an issue or field of endeavour is unimportant. An issue being excluded from the CCS may actually have more to do with the capacity and resources of WHO than the relative importance of a topic.

The management of the CCS, both in its development and implementation, is heavy. Part of this heaviness was due to the new working methods being proposed where more of the responsibility is passed to the Thai Government, but it still remained a complicated and somewhat repetitive process with multiple layers of approvals and processing. The cycle of CCS development, workplan development, a quality assessment review, five subcommittees, a steering committee/executive committee, external audit reports, a midterm review, an oversight committee and a final evaluation is complex and costly in both time and money.
4.2 Input and analytical element

The original CCS documented the importance of and background to the priority programmes that were chosen, and their selection was linked to analysis of the health situation in Thailand. The initial workplans and targets were sometimes overly ambitious, with this being most notable for the community health programme. The overly ambitious targets in community health were one of the reasons for it having difficulty in coming up with a feasible workplan, falling behind in implementation, and eventually being dropped from the CCS. The time and quality of managerial attention on the part of the lead agency were also questioned. Changes in management at both the MoPH and the lead agency also contributed to its being dropped.

Multiple informants noted that the financial inputs of WHO were relatively minor compared with total funding for all programmes. However, there were aspects of the funding that were noted to be useful in leveraging support or providing seed money for innovation or needed studies and in some cases were even described as flexible. It is also recognized that the role of WHO is not to be a major share of total funding for an area of work.

The CCS is meant to channel more of WHO’s efforts and funds towards the CCS priority programmes. The table below prepared by the WHO Country Office for Thailand shows in US dollars the expenditure for the 2012–2013 and 2014–2015 bienniums and that planned for 2016–2017. The funds to support the WHO Thailand Country Office are shown separately from the CCS programme funding although it should be noted that the functions of the WHO Office are necessary for the WHO CCS to be implemented. The table below combines Assessed Contributions (AC) and Voluntary Contributions (VC) funding sources. The AC categorization is for assessed contribution funds from Member States – the budget that is directly determined by WHO’s governance structures. The VC categorization is for voluntary contributions that are from donor grants to WHO which typically are earmarked for specific activities that fit into the WHO Global Programme of Work but for which WHO has less flexibility about choosing activities. Table 1 shows expenditures for 2012-2015 and budget for 2016–2017 (in USD)

<table>
<thead>
<tr>
<th>Programme</th>
<th>2012-13 HR and Activity</th>
<th>2014-15 HR and Activity</th>
<th>2016-17* HR and Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>1,123,171</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NCD</td>
<td>190,439</td>
<td>780,524</td>
<td>169,435</td>
</tr>
<tr>
<td>Ageing</td>
<td>-</td>
<td>67,677</td>
<td>13,022</td>
</tr>
<tr>
<td>BMH</td>
<td>501,724</td>
<td>1,403,488</td>
<td>160,558</td>
</tr>
</tbody>
</table>

Table 1. CCS and Non-CCS Implementation (HR and Activity combined) (3 Biennium) as of 08 June 2016

4.3 Consistency with the UNPAF

The joint UN Country Team takes guidance from the UN Partnership Framework (UNPAF) Thailand 2012–2016.\(^8\) WHO was felt to be a valued member of the UN Country Team in Thailand and was said to have served as a leading source of technical expertise and guidance in health for the UN Country Team. The WHO CCS and the UNPAF in Thailand were entirely consistent with each other, presumably due to WHO input into the UNPAF process.

The CCS in Thailand was focused on collaboration with Thai partners, although certain programmes had important interaction with other partners. These partners included the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United

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\(^{7}\) Figures obtained from the WHO office as of 8 June 2016. They will change as the 2016-17 biennium progresses.

4.4 Analysis of Collaboration with Partners

The current CCS was designed to foster multisectoral and multiagency cooperation in the health sector, particularly with increased collaboration with entities outside the MoPH. The health sector in Thailand is now quite diffuse with multiple points of influence and implementation. For example, Thailand has opted to develop a provider-purchaser split in its health services with three separate health financing agencies. There is a relatively autonomous health promotion foundation financed through ‘sin’ taxes. The National Health Assembly and its Secretariat, the National Health Commission Office, work on issues of health sector reform, civil society and peoples’ participation in the health sector. There are also quasi-autonomous research agencies and, of course, academia.

The main technique for increasing multisectoral action was placing the lead agency for each programme outside the MoPH with oversight through a multisectoral substeering committee for each programme. As expected with new initiatives, this decision was met with some scepticism and misunderstanding. It was a large departure from previous WHO support to Thailand, which has been described as WHO supporting a myriad of disconnected, relatively small projects scattered throughout the MoPH.

The new mechanism functioned well in some instances and less well in others. For example, in the International Trade and Health (ITH) programme, the lead agency was experienced in dealing with multiple agencies and donor funds, was able to formulate a solid workplan, and the subcommittee actually was able to widen the influence of the programme as membership was expanded to include other ministries involved in trade issues. It also may have functioned better because the scope of the programme was narrower. In NCDs, the topic is more diffuse; there was more confusion between various interpretations of NCD policy in Thailand, and implementation was less smooth and participation of MoPH partners was less than ideal. However, most informants felt that the CCS programme contributed to forward movement in bringing about a more coherent NCD response although much work remains to be done. In other cases, such as community health, the mechanism and programme did not function well and the programme was discontinued.

The newness of the arrangements for managing the CCS did elicit pushback in some quarters, and after changes in management in the MoPH, the Steering Committee was disbanded and an Executive Committee took over the function of oversight of both the CCS and the non-CCS parts of the WHO programme in Thailand.

All informants recognize that the health sector has many actors and that many of the key determinants of health lie outside the health sector. However, there is a wide range of opinions on the best position for WHO to occupy in this complicated
picture. These opinions varied from a traditional view of WHO being closely tied to the MoPH and its primary role being to support the MoPH in assisting it in navigating through its collaboration in the health sector to the opinion that WHO is too close to the MoPH. Others voiced the opinion that the position of WHO in this picture depends on the issue and context. Sometimes the MoPH is the most appropriate partner or lead agency. Sometimes others are.

Pooling of funds for the CCS programmes was considered one of the methods for increasing collaboration. Early on, it was agreed that it was not feasible for WHO to truly pool funds and throughout the period of the CCS, funds from WHO were passed to the lead agency through the DFC mechanism of WHO and they were accounted for tied to specific activities that were in an approved workplan. This is somewhat contrary to the principles of the Paris Declaration on Aid Effectiveness to which WHO is a party. This situation is not unique to WHO Country Office for Thailand. The WHO Office did try to arrange systems that were an acceptable interpretation of the principles of aid effectiveness and donor coordination but still remained within the administrative rules of WHO.

A rationale for the priority programme management arrangements was that it would assist in leveraging support for the programme from sources other than WHO. Support for international trade and health, NCD networking, and road safety document multistakeholder funding was achieved, although it cannot be stated with certainty whether WHO funding leveraged the other participants into joint funding. Border and migrant health, disaster medicine, and ageing did not have records demonstrating CCS funding from other sources. Although all of them have a broad array of funding, it was outside the CCS mechanism. Table 1 shows the information about the funding sources for the CCS Priority Programmes in Millions of Thai Baht. Note that these are not audited figures and they were derived from various programme sources. For road safety, an additional US$ 582 000 was supplied by the Bloomberg Philanthropies through WHO.

### Table 2. Funding sources over 5 years (in Millions of Thai Baht)

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<tbody>
<tr>
<td>ThaiHealth</td>
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<td>14,9</td>
<td>18</td>
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<td>NHCO</td>
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<tr>
<td>HSRI</td>
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<td>11</td>
<td>0,9</td>
<td>19,2</td>
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</tbody>
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There were comments from some programme managers and WHO technical assistants that CCS implementation would go more smoothly if there were fulltime programme staff, presumably paid from WHO funds, who were assigned CCS implementation responsibilities. That is likely true, but it would also undermine sustainability and also be outside the usual working methods of WHO.

In 2014, an Oversight Team (OST), later renamed the Oversight Committee (OSC), was formed by the Executive Committee as described in section 2 of this report. The OSC met regularly, reported to the Executive Committee, produced operational guidelines for the CCS programme and generally performed functions as outlined in their terms of reference. Documents from the OSC were one of the best sources of overall information and an overview on the CCS priority programmes. It is irregular for WHO to provide direct financial subsidies including salary support for a unit inside a Ministry of Health. However, the OSC was the best source of summary information on the CCS priority programmes, and the OSC is performing a necessary function at this time. It is also noted that external financial audits were performed for all of the priority programmes. The financial audits were rather perfunctory and documented that accounting procedures had been followed with no evidence of malfeasance, but did not give any insight on whether the funds had been used efficiently or effectively.

All informants recognized that WHO and the CCS are not a major source of financial support and none expected WHO to play that role.

The preferred roles of WHO were several. All informants recognized the normative role of WHO in the global context. The normative role was felt by all to be the adaptation of global or regional norms, standards and policies to the Thai context, and this is one of the most valued functions of WHO. There is also much interest in WHO playing a role in helping Thailand provide inputs to the development of norms, standards and policies beyond its borders. Knowledge management and strengthening the evidence base for decision-making were mentioned by several informants as roles WHO should play. It is noted, however, that there are now many easily available sources of normative guidance outside WHO, which presents a challenge to WHO’s traditional role.

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<td>WHO</td>
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<td>MoPH</td>
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<tr>
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<td>28,2</td>
<td>48,1</td>
<td>35,1</td>
<td>1,7</td>
<td>1,6</td>
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</tbody>
</table>

Most informants recognized the convening and brokering roles of WHO. The convening role is not controversial, and WHO’s role in bringing diverse partners from within and outside Thailand together is appreciated. Brokering is more controversial, but most informants felt that there is a role for WHO to play in brokering solutions when there are differences of opinion on issues of public health importance between various parties in Thailand. Other informants felt that there was little or no role for outside agencies to play in such situations. All agreed that if such involvement occurs, it requires skills, experience and tact on the part of WHO to fill the brokering role.

Technical assistance through WHO is also valued although some reservations about the quality and usefulness of the assistance were raised. Thailand is justly proud that it is recognized as having a high level of expertise in the health sector. The nature of technical assistance needed has therefore changed. The need is felt to be for more ‘detailed’ or highly specialized technical assistance in specific areas, something that a public health generalist might have trouble providing. Another area of technical assistance mentioned was in programme management, particularly in the establishment of indicators and monitoring and evaluation. Informants also said that there were times when WHO technical assistance needed to be provided in a more proactive fashion, moving around, knocking on doors and actively pushing collaboration between partners. It is a fine balance to keep between being too passive and being seen as interfering. It was felt that WHO could do better in providing technical assistance, perhaps by having a technical assistance plan that identified needs and sources as part of the planning process.

Advocacy is an area where several informants felt that WHO collaboration and technical assistance was important, useful and potentially needs to be strengthened. WHO advocacy is particularly appreciated when there are public health issues that are receiving pushback or opposition from powerful sources from both the government and outside the government. The advocacy seems to be most appreciated when WHO is seen as an ally in a dispute, bringing international norms and authority to the argument. Advocacy is less appreciated when WHO is seen as a potential critic.
Recommendations

- A clear development process for selecting priority programmes for the next CCS should be defined and disseminated to all relevant parties in a clear and transparent manner early in the process. Any changes in the procedures during the process should be widely disseminated to stakeholders.

- The selection of lead agencies is particularly sensitive. A combination of some lead agencies from the MoPH and some from the broader health sector may be a reasonable strategy if such a combination meets the needs of the programme. Lead agencies with no executive function in the area where they work have difficulties if the workplan calls for direct action by implementers outside their line of authority.

- Multisectoral and multiagency work done by the subcommittees is a strong part of the CCS in several of the current programmes. This should continue and be fostered. The multisectoral committees have existed and functioned where the lead agencies were outside the MoPH in the current CCS. Having an MoPH entity as the lead agency but still having an active multistakeholder subcommittee should be considered in the future. Examples in the current programme where this might have been useful are border and migrant health, ageing, and tuberculosis. In addition, the subcommittees should not be established as WHO CCS-specific committees but have broader multisectoral responsibilities for multiple partners. If managerial subcommittees are not possible, multistakeholder technical working groups are an alternative.

- All parties involved need to recognize that partnerships beyond the Ministry of Public Health and even beyond the health sector are needed to tackle some of the more important and complex health issues. Such partnerships do not come as naturally as the long-standing relationship between WHO and the Ministry of Public Health. When wider collaboration is needed, there will also be a need for increased effort on the part of WHO, including increased technical assistance skilled in brokering convening and advocacy, to foster those relationships.
A lighter process for managing the CCS should be pursued. More emphasis on developing strong monitoring frameworks with clear objectives linked to activities and indicators that are monitored by the lead agency, the OSC and WHO Thailand, rather than depending so heavily on outside evaluation teams would be desirable. The initial monitoring framework written in the early part of the WHO CCS process may require more attention from both the lead agency and the WHO technical team to ensure that a framework linking activities to objectives with robust, feasible indicators with clear targets are part of the CCS planning process.

Technical assistance needs should be identified early in the CCS process so that there is a greater chance that they can be met on a timely basis.

WHO should pursue with the MoPH methods of providing the OSC functions in a more sustainable manner. Phasing out salary supplements should be a medium-term objective.

The new method of working for the WHO CCS using subcommittees and lead agencies should be considered a partial success. The rapid turnover of personnel in both WHO and the MoPH is likely to have hampered its implementation. The learning curve for this new way of working was almost certainly disrupted by all of the personnel changes.

Health has many determinants outside the formal health sector. The potential benefits of multisectoral work almost certainly justify the added complexity that happens when implementing multisectoral programmes.

In conclusion, the WHO CCS Thailand 2012–2016 was well aligned with the health priorities of Thailand. It has been successful in orienting the resources of WHO towards those priority programmes. Most of the activities have been implemented and they have contributed to partial achievement of the stated objectives. The method of working through lead agencies and multisectoral subcommittees has been a partial success and holds promise for the future.
Acknowledgements

The review team wishes to acknowledge the assistance of the many key informants from the multiplicity of organizations in the health sector in Thailand as well as technical officers from the WHO Office in Thailand, and in particular Dr Nima Asgari-Jirandeh, who was instrumental in organizing the evaluation and Dr Liviu Vedrasco, who coordinated the review of the evaluation and its publication. We also express our appreciation to the WHO Thailand Country Office support staff in general and to Ms Sunida Theo-pradit and Ms Nathaporn Wongsantativanich in particular for their patience and assistance in finding documents, arranging meetings, answering questions and generally helping us to make the mission more successful. We hope that it is of value to WHO and to the people of Thailand.
Annex 1 - TOR

1. Background

The WHO-Thailand CCS 2012–2016 was developed and launched to guide an innovative partnership programme approach for collaboration between WHO and the Royal Thai Government (RTG). The new approach sought to reflect the implications of Thailand’s status and achievements as an upper-middle-income country, the changing nature of the health and development challenges and the overall characteristics of the health sector. Accordingly, the CCS proposed a more evidence-based strategic and focused selection of priorities for collaboration.

The agreed monitoring and evaluation procedures for the CCS included a midterm review and a final evaluation. The midterm review was carried out in June 2013 in order to:

- review progress, process, outputs and outcomes of the PPPs
- identify lessons learnt from planning and implementation, and
- propose potential changes

WHO has recently revised the guidelines for the formulation of the CCS to ensure that the process ensures co-ownership, involves all relevant stakeholders, is consistent with UNPAF and SDGs commitments, and results in a more strategic document.

2. Objectives of the final evaluation

- To assess the relevance and overall outputs, outcomes and impact of the PPPs in relation to national health priorities in the following areas:
  - Community health systems
  - Multisectoral networking for noncommunicable disease control
  - Disaster preparedness and response
  - International trade and health
  - Road safety
  - Migrant health
  - Ageing
To identify and document lessons learnt from planning and implementation of the PPPs

Assess the balance between PPPs and other MoPH/WHO priorities (unfinished agenda section of CCS)

Suggest improvement for the formulation process of the CCS for 2017-2021

The final evaluation will also be expected to identify and document lessons learnt in terms of the effect of the approach on:
- channelling additional funds to activities in the priority areas
- the quality of the activities performed
- intersectoral collaboration
- the roles played by WHO and MoPH in the process

3. Methodology

It is anticipated that the evaluation will include the analysis of documents as well as in-depth structured interviews and consultations with key stakeholders. The evaluation will be conducted by a team of four external independent reviewers recruited by the WHO Office in Thailand. One of the reviewers will be recruited as the team leader with additional responsibilities for evaluation design and completion of the final report.

The evaluation will be scheduled for two weeks. A final report will be submitted to WHO two weeks after the completion of the evaluation.

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<thead>
<tr>
<th>Deliverables</th>
<th>Responsibility</th>
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<tr>
<td>Concept note with review framework and methodology</td>
<td>Team leader</td>
</tr>
<tr>
<td>Evaluation conducted –individual reports finalised</td>
<td>All evaluation team members</td>
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<tr>
<td>Draft report compiled</td>
<td>All evaluation team members</td>
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<tr>
<td>Presentation for RTG-WHO Executive Committee</td>
<td>WHO Thailand</td>
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<tr>
<td>Final report</td>
<td>Team leader</td>
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4. Role of the evaluation team members

The evaluation team members will:

- Need to become familiar with the CCS, the Midterm Review, progress reports and other relevant documents concerning the Partnership Priority Programmes prior to the interview phase
- Participate in the finalization of the evaluation instruments
Collect data through interviews, site visits and from other documents to complete an in-depth review of the outputs, outcome and impact (in his or her assigned areas or PPPs) and of the processes involved.

Provide the following information, in writing, about findings in his or her assigned areas for further consolidation into one report:
- Short summary of the achievements and other key findings from the analysis of documents, reports and interviews
- Lessons learnt
- Key recommendations
- Other relevant information on constraints and barriers to implementation

Review the consolidated draft report and provide additional inputs, explanations and suggestions.

5. **Additional duties of the team leader**

In addition to the responsibilities outlined above, the team leader will also be expected to perform the following duties:

- Develop a concept note outlining a framework for the evaluation for discussions with the CCS working group made up of designated representatives and focal points at the MoPH and WHO Thailand Country Office
- Lead the development of the evaluation instruments and questionnaires
- Assigned responsibilities to team members and brief them and oversee the general conduct of the data collection for the evaluation
- Organize the preparation of a draft report on the findings of the evaluation as well as a presentation to brief the RTG-WHO Executive Committee
- Prepare and submit a final evaluation report to the WHO Thailand Country Office.
## Annex 2 – Interviewees

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<thead>
<tr>
<th></th>
<th>Name</th>
<th>Position &amp; Address</th>
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<tbody>
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<td>3</td>
<td>Dr Anurak Amornpetchsathaporn</td>
<td>Director, Bureau of Public Health Emergency Response (BPHER), Ministry of Public Health, Focal Point for DM</td>
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<tr>
<td>4</td>
<td>Dr Attaya Limwattanayingyong</td>
<td>Deputy Director, Bureau of the International Health, Office of Permanent Secretary, MoPH</td>
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<td>5</td>
<td>Dr Bhichit Rattakul</td>
<td>President, Navamindradhiraj University. Chair of the DM Sub-Steering Committee</td>
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<td>6</td>
<td>Dr Bundit Sornpaisarn</td>
<td>Director, office of major health risk, Thai Health Promotion Foundation</td>
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<tr>
<td>7</td>
<td>Dr Chai Kritiyapatchatkul</td>
<td>Former national programme officer of WR Country Office and first focal point on NCDs network since the programme started</td>
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<td>8</td>
<td>Dr Chaninan Sonthichai</td>
<td>Project Manager for BMH, Vaccine Preventable Diseases Section, Department of Disease Control, Ministry of Public Health</td>
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<td>10</td>
<td>Mr Chawalit Tantinimitkul</td>
<td>Former WHO national programme officer on communicable diseases and IHR</td>
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<td>11</td>
<td>Dr Chawetsan Namwat</td>
<td>Director, Bureau of Tuberculosis Department of Disease Control, Ministry of Public Health</td>
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<td>12</td>
<td>Dr Chutima Akaleephan</td>
<td>Senior Researcher, International Health Policy Program, Thailand</td>
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<td>13</td>
<td>Dr Ekachai Piensriwatchara</td>
<td>Director, Bureau of Elderly Health, Department of Health, Ministry of Public Health</td>
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<td>Name</td>
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<td>31 Dr Potjamarn Siriarayaporn</td>
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<td>35 Ms Rungarun Limlahaphan</td>
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<tr>
<td>38 Dr Siriwan Pitayarangsarit</td>
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<td>44 Dr Supreeda Adulyanon</td>
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<td>47 Dr Vijj Kasemsup</td>
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<td>48 Dr Viroj Tangcharoensathien</td>
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<td>49 Dr Waraluk Tungkanakul</td>
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<td>50 Dr Witaya Chadbunchachai</td>
<td>Director, WHOCC for Injury Prevention and Safety Promotion, Khon Kaen Regional Hospital</td>
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<tr>
<td>51 Dr Yongyot Thammavudhi</td>
<td>Present director, office of Thai Healthy Lifestyle. Office of Permanent Secretary, Ministry of Public Health</td>
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Annex 3 – Ageing

Background

Thailand is going through a demographic transition, and the proportion and absolute numbers of the population that is older is rapidly increasing. In 2015 15.8% of the population was estimated to be over the age of 60 and this is projected to increase to 37.5% by 2050.\(^{11}\) The Government of Thailand has recognized the importance of ageing as an issue in Thailand and there is a National Commission on the Elderly that was established by a parliamentary act in 2003 as well as a 2nd National Long-term Plan for Older Persons (2002–2021).\(^{12}\)

Although the issue of dealing with the challenges of an ageing population has been made a priority, the response in Thailand is fragmented with multiple ministries, institutes and civil society organizations involved and a rather confusing overlapping of plans, policies and responsibilities.\(^{13}\) Even within the Ministry of Public Health there are at least three bureaus or departments with plans concerning ageing, as well as involvement of the National Health Commission Office, the National Health Security Office, and the Thai Health Foundation with little interaction between them to date.

Ageing was not an original part of the WHO CCS, but it was added at midterm through a decision of the Executive Committee and WHO. This decision was taken at about the time that community health was dropped from the CCS.

Considerable interest has been expressed in this topic by interviewees within the MoPH, within the broader health sector, and also within the UN system with Thailand. Ageing is an issue of increasing importance within WHO at both the regional and global levels.\(^{14}\)

The general objective as stated in the project proposal was to have evidence-based policy recommendations for the national ageing programme.

Specific objectives were:

- Strengthen health system for active ageing policy to address the health needs of the elderly.
- Promote active participation of the elderly and relevant stakeholders.
- Encourage comprehensive security development for enhancing active ageing.

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11 Chulalongkorn and HelpAge International. The Situation of Thailand’s Older Population. 2014.
14 69th World Health Assembly Resolution May 2016
Findings
The programme was initiated in 2015. The Bureau of Elderly Health, Department of Health, MoPH, is the programme manager. Several months were taken up in the process of developing and obtaining approval for a workplan. An initial budget of 2.08 million Baht was submitted that consisted of six literature reviews. It was rejected and in July 2015, a 1 million Baht budget that contained four literature reviews was developed and approved, submitted to WHO on 28 August 2015, and the funds were disbursed on 05 September 2015. Three literature reviews were completed by mid-December 2015.

A 2016 proposed workplan has been received but final approval was not yet complete.

Achievements
Literature reviews were completed on three topics: health service delivery for active ageing in Thailand, health workforce for elderly care in Thailand and foreign countries, and social participation of the elderly in Thailand.

A fourth study on security for enhancing active ageing was not completed due to a limitation of time. A request to WHO was made to use the remaining funds for two meetings but this was not approved. 358 820 Baht were returned to WHO.

Gaps and challenges
The ageing CCS programme does not have the same subcommittee structure as the other programmes. This is reasonable as the funding levels are low and the start-up was late.

The English translations of the studies completed were brief, and the information provided was relevant but rather cursory. The policy recommendations were general and would need further development to lead to action in Thailand.

Conclusions and recommendations
Ageing of the population and the implications for the health sector is of high relevance in Thailand. It will become of greater importance as the demographic transition continues and as economic and cultural patterns change. The response to date in Thailand has been rather fragmented both within and beyond the health sector.

Ageing should be approached in a cross-cutting way, both across traditional professional and ministerial boundaries, but also across different levels of government, ranging from community to national level. The need for such diverse and varied action is an opportunity and also a challenge. One interviewee did mention that ageing could be the only cross-cutting or holistic area approach in the WHO portfolio, particularly since community health has been dropped.
Quality control for development of research study proposals needs to be strengthened.

More timely submission, vetting and approval of proposals would be desirable. Proactive technical assistance might be necessary to accomplish this.

Ageing is an important topic for Thailand and for WHO. The context in Thailand is complicated and if WHO wants to be involved in a meaningful way, the ability to provide technical support will need to be stronger.

If WHO continues to work in ageing, a decision will have to be made whether to focus on collaboration within the MoPH, within the entire health sector, or broader multisectoral collaboration. The most comfortable niche for WHO might be working in a collaborative way within the MoPH on service provision. A more challenging approach, but one with potentially greater gains for the elderly, would be to work on collaboration across the broader health sector, including both the broader governmental health sector and civil society. This would require a more substantive commitment to technical assistance and funding in the area of ageing.
Annex 4 - Antimicrobial Resistance (AMR)

Background

Antimicrobial resistance (AMR) is one of the major threats for public health worldwide. The need to control AMR is well recognized at both the global and national levels. At the global level, AMR was the topic of World Health Day in 2011; WHO SEARO issued a regional strategy on AMR from 2010–2015; and in 2015, the World Health Assembly endorsed a global action plan that called on all Member States to develop national strategic plans on AMR by 2017. In Thailand, the national strategy on AMR has yet to be finalized. Presently, AMR is dealt with under two national policies: (1) the national strategic plan for emerging infectious diseases (EIDs) 2013–2016 and (2) the national drug system development strategy 2012–2016. The focus of the EID strategic plan is on prevention, surveillance and containment. The drug system strategy emphasizes the quality, distribution and rational use of antimicrobials.

Findings

During the past 5 years, WHO has been involved in two AMR projects. The first is the “Development of Thailand National Strategy on Antimicrobial Resistance”. This project is completed. The second project is “System analysis of antimicrobial utilization in human and animals: actors and legal framework in support of antimicrobial use (AMU) monitoring”. This project was approved on 15 June 2016 and has not yet started. In this report, only the first project will be evaluated.

AMR is of high relevance within global and national policy. The 8th National Health Assembly in 2015 passed a resolution urging all sectors to tackle the crisis of antimicrobial resistance through integrated problem solving. WHO at both regional and global levels has called on Member States to take action.

There are three major partners initially: Ministry of Public Health (MoPH), Ministry of Agriculture and WHO. Under the MoPH, there are four departments: Thai FDA on regulation and rationale usage, Department of Medical Sciences on laboratory surveillance, Department of Disease Control on prevention and control of hospital acquired infection, and Office of Permanent Secretary on Health Services. In the Ministry of Agriculture, there are three departments: Livestock Development, Department of Fishery, and National Bureau of Agricultural Commodity and Food Standards.

16 WHO SEARO. Regional strategy on prevention and containment of antimicrobial resistance. WHO 2010.
18 National Health Assembly (NHA 8) at http://en.nationalhealth.or.th/nha8 accessed 25 June 2016
The Thai FDA in the Bureau of Drug Control acts as project manager. The status is that of a starting project with one manager and a few part-time support staff. The project utilizes the governance mechanism of the CIC (coordination and integration committee) chaired by the Deputy Permanent Secretary who oversees the FDA.

**Achievements**

Overall, the project has completed the expected activities and output in a timely manner with good documentation. The project has produced the Draft National Strategic Plan on AMR 2016–2018 and the stakeholder analysis “Landscape of antimicrobial resistance situation and action in Thailand”.

The draft national strategic plan aims to establish the essential infrastructure to consolidate multisectoral collaboration and action to reduce morbidity, mortality and the economic impacts of AMR. There are six strategies:

- Develop AMR surveillance and warning system.
- Strengthening surveillance and regulation of antimicrobial distribution.
- Strengthening infection prevention and control of antimicrobial stewardship in hospitals.
- Prevention and control of AMR and antibiotic residues in agricultural food and commodities.
- Improve public awareness.
- Establish coordinating mechanisms, both national and international.

The draft national strategic plan is now undergoing final scrutiny by the MoPH. It is planned to submit it for cabinet endorsement in 2016.

WHO has been in contact with all key departments in the MoPH and provided funding of 947 920 Baht to support this project. The Department of Medical Sciences is a key partner in laboratory surveillance and also a WHO Collaborating Centre. At the international level, the collaboration of WHO and World Organisation for Animal Health (OIE) and Food and Agriculture Organization (FAO) will help in collaboration at the national level. Aligning the work in AMR done through the International Health Regulation (IHR) and the Global Health Security Agenda (GHSA) initiative of the US Government can be an opportunity in the future.

**Gaps and challenges**

Once the national strategic plan is endorsed by the Cabinet, action plans for each participating sector, including defining the role of each sector, have to be developed, integrated and implemented over the next three to five years. There will be a need for
much coordination within the MoPH and also with other ministries and the private sector, both for-profit and civil society. The MoPH needs to identify the lead agency for this coordination. There are three likely candidates to lead the coordination efforts – the FDA, the Department of Medical Sciences, or the Department of Disease Control, although other alternatives may be found. It is the prerogative of the MoPH to determine what the managerial structure will be and then to ensure that it has sufficient capacity to perform the assigned tasks. Strong coordination is needed to avoid problems in implementation and monitoring progress in this complex, multisectoral, multidisciplinary effort.

According to the six strategies in the draft AMR strategic plan, there will be a need for technical input in multiple areas. Some of the expertise needed may need to be found from outside of Thailand.

**Conclusions and recommendations**

AMR is a significant health threat nationally, regionally and globally. WHO has successfully supported the Thai FDA to develop the draft national strategy on AMR and in performing a stakeholder analysis. The draft AMR national strategy is expected to be endorsed by the Cabinet in 2016 and implemented from 2016–2018. There is a need for WHO to continue to collaborate with the MoPH in the next phase of AMR, which will focus on implementation of the strategic plan. The next phase of AMR implementation is likely to need more technical assistance, including from outside Thailand.

WHO should continue the support to AMR programming into the next biennium. It needs to be managed as a programme according to the national strategic plan. WHO can play a crucial role by providing technical support and linking the Thai AMR programme with international experts and institutes in multiple areas, e.g. laboratory surveillance, surveillance of drug distribution, and hospital-acquired infection control to name only a few.

Identifying a lead agency to coordinate AMR activities within and outside the health sector should be a high priority for the MoPH.
Annex 5 – Border and Migrant Health

Background

In Thailand, the World Health Organization has a long history of involvement in border and migrant health.19 Cooperation with the Royal Thai Government (RTG) on the borders was once mainly focused on supporting disease control, data surveillance, cross-border interventions and multipartner coordination for health services in these areas. These services targeted refugees and displaced persons in encampments, as well as Thai nationals living along the border.20 In the last two decades, the Thai economy’s need for migrant workers rose sharply and so did the number of migrants, mainly from Myanmar, but also from Cambodia and Lao PDR.21 The role of WHO evolved with the situation, adapting to the changing nature of the issues surrounding migrants’ health in the country’s health system, encompassing a broader scope geographically and topically. The decision, after the Mid-Term Review of the Country Cooperation Strategy, to add “Border and Migrant Health” within the CCS priority programmes is an indication of the importance both RTG and WHO grant to the growing challenge of migrant health.

Currently, “migrant health” in the Thai health system is split in three separate programmes: “Border health”, “Migrant health” and “Special Economic Zones (SEZ)”. “Stateless” populations22 have been added to these three recently. These programmes are run in different geographical zones that sometimes overlap, sometimes with different sponsors or sometimes the same sponsors, deliver different or similar services to different target populations. Services are implemented through different partnerships and sometimes governed by different authorities, e.g., the SEZ are under the responsibility of the provincial Governors. All this renders the multipartner and multisectoral coordination of migrant health particularly challenging. The WHO-RTG Country Cooperation Strategy “Border and Migrant Health” priority programme approach is nevertheless holistic and encompasses the four different foci mentioned above.

Findings

“Border and Migrant Health” area of concern was “upgraded” from a “major public health challenge” to a “CCS priority programme” upon midterm review recommendation, with the mutual agreement of WHO and RTG. The programme started in June 2015, much later than other programmes (2012). Bureau of Policy and Strategy (BPS), Permanent Secretary Office, Ministry of Public Health serves as the lead agency with Dr Pongsadhorn Pokermdee, Director, BPS as programme manager.

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19 Notably following a simultaneous request by both Myanmar and Thailand Governments for WHO to assist.
20 Defined as living in the border districts.
21 Migrants – all categories together – are said to represent 3% of the population of the country and 6% of the GDP.
22 Approx. 100,000 people.
In Oct. 2013, WHO was requested to organize a “Task Force on Migrant Health” for international organizations and NGOs to provide technical inputs to the Government on implementation for the new migrant health policy. The Task Force (TF) met only twice, but these meetings were reportedly very useful.

Achievements

The programme was affected by the turnover of key staff, including the programme managers. At the time of the final evaluation, a new director of the BPS had been appointed and became the de facto CCS programme manager for “Border and Migrant Health”. The new leadership of the programme is promising and seems to illustrate the MoPH’s commitment to border and migrant health.

Despite the late start and the staffing challenges, the BPS completed successfully the Phase 1 objectives:

The following are titles of the studies as in the final translated report of the CCS BMH programme phase 1:

1. A Literature Review of Health Insurance Card for Migrants
2. A Literature Review of Policy to Provide (Return) Basic Health Benefits to Persons with Citizenship Problems according to the Cabinet Resolution dated 23 March 2010
3. A Literature Review of Social Security System for Migrants
4. A Comparison of Benefits Packages
5. An Analysis of Migrant Health Information System
6. An Analysis of Primary Care Service System in Special Economic Zones and Borders: A Case Study of Mae Sot Special Economic Zone, Tak Province
7. A Literature Review to Identify Knowledge Gaps in Implementing Health Care System for Migrants in Thailand
8. Qualitative Study of Health Care Policy for Migrants in Thailand Focus group and in-depth interview of the experts on policy framework on migrants

While these studies and the organization of a subsequent focus group of experts on policy frameworks for migrants represent a 100% completion of the proposed activities for the CCS programme, one should underline here that these activities actually represent only a tiny portion of the overall activities undertaken in border and migrant health, and to which WHO provided a whole array of support, including through the

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23 organized by WHO upon RTG request, for IOs and NGOs to provide technical inputs to the Government on implementation for the new Migrant Health policy.
implementation of a “Border Health Development Master Plan 2012–2016” and the management of an EU-sponsored project (see below). As mentioned earlier, migrant health activities are actually implemented through “border health”, “migrant health” and “special economic zones” programmes separately; these programmes achieved a whole set of activities – funded by ThaiHealth Foundation and/or by the EU project mentioned above – appearing in their respective reports.

Since 2011, WHO Thailand has been implementing an EU-funded project – the “Strengthening Health Security in Thailand by Improving Health Status of Myanmar Refugees and Displaced Persons in Thailand”25. The work in 2015 included support to establish and scale up border ‘Health Information Centres’ for migrants in a province, as well as helping to maintain a Health Information System operating in camps for displaced persons on the Thai-Myanmar border; supporting the translation from Thai into Burmese language of the MoPH handbook for Maternal and Childhood Health, and printing copies; holding a workshop to support young adults to develop video films aimed at promoting a positive attitude towards refugees and displaced persons in Thailand, etc.

It was admittedly challenging for the mission to keep track of all the various activities undertaken under the different migrant health-related programmes, as no centralized report gathering “border health”, “migrant health” and “special economic zones” seems to exist. Likewise, the Oversight and Support Committee reported to the Executive Committee exclusively on the CCS programme phase I activities (i.e. the studies mentioned above).

While fragmented, other activities that came to the knowledge of the mission were: a workshop for the SEZ (with every SEZ province represented and relevant NGOs participating); a bilateral agreement between the two respective ministries of public health of the Royal Thai Government and the Royal Cambodian Government on cross-border operations, joined strategy on communicable diseases, training, hospital collaboration, including cross-referral systems, capacity-building, etc.

The only CCS-funded activities were the seven studies, which means that evaluation of the CCS evaluation activities is not sufficient to assess the effectiveness and the efficiency of the overall and much larger BMH programme.

The bureau of Policy and Strategy appears ambitious and determined to contribute to RTG’s aspiration to pose as a model on migrants’ health, notably on migrants’ health financing. Under the “Health Development” agenda of ASEAN, Thailand will participate in the related ASEAN conference in Manila in July 2016. RTG is also active in the Greater Mekong Subregion migrant-related initiatives, to which

25 The project signed between WHO and the EU covering a 5-year period from 23 December 2010 - 22 August 2015). Most of the RTG-WHO mutually agreed CCS activities on “Migrant Health” were funded by the EU project (EU DCI-ASIE/2010/2456.451).
WHO contributes notably through the 6-year old “Mekong WR forum” across SEARO/WPRO WHO Regions.

BPS is actively planning phase II of the CCS programme. This includes notably (i) set up a CCS Programme Sub-Steering Committee (the proposal was reportedly accepted at time of the mission); (ii) distribute the budget proposals to potential donors and partners; (iii) implement action plan activities; (iv) monitor and report to the Programme Sub-Steering Committees; (v) identify indicators and (vi) monitor the implementation. (NB: Designing a Phase II is not in the terms of reference for the final evaluation.)

WHO has been active in border health since the early 1980s, when the first waves of refugee influxes from Myanmar crossed the border. WHO’s involvement has evolved from areas such as support to outbreak investigation in border-displaced person camps in the past to much broader support, such as countrywide migrant health financing currently.

Throughout the past two decades, WHO was able to advocate for migrants’ health – including sometimes through challenging political environments – invoking alternatively or simultaneously health security (i.e. protecting also the Thai population) and/or the right to health as a human right for migrants. The organization also advocated with donors and MoPH (e.g. for availability of essential medicines and medical supplies to refugee camps, and to NGOs providing service to migrant populations).

Currently WHO’s involvement covers all core functions of the organization: technical assistance (CDC, vaccinations, data collection, planning, etc.) in and out of refugee or displaced person encampments: normative role (i.e. providing NGOs with the guidelines and protocols needed in their assistance to migrants); and convening power, calling all stakeholders (including United National High Commissioner for Refugees (UNHCR), International Organization for Migration(IOM), donors, NGOs, local health authorities, etc.) for migrant-related roundtables notably on malaria, tuberculosis, immunization, infectious diseases, etc.

WHO also organized or co-organized national, subregional events (i.e. WHO is proactive in the Mekong subregion, beyond the SEARO-WPRO geographical divide), or regional (ASEAN), on migrants health; WHO plays an important advocacy role, notably in specific forums, such as the CCSDPT subcommittees on refugee and displaced persons’ health, or Task Force on migrant health, or various migrant health-related working groups. The organization is regularly requested to review migrants’ health-related policy papers.

The “Border Health Development Master Plan 2012–2016” prepared by the MoPH Bureau of Policy and Strategy received valuable support from WHO, with WHO driving discussions on certain issues.
Although the EU project was originally limited in scope to refugees and displaced persons on the border, WHO leveraged the funding to contribute to initiatives of a larger scope.

To support ethical and evidence-based policies, WHO has worked closely with recognized research institutions such as the Institute of Population and Social Research at Mahidol University. It also developed an academic network, with a research agenda on migrants’ health, establishing a forum on research gaps. WHO is invited every year to comment/present at the international conference on migrant health organized by the Mahidol University “Migration Centre”.

Regionally, WHO is part of the “The Joint United Nations Initiative on Migration, Health and HIV in Asia” (JUNIMA), which brings together governments, including the ASEAN Secretariat, leading Civil Society Organization (CSO) networks, and the United Nations family, to promote universal access to HIV prevention, treatment, care and support for mobile and migrant populations in Asia. In Thailand, the global UN system approach is implemented under the UN Resident Coordinator through a network on migration, to which WHO contributes on the health and well-being aspects. WHO has also signed an MoU with ASEAN, with specific collaborative arrangements on migrant health.

**Gaps and challenges**

The past political turmoil has had some implications on migration policies at a high level – be it sometimes by simply creating a climate of uncertainties – and WHO had to adapt its advocacy stance to ensure migrant health would remain on the agenda.

The high turnover of staff at the BPS caused delays in the programme, but the issue seems to have been addressed appropriately with the arrival of the new programme manager and his new staffing and capacity-building plans. It is critical that the BPS be sufficiently staffed with personnel of the right qualifications to follow closely migrants’ health policies and implementation countrywide. In the next CCS programme plan (phase II), BPS will assign at least four staff to BMH work. To retain these staff, BPS intends to solicit CCS WHO funding, for both salary and capacity-building.

Monitoring and evaluation remains weak and the high turnover of staff compounds the issue since institutional memory is also gone.

There are many institutions involved in migrant issues. To be operationalized, migrants’ health, as a multisectoral field of work, requires multistakeholders’ interventions; yet, partnership management is a complex process, requiring specific skills not always available locally. Moreover, in some instances, forums may be held exclusively in Thai languages, limiting the contribution of non-Thai WHO officers.
While monitoring and evaluation is weak, there exist planning documents, such as the “Border Health Development Master Plan 2012–2016” (NB. The new one is now ready), that contain sound indications of goals, objectives, strategies, down to indicators and core activities. These are the closest to a programme log frame, and with proper and sufficient staff assigned, one may expect these plans to be converted into a sound log frame providing a better basis for monitoring and evaluation. WHO should support and ensure that the logical framework of the programme is result-oriented.

Some key informants mentioned that for some officials, being the RTG-WHO CCS programme manager constitutes an extra workload. WHO regulations, for instance, forbidding the payment of supplements to civil servants involved in implementing the CCS (including PM) constitute sometimes a disincentive. This – to this key informant – explains the high turnover of programme managers and why it is very difficult to find CCS PM.

Conclusions and recommendations

The CCS migrant health programme started late and was delayed by a high staffing turnover. However, the sole activity planned under phase I was implemented and all money allocated to it was spent.

The migrant health programme managed by the Bureau of Policy and Strategy is a much broader programme than the CCS programme phase I, and WHO contribution is to be found more in this broader programme than in the CCS programme phase 1. WHO contribution indeed was in all aspects and was highly recognized both in the literature and by key informants.

Given the growing importance that migrant health is taking in the RTG’s agenda, while the topic is also a global priority for WHO, as well as for the UN system globally and regionally, for ASEAN and the Mekong Subregion, the CCS programme is highly relevant and it is equally recommended to continue it.

Governance: given the complexity of this sector of health policy, and the challenge of its operationalization, the BMH would require at least two types and levels of governance: one for the high level policy and another for the practical operational level. This could be done through (i) a Sub-Steering Committee and (ii) very focused Technical Working Groups. While WHO should be part of both, WHO participation may require different officers with different expertise.

The “Border and Migrant Health” programme has no Sub-Steering Committee to date. It is recommended that a “Sub-Steering Committee on Migrant Health” be established bringing together all stakeholders involved in Border Health, Migrant Health, SEZ and Stateless. BPS has submitted a proposal in that direction. The sub-SC should provide oversight of the overall migrant health strategy and programme rather
than exclusively the CCS programme. The Border Health Development Master Plan 2017–2021 – currently under finalization at BPS – together with all respective plans for migrant health, special economic zones and stateless should serve as a reference to select members of the sub-SC among the various programmes’ stakeholders.

In addition to the sub-SC overseeing the migrant health programme, very focused multistakeholder smaller bodies – such as task forces or technical working groups, whether formal or informal – are also recommended to discuss and follow closely pilots and migrant health initiatives on detailed policy implementation.

The evaluation of all the overall migrant health-related activities is particularly challenging due to the fragmentation of the sector and the absence of a clear unified log frame. It is therefore recommended that a more unified approach of “border health”, “migrant health”, “special economic zones” and “stateless” be prepared within a single “migrant health” strategy presented in a one log frame. In the latter should appear the various activities undertaken under the various sponsors and implemented by the various partners. The log frame should contain a clear breakdown of SMART and result-oriented indicators within a clear timeline. The same would apply for a one “migrant health” programme budget.

The mission welcomes the arrival of the new CCS BMH programme manager, and recommends that such recognition of the importance of migrant health within the BPS be quickly institutionalized, notably through the allocation of long-term BMH-dedicated staff.

Given the multisectoral aspect of migrant health, one may also recommended the establishing of a dedicated migrant health clearinghouse. While the BPS could hold that body, it is recommended that this institution would rather be established within an existing institution already involved in broader migration issues, and a stakeholder in migrant health, such as the Institute of Population and Social Research of the Mahidol University. This clearinghouse would not only serve as the repository for all migration-related materials, but would also act proactively in the dissemination of these up-to-date materials to all stakeholders. This clearinghouse could then serve as the right arm of BPS to prepare all evidence-based materials to develop migrant health policies and strategies.

The new migrant health strategy and plan should integrate the newly released MoPH 20-year strategy. The latter – notably the 18-month 4-Excellence strategy – contains explicit references to the health in the SEZ and health for the stateless.

While the CCS approach was praised by most key informants, in practice, some noted, WHO financing system may still promote a project-based

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26 Assessing the results of the programme through mainly reviewing WHO DFC reports and OSC presentation slides to the EC is felt to be insufficient. A log frame is needed.
27 No English translation available at time of the mission.
approach (i.e. DFCs by project signed by separate implementers). One way to address this would be to ensure that the oversight body reviews and approves a detailed programme plan (preferably in a clear log frame), so that past that approval, one-to-one (DFC/APW between WHO CO and PM) contracting can take place without affecting the CCS strategic approach.

The Bureau of Policy and Strategy intends to become a training centre for MoPH and provincial staff on planning and strategizing (reportedly starting in 2–3 months with 15 trainees). WHO could play a significant role in this initiative, which would impact beyond the BMH. It is recommended that WHO helps also broker technical and financial support with other funding agencies (including through possible secondments) for BPS capacity-building. This capacity-building could include also multistakeholders partnership management.

In the past decade, Thailand has acquired a recognized experience in migrant health and the country has expressed willingness to share this experience abroad. WHO, in its knowledge management approach, could support Thailand’s experience.

It is highly recommended that WHO CO be staffed with a national programme officer dedicated to migrant health. In addition, given the multisectoral approach of migrant health, it is likely that some expertise required may not be available at the WHO Thailand Country Office level. The WHO Regional Office and headquarters could be solicited on an “as needed” basis to provide the missing expertise. This may include special expertise on human rights, multistakeholder partnership management, etc.
Annex 6 – Disaster Management (DM) programme

Background

The two last major natural disasters occurring in Thailand – the tsunami that hit the west coast of southern Thailand in December 2004 and the major flood in 2011 affecting 65 provinces – prompted the RTG to upgrade its emergency preparedness and response mechanisms and revise its related legislation and regulations. In 2008, the Emergency Medicine Act B.E. 2551 established the National Institute for Emergency Medicine (NIEM). In March 2012, the Ministry of Public Health established a Bureau of Public Health Emergency Response (BPHER), under the Permanent Secretary’s office. The World Health Assembly passed a resolution in the aftermath of the tsunami requesting the Director-General of WHO to provide the necessary technical guidance and support to Member States for building their health sector emergency preparedness and response programmes at national and local levels, including a focus on strengthening community preparedness and resilience. In 2010, disaster preparedness and response was selected by representatives from major public health agencies in Thailand to be a “priority programme” in the WHO CCS. The CCS programme started in January 2012.

The objectives of the DM programme are to:

(1) Establish coordination and collaboration mechanisms in the Disaster Health Emergency Management System among various national and international agencies;

(2) Further support development of the Disaster Health Emergency Management System to be effectively and efficiently integrated and linked with relevant agencies at all levels in institutional, legislative frameworks, policies, SOPs, contingency plans and capacity building;

(3) Engage various sectors systematically to establish mechanisms for disaster prevention, preparedness, response, recovery and rehabilitation.

Three major activities of the programme were:


(2) Health System: Interventions consist of developing standards to assess and develop safe health facilities in disaster prone areas, studies aimed
at developing core and alternate disaster hospitals, and developing the emergency medical assistance system.

(3) Community readiness: Establishing an information centre on disaster preparedness and developing tools and creating multiple channels for educating people.

Findings

National Institute of Emergency Medicine (NIEM) in coordination with the MoPH Bureau of Public Health Emergency Response (BPHER) serves as the lead agency. The programme manager is Dr Anuchar Sethasathien, NIEM Secretary General and in coordination with Dr Anurak Amornpetchsathaporn, BPHER director.

The DM Programme is highly relevant as it aligns fully with RTG (MoPH plan) and WHO priorities, including WHO General Programme of Work (Ref. Impact goal and Cat 5 notably), as well other global (United Nations\(^{28}\)) and regional priorities (ASEAN\(^{29}\)).

Achievements

Indications of the achievements of the programme could be found through DFC reports or through PowerPoint presentations (some mainly in Thai language) delivered by the OSC to the Executive Committee. The main achievements recorded from these limited sources were as follows:

- Establishment of the Sub-Steering Committee for the Disaster Management programme\(^{30}\) (MoPH Order No. 3/2015).
- NIEM working closely with BPHER and WHO, strengthened the systems for disaster risk reduction and management, including by the following:
  - Developed medical and public health disaster preparedness and risk reduction plans, as well as Standard Operating Procedures for coordination of responses between concerned health agencies.
  - Adapted and piloted Hospital Safety Index (HSI) in Thailand.
  - Developed Public Health Emergency Operation Centre (PHEOC).

\(^{28}\) International Strategy for Disaster Reduction (General Assembly (GA) resolution 54/219) and Sendai Framework for Disaster Risk Reduction adopted by the Third UN World Conference on Disaster Risk Reduction on 18 March 2015.

\(^{29}\) ASEAN Agreement on Disaster Management and Emergency Response, July 2005. Signed by the Foreign Ministers of ASEAN in Vientiane, Lao PDR in July 2005, the Agreement has been ratified by all ten Member States and entered into force on 24 December 2009. A work programme for the period of 2010 - 2015 has been developed and its progress has been monitored.

\(^{30}\) Executive Committee of RTG-WHO Collaboration Order No. 3/2015 (dated 15 January 2015) establishing of the Sub-Steering Committee for Disaster Management
National IHR (2005) core capacities were consolidated and further strengthened. Ebola preparedness activities included a joint “WHO-MoPH workshop on Risk Communications for Response to Ebola and other EIDs”, a SEARO workshop on clinical management and Infection Prevention and Control hosted by Bamrasnaradura Hospital and a joint MoPH / WHO review of national Ebola preparedness. In response to the outbreak in the Republic of Korea, preparedness was also enhanced for MERS-CoV, which proved to be timely when an imported case in Thailand was subsequently reported and successfully contained. Laboratory capacity in Thailand for biosecurity and biosafety was also strengthened with funds provided by the European Union.31

BPHER strengthened the strategies for Public Health Emergency Management (PHEM) by analysing disaster risks and response plans at all levels, setting and managing the PH Emergency Operation Centre (PHEOC) for disaster situations at each level, and running Full Scale Function Exercise (FTX) at central, department and health regional levels once a year, as well as Table Top Exercises at provincial level once a year.

BPHER also developed the Emergency Operation Centre (EOC) and Incident Command System structure at the MoPH.

Since one of the key objectives of the programme is to establish coordination and collaboration mechanisms, activities included numerous consultative meetings, workshops and brainstorming sessions with all relevant stakeholders (see box). Both NIEM and BPHER organized a large set of such consultative meetings (i.e. hospital safety index, disaster risk reduction, medical and public health disaster preparedness, public health emergency management, etc.)

### Box. Coordination and brainstorming meetings

Below is an illustration of meetings organized by BPHER:

1. Consultation Meeting among key officers for the development of medical and health disaster preparedness plan
2. Working group meeting among key officers for the development of medical and health disaster preparedness plan
3. Working group with officers on the after-action review (AAR)/lesson learnt of the MoPH on the medical and public health assistance to earthquake-affected people in Nepal,
4. Coordination Meeting among officers of key stakeholders on the medical and health disaster preparedness plan/ disaster risk reduction plan,
5. Subcommittee meeting among officers and the team from Department of Disease Control and BPHER,

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NIEM produced materials for community education on disaster preparedness. It developed an education tool kit (a series of cartoon animation, board game, etc.) and went to selected schools across Thailand to field-test these materials and developed training curricula.

NIEM has a very ambitious national – and regional (ASEAN) – plan. The institute has been appointed as the ASEAN focal point for disaster preparedness capacity-building for all ASEAN countries, and is supported in this responsibility by the Japanese International Cooperation Agency (JICA).

The future Master Disaster Management Plan #3 was prepared jointly by NIEM, BPHER and WHO, and has subsequently been approved by the Board.

### Gaps and challenges

The issue of the lack of clarity between of the respective roles of NIEM and BPHER, which was already flagged by the MTR, remains and still causes frustration and delays in the programme. Despite repeated requests from the Sub-SC, clarifications still have not been made. The issue might have been overemphasized as there are a number of examples of good cooperation between the two institutions.

A more critical issue is the low capacity of the BPHER (staffing, operational capacity, etc.); given the critical role the institution is mandated to play.32

In the absence of a clear log frame or workplan, evidence of achievements were found through the reports of DFC or PowerPoint presentations (some mainly in Thai language) of the OSC to the Executive Committee. This renders any evaluation of effectiveness and efficiency rather challenging as completed activities are not presented against clear baseline or preset targets within a given timeline.

The Disaster Management programme is governed by two parallel steering committees: the JICA and the WHO. This is time- and energy-consuming and does not promote integration.

There are questions on whether the MTR recommendations had been well acknowledged and taken into consideration in the subsequent months after that mission. Some of the flagged issues and recommendations do not seem to have been addressed. The monitoring and evaluation, for instance, remains weak.

The role that WHO plays in the DM programme was highly valued by all key informants. Informants stated that the WHO roles have been multiple and led to significant results such as:

- WHO used its convening power to call events at national or regional levels. For instance, WHO convened an “International Conference on the Implementation of the Health Aspects of the Sendai Framework for Disaster Risk Reduction”.
- WHO provided technical support through its dedicated foreign expert, assisting notably in planning at central and provincial levels, as well as technical support throughout implementation.
- WHO CO receives regularly requests for disaster-related guidelines/standard definitions, etc.

While WHO funding support is not significant compared with the total, it was reported by key informants that it was tactically well placed, notably when WHO provided “seed money” to initiate the Hospital Safety Index development, which was then further developed by NIEM. A key informant stated that WHO also “keeps budget to work together”.

WHO CO has played a recognized role in knowledge sharing, including in research (e.g. Technical Officer cooperating with Mahidol University), and there were repeated requests for WHO role to further develop its work in knowledge management. One key informant requested for instance that WHO share worldwide lessons learnt on life saving in rescue operations.

WHO played a significant advocacy role in the DM programme. WHO was the initiator of the Global Hospital Safety initiative; the organization also helped Thailand to focus more on the broader public health approach, beyond the DDPM. “WHO came at the right time, made us make the right move!” said a key high level informant.

Several key informants suggested WHO to step in and voice its concern over the NIEM-BPHER “bicephalic management” in the DM programme, stating that WHO could invoke the end of the project-based approach and its limited organization resources.
“WHO is only one of the many partners” declared one of the key informants… and to add immediately and diplomatically “…but it’s the leader!”

Conclusions and recommendations

WHO, RTG and JICA should consider the possibility of establishing a single Sub-Steering Committee for both WHO and JICA. This Sub-Steering Committee would oversee the national Disaster Management Master Plan #3 – including activities of both WHO and JICA programmes. This would prevent duplication and enhance coordination.

The bicephalic management (NIEM and BPHER) of the DM programme causes delays and misunderstandings. Ideally this would be solved before the next CCS programme plan. NPFHER capacity needs to be significantly enhanced to enable a fair sharing of the responsibilities between the two institutions. The pending arrival of a new BPHER director could provide the necessary momentum to plan for the much needed enhanced capacity of that bureau. Clear delimitation of responsibilities of the two institutions based on their respective comparative advantages and mandates should lead to the subsequent and respective plans.

Given the importance of the leadership of the CCS programme, the decision by the current NIEM Secretary General (and CCS PM) to step down or continue in February 2017 will likely impact on the implementation of the next CCS plan. Given the current weak programme reporting mechanism, much relies on individual memory and measures should be taken to ensure a smooth handover to his replacement.

While the weak monitoring and evaluation system was underlined in the MTR and properly relayed by the OSC at the Sub-Steering Committee, the issue remains. The next plan should contain a clear framework with SMART indicators, so as to allow better measurement of outcomes and impact of the programme.

As suggested by one senior key informant, key outcome indicators for the next CCS DM programme could comprise (1) enhanced and institutionalized capacity in disaster management at all levels (central, provincial, community level), (2) sufficient and sustainable funding of the DM programme budget (must be sizeable and serve from central to local levels), (3) policies and guidelines are duly implemented wherever they should be.

In conclusion, the CCS DM programme seems to have received the appropriate support from the WHO and continuation is recommended. However, growing involvement of other partners (Japan, United States, etc.) may influence the relevance of WHO contribution in the future. It is therefore critical that RTG-WHO partnership be constantly adjusted in light of that changing environment.
Annex 7 - International Health Regulation (IHR)

Background

Thailand has implemented the IHR 2005 since the regulation took effect. The programme was established by the Ministry of Public Health. In 2008, the cabinet endorsed the first 5-year national strategic plan for IHR. The IHR national strategic plan includes four main components: surveillance and response capacities, laboratory capacities, point of entry capacities, and integrated management of the IHR. The Bureau of Epidemiology, Department of Disease Control, was assigned as IHR focal point. The main budget to run the programme comes from the MoPH with additional funding from WHO to supplement the implementation of the national strategic plan. At the end of 2012, Thailand requested an extension of the implementation timeframe on IHR for another 2 years and requested support from WHO during this second phase.

Findings

The programme has high relevance to the World Health Assembly resolution on IHR and also the 12th general programme of work of WHO. The Thai Government Cabinet has endorsed the first national strategic plan of IHR and also its extension.

Key partners include Ministry of Public Health, four departments - Department of Disease Control, Department of Medical Sciences, Department of Medical Service, and Office of Permanent Secretary; Ministry of Agriculture - Department of Livestock Development; Ministry of Transportation and Communication; and WHO.

The Director of the Bureau of Epidemiology is the IHR focal point with a project team located under the Bureau of Epidemiology (BoE), Department of Disease Control. The programme manager coordinates all of the implementation of IHR work.

Governance structure: An executive committee chaired by the Permanent Secretary of the Ministry of Public Health with five subcommittees. Each subcommittee has their workplan and implements it accordingly. The executive committee meets every year and the subcommittees meet 2 to 3 times a year.

The IHR programme aims to build eight core capacities as required by IHR and also responds to five specific public health threats (infectious diseases, zoonosis, food safety, chemical, radiological).

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Achievements

The IHR programme is institutionalized with four staff under the Bureau of Epidemiology with adequate government budget support.

The 5-year strategic plan was extended for another two years in order to fulfill all core competencies including the expansion of Surveillance and Rapid Respond Teams (SRRT) from districts to subdistrict level. The 18 designated points of entry are functioning per IHR requirement. Thailand confirmed to WHO that it had fulfilled all competencies as required by IHR in 2014.

The concept of IHR and the experience with many new emerging infectious diseases were a good input for the Department of Disease Control in revising the 1980 communication control act. The new act officially took effect in March 2016.34 One major component of the act is to have national and provincial communicable disease control committees and every district needs to have a surveillance rapid response team with trained personnel.

Integrating IHR with the new Global Health Security Agenda (GHSA). GHSA is a new agenda proposed by the US Government to supplement IHR. Initially it caused some confusion and risk to be a separate programme. For the GHSA, Thailand is a lead country of workforce development on epidemiology.

During the first phase, WHO assigned one national programme officer as focal point on IHR which helped participation from both sides. In the second phase, as the programme is institutionalized and sustained, the communication and consultation on IHR between the Ministry of Public Health and WHO is visible during public health emergency situations, but less visible during more routine times. As the WHO Thailand Country Office is under SEARO, there is less collaboration between WHO and ASEAN than might be ideal for Thailand.

Gaps and challenges

The IHR programme under the Department of Disease Control has implemented the action plan as best as it can. It has received adequate financial support. However, the participation from the other 15 Ministries on the executive committee and subcommittees has not been satisfactory as they do not yet fully understand the concept of IHR and do not yet fully perceive how they can contribute to IHR or appreciate their responsibilities in the international and national frameworks.

Although Thailand has fulfilled the core competencies as required by IHR, some areas need more attention, e.g. international designated point of entry will need further

certification to meet international standards. Risk assessment is another technical area that needs strengthening. Lastly, Thailand needs to gain more experience on dispatching teams for international outbreak response operations in the Region and beyond.

WHO SEARO is perceived as not so active in working with ASEAN. This may be because only three countries in SEARO are ASEAN members. However, public health threats do not respect national borders or regional definitions and the purpose of IHR is more likely to be achieved when regional collaboration is strengthened.

The new GHSA can be a complement to IHR, not a competitor, depending on the approach of the MoPH, WHO and GHSA. It would be best to make GHSA and IHR as essentially the same programme. The joint evaluation of the IHR framework seems to be well accepted by Thailand with the hope that this will be a new additional tool to achieve and maintain IHR core capacities.

**Conclusion and recommendations**

The IHR programme of the Thai Ministry of Public Health has evolved from the inception phase in 2007, through an early implementation phase, and at present a sustainable maintenance phase seeking to continuously improve quality. WHO at all three levels has provided crucial support for the first national strategic plan development and its extension. Thailand has fulfilled the core capacities requirement according to IHR in 2014. Although funding is not an important issue WHO can still be a strong partner by maintaining close communication and consultation regarding the overall strengthening of IHR core capacities and connecting the Thai IHR programme with other countries in the Region without neglecting the connection to ASEAN.

WHO and RTG continue placing IHR as a major programme of work in the next two bienniums as laid out in the twelfth general programme of work. The programme might be renamed as “Strengthening response systems to public health threats according to IHR” in order for other collaborators to more readily understand its purpose and their role.

- WHO can help in strengthening the programme in areas such as risk assessment and the dispatch of SRRT team(s) to work with the regional or global outbreak alert and response network team (GOARN).
Annex 8 – International Trade and Health (ITH)

Background

The effect of trade and trade agreements on the health sector and population health has been increasingly recognised over the past 20 years. Topics of interest include intellectual property protections, tariffs on medical goods, movement of health workers across borders, phytosanitary standards, and a host of other issues. It has become increasingly recognized as an area of public health interest and WHO has responded with World Health Assembly resolutions, publications and support to its member states. 35, 36

Thailand expressed a particular interest in several topics including trade and regulation of health-related products such as tobacco, alcohol, food marketing and food safety; international trade in health services; and intellectual property and access to essential technologies and medicines.

The main responsible organization on trade negotiations in Thailand is the Department of Trade Negotiations (DTN) of the Ministry of Commerce. Other relevant ministries are also involved, and it was described that ‘occasionally’ the Ministry of Public Health was invited to participate in consultative, expert or ad hoc meetings on trade topics of interest to the health sector.

A policy decision was made that the health sector needed to be more active in the field of trade and as part of that effort, International Trade and Health (ITH) was placed as a priority programme in the WHO CCS.

The programme is coordinated by the International Health Policy Programme (IHPP) of the Ministry of Public Health (MoPH) and has been supported by the MoPH, WHO, the Health Systems Research Institute (HSRI), the National Health Security Office (NHSO), the Thai Health Promotion Foundation (ThaiHealth), and the National Health Commission Office (NHCO).

The stated goal of the programme was to build up and strengthen individuals and institutional capacities to generate evidence for evidence-based policy decisions and coherence of policies between international trade and health for the positive health outcomes of the population.

There were four goals for the programme:

- To generate and manage knowledge on international trade and health.
- To strengthen the evidence based, transparent and participatory trade negotiation processes and mechanism related to health in line with mechanism of the Article 190 in the 2007 Constitution.
- To build up capacity of all partners to understand the implications and to be able to get the most benefits from international trade, with adequate and effective measures to avoid or mitigate the negative consequences.
- To advocate the knowledge and policy recommendations generated by the programme to the public and the relevant trade negotiation.

**Findings**

The programme has a clearly described framework that links the objectives with activities. The activities occur in three areas (1) Knowledge management – mapping, web clearinghouse, research studies and day to day research; (2) Networking – identifying stakeholders, journal club, technical meetings and workshops, and contacts with academia; and (3) Capacity-building – secondments, workshops and study visits.

A sub-steering committee was formed that monitored the programme and it included participants from the financial supporters but in addition also had input from the Department of Trade Negotiations of the Ministry of Commerce as recommended in the midterm review.

**Achievements**

Regular steering committee meetings were held that are put into minutes and an annual summary technical report is available in English with summaries of studies completed in English. Activities in 2015 included the translation and printing of two easy to read booklets on relevant trade topics, five research studies funded and completed, a training workshop on technical barriers to trade committee meetings, and a 2nd annual joint conference on ITH.

Key informants were well aware of the issues relating to international trade and health, particularly as they relate to intellectual property dealing with medicines and drugs and the migration of health workers across borders. Also, issues surrounding medical tourism featured in discussions.

A key finding is that senior decision-makers are aware that there are effects of trade negotiations on health and those decision-makers acknowledge that mitigation of any ill effects of trade negotiations needs to be considered.
The Department of Trade Negotiations expressed awareness of the ITH programme and appreciated the increased knowledge and evidence that was available on topics surrounding trade negotiations and health. They seemed to be active and appreciative participants in the process.

**Gaps and challenges**

Skilled technical assistance from external sources, such as WHO, in specific areas might be useful at times. Possible areas include phytosanitary standards, food safety, medicines and diagnostics.

As much as evidence is important, trade negotiations remain rather opaque. The DTN expressed appreciation for the evidence and dialogue, but then could not or would not give an example of any direct effect of input from the ITH programme on a trade negotiation outcome. That is not surprising and needs to be understood by those who support the programme. Trade negotiations are likely to always be something of a ‘black box’ phenomenon, and expecting definitive outcomes in relation to specific inputs would be expecting too much.

Trade negotiations are and will remain an almost exclusively Thai undertaking, as it should be. However, the input of entities such as WHO is felt to be useful, particularly on topics such as tobacco control, alcohol and access to medicines where there are powerful national and international interests lobbying against public health interests. Such advocacy needs to be diplomatic, evidence-based and strategically implemented.

**Conclusions and recommendations**

ITH has been an active programme that has achieved most of its objectives. The direct impact on changes in trade agreements cannot be documented and that is expected. The programme has succeeded with the management model established by the CCS better than most programmes with a variety of funding sources and a subcommittee that is multisectoral and functions. This is probably due to the experience of the programme manager in dealing with multiple partners and donors already, and also to the more restricted agenda dealing with commissioning or performing studies and the various aspects of knowledge management.

WHO should remain involved in international trade and health. WHO’s convening power and potential for effective advocacy can be of benefit to public health in Thailand. It may be possible for WHO to continue to play that role without making ITH a separate CCS programme.
Annex 9 - Noncommunicable disease control

Background

Noncommunicable diseases (NCDs) was officially recognized as part of the Thailand national agenda when the Ministry of Public Health (MoPH) in collaboration with the National Economic and Social Development Board (NESDB) successfully submitted the Thailand Healthy Lifestyle Strategic Plan (THLSP) 2011–2020 for endorsement by the cabinet.37 The main aim of the THLSP is to bring both health and nonhealth ministries on board to control NCDs. The THLSP was admired as a comprehensive strategic plan and paves the way for Thailand-WHO collaboration. In 2012, WHO and the MOPH agreed to set multisectoral networking for noncommunicable disease as one of 5 priority programmes under the WHO Country Cooperation Strategy (CCS) in Thailand for the period of 2012–2016. The initial goal is to use this multisectoral approach to facilitate networking and implementation of THLSP. The midterm CCS review38 of this priority programme was conducted during June 2013 and the final external evaluation was planned for 2016 before the end of the programme.

Findings

There is no doubt that this programme is of high relevance to national needs as confirmed by the endorsement of the Cabinet for THLSP and the United Nation agenda. In 2012, NCDs were placed more firmly on the global agenda by the UN 66th General Assembly through a resolution asking WHO and all member countries to prevent and control NCDs. The assembly voted to “Request the Secretary-General, in close collaboration with the Director General of the World Health Organization, and in consultation with Member States, United Nations funds and programmes and other relevant international organizations, to submit by the end of 2012 to the General Assembly, at its sixty-seventh session, for consideration by Member States, options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership.”39

There are six major partners comprised of WHO, the Ministry of Public Health, the Thai Health Promotion Foundation (ThaiHealth), the National Health Security

Office (NHSO), the Health System Research Institute (HSRI) and the National Health Commission Office (NHCO).

Since the start-up in 2012 until present, there are three managers. The first one for 2 years, the second one for 1.5 years, and the current one is almost a year as of June 2016. The programme support teams are staff of the International Health Policy Programme (IHPP) under the IHPP Foundation. According to the information from one programme manager, the reason that all managers are from outside of the MoPH is was felt that the manager and its coordinating office should be a neutral unit outside those 6 partners.

The programme manager has oversight by a steering committee (sometimes referred to as a subcommittee in CCS documents) composed of 13 members from key partner agencies and delegates from related departments in the Ministry of Public Health and it is chaired by a prominent professor. The steering committee met every 3 months. Similar to the other four priority programmes under the CCS, the multisectoral NCD networking programme also reported to the executive committee, chaired by the deputy permanent secretary of health twice a year.

Initially the steering committee approved five strategies:

- Facilitate the implementing of THLSP
- Form a network of NCDs partners both national, local and international
- Public communication on NCD to raise awareness
- Promoting research and monitor the progress of NCD control
- Work with ageing

After two years of work and inability to facilitate implementation of THLSP, strategies were revised and changed to:

- Social mobilization and advocacy
- Capacity-building
- Knowledge transfer
- Knowledge generation

**Achievements**

Created a dialogue and consultation forum among health professionals and academia. This eventually evolved to a recently established network under the name of “NCD Alliance”, which has 26 associations.

- Supported Salt-net to raise awareness of excessive sodium intake from daily meals.
○ Developed and provided several policy advocacy training courses for interested parties.

○ Worked with the Department of Disease Control on pushing NCD 9 global targets for the National Health Assembly and cabinet endorsement in Thailand.

○ Built the capacity of approximately seven junior policy researchers who have high interest in NCDs.

○ Produced many good documents about the NCD situation in Thailand.

○ Campaigns on obesity, salty diet, etc.

During the first two years of this programme, WHO recruited a retired ministry official to be the national programme officer on NCDs including tobacco and alcohol. Having a good person with a strong background on the culture of work of the ministry and government officials is a social asset, which can serve to connect WHO to MoPH and other partners. Unfortunately, WHO has not maintained this approach and the last two years there is no national programme officer to serve as a connector and supporter of this programme.

**Gaps and challenges**

The major expectation was to have this NCDs network as a mechanism to strengthen the implementation of THLSP. It is clear that the NCD network did not fulfil this purpose. The inability to execute THLSP since its inception caused the low profile of other ministries in NCD control both at national and provincial level. However, the lack of execution of the THLSP master plan has many internal factors such as understaffing of THLSP secretariat office, no full time manager and lack of clear policy decision in recruiting other departments to shoulder the task. The THLSP governance structure is impractical. It is composed of 49 director-generals from most departments of almost all ministries as well as many health professional associations.

The MOPH seemed to have a low level of ownership of the CCS programme. There may be multiple reasons why the MoPH did not actively participate. Several informants expressed the view that the selection of a manager and secretariat office outside the MoPH setting decreased MoPH staff interest and engagement. The end result was that the programme managers were lecturer and policy researchers who are not responsible units for implementation of the THLSP. Another reason may be that some parts of the MoPH have difficulty in navigating complex multisectoral environments and therefore avoid them. That does not change the fact the effective NCD control requires multisectoral action.

Priority setting did not always reflect programme implementation needs. Programme managers who are academics and researchers have more passion on
training and knowledge generation than facilitating and mediating to move the policy to implementation at all levels.

Lost opportunities to build capacity for multisectoral work in NCDs. The current CCS programme should be a good opportunity to build capacity for the direct responsible unit but the lack of a focused leader for implementation caused confusion and slowed progress.

New challenges and opportunities are arising. The 66th World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 (resolution WHA66.10). The National Health Assembly and Cabinet have endorsed the country effort to achieve the nine global targets on NCD control. The Ministry of Health has assigned the Department of Disease Control to be the main coordinator to come up with a new integrated plan of NCD control. The new process on developing a strategic and action plan is just beginning. It is possible that the former THLSP can be combined with the nine global targets on NCDs and pave the way for a strategic plan that provides a practical and efficient way forward. A more effective method of work is necessary to achieve an NCD control programme that is multisectoral and involves all ministries and civil society.

Conclusions and Recommendations

NCDs are a major health problem because of the high morbidity and mortality they cause, as well as being a huge financial burden at all levels in society. Selection of NCDs as a priority programme for the CCS is very relevant to national, regional and global needs of the country. The main purpose of the WHO CCS in NCDs is to create a network of health sector and nonhealth sector implementers in order to move the Thai Healthy Lifestyle Strategic Plan 2011–2020 forward into implementation. The multisectoral NCD network has achieved many good works such as initiating a forum for academics to meet and discuss, producing good NCD research and documents and generating knowledge on NCDs, forming professional networks to improve NCD health services, and networking with international partners on global health policy. The multisectoral NCD network has not been able to help the MoPH to implement the THLSP as much as envisioned in the original WHO CCS. However, it was able to facilitate the global action plan on nine NCD targets being considered and endorsed by the national health assembly, which led to the nine NCD targets being endorsed by the cabinet. It is a new hope that the action plan on NCDs’ nine global targets can supplement the THL national plan in the coming year and lead to more effective action.

Continued support to the control of NCDs should be considered for the next CCS. If it is to continue, consideration should be given to breaking the programme into three components with different lead agencies as follows:

- Networking of professionals - NCD alliance. This is an area which ThaiHealth has the strength and interest to support.
- Policy study and advocacy and producing NCDs policy researchers. This is the area in which IHPP has its strength and mandate.
- Policy decision, implementation of health and nonhealth action plan, surveillance and monitoring the progress. These areas are under the mandates of the Department of Disease Control and the Thai Healthy Lifestyle office although there is limited capacity to carry out those mandates.

For management, the CCS executive committee could identify a project manager in each area. However, there needs to be a lead agency to coordinate all those three areas that has the authority, interest and experience to work multisectorally.

WHO should play a proactive role using its strengths in: (1) providing technical assistance to NCD programmes on request and sharing of best practice from other countries; (2) Advocating NCD control on particular issues or in particular circumstances along with appropriate Thai partners; and (3) Connecting the Thai NCD programmes with other countries and international forums.
Annex 10 - Road Safety

Background

Road safety (RS) was selected as one of the five priority programmes (PPs) for the Thailand Country Cooperation Strategy 2012–2016 due to the high morbidity and mortality from road traffic accidents in Thailand and the global evidence that RTIs (road traffic injuries) are preventable. RS was selected with the intention to strengthen coordination among relevant stakeholders in order to implement programmes more effectively. The lead agency for RS is the Thai Health Promotion Foundation (ThaiHealth) and the implementing agency is the WHO Collaborating Centre for Injury Prevention and Safety Promotion (WHO CC) based in Khon Kaen. The RS workplan was developed by ThaiHealth and the WHO CC, reviewed by an external reviewer, and revised before being submitted to the Steering Committee for approval.

The quality assurance team, in May 2012, made several critical comments about the quality and managerial robustness of all five programme workplans. For RS, the review emphasized a need for a more comprehensive, less fragmented workplan with clear outputs and outcomes defined and the need for a strong, fulltime team to manage the programme. A revised version was produced but not all comments were incorporated. Implementation began in June 2011. The midterm evaluation was undertaken in 2013.

Findings

The modalities of implementation in the five PPs, including road safety, were; a high level Steering Committee that later changed to an Executive Committee for overall governance, a sub-steering Committee for monitoring implementation of each PP, and a Lead Agency and a Programme Manager. An Oversight Committee (OSC) within the MoPH was established in 2015 for monitoring of all programmes after HSRI (Health Services Research Institute) withdrew from that role.

ThaiHealth was selected as the lead agency for the road safety programme. Road safety is part of its mandate and it played a catalytic and funding role to the programme. Day-to-day implementation responsibility was assigned to the WHO CC. The workplan was mainly prepared by the WHO CC with some involvement of other partners.

Funding came from three sources:

- Bloomberg Philanthropies funds, through WHO, supported the Injury Prevention Unit, BNCD, to improve and strengthen traffic laws and training

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of media personnel. The amount of support, including one technical staff, was US$ 286 000 per year.

- Thai Health supported most of the activities in the workplan. Twenty million Baht were committed and 13 million have been disbursed for the CCS.
- WHO provided technical and financial support to both the WHO CC and the Bureau of Noncommunicable Diseases (NCD) in the MoPH mainly to develop integrated road traffic injuries reporting and traffic injury investigation, training of traffic police on law enforcement, and advocacy activities. Total funding disbursed to the programme in the 3 bienniums 2012–2016 was US$ 279 987.

A summary of financial support to the programme is shown below:

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<tr>
<th>Year</th>
<th>Source of funding</th>
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<tr>
<td></td>
<td>MoPH (Baht)</td>
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<tr>
<td>2011</td>
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<td>2016</td>
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<td>Total</td>
<td>1 000 000</td>
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</tbody>
</table>

Source: WHO Thailand Country Office.
* Baht 8,467,800 was funded to WHO CC and Baht 2,880,400 to BNCD
** Covers cost of one technical staff and activities

Early in the process there were a number of stakeholders that participated in the discussions but later in the programme there were only two implementers, the WHO CC and BNCD (Bureau of NCD) perhaps because there was no clear plan for other stakeholders. This was different than the intention of stimulating multistakeholder road safety planning and action. The programme did not appear to be short of financial support but rather lacked managerial and coordination skills and also lacked authority beyond that of the immediate implementer.

Achievements

Since the WHO CC also implemented ThaiHealth’s road safety workplan, it was somewhat difficult to differentiate between CCS workplan activities and non-CCS activities. The CCS activities were more like a supplement to ThaiHealth’s road safety workplan. Although most programme activities were implemented according to the
plan, the programme could not really achieve the two objectives above because the objectives were overly ambitious and not well linked to the activity plan.

Even though the implemented activities did not contribute directly to the programme objectives, many of the activities were felt to be useful, e.g. capacity-building, production and provision of a national and global road safety status report, and development of a reliable road traffic injury (RTI) reporting system. Follow-up would be necessary to assess their future impact. Several models developed by the WHO CC have been replicated by the MoPH, e.g. integration of RTI death data from three sources, identification of RTI risk spots, and setting up check posts during festivals.

**Gaps and challenges**

Gaps identified by the midterm and final evaluations include:

- The workplan did not provide clearly defined activities that identified responsible agencies, indicators and budget lines. This made monitoring and evaluation difficult. There was also little link of planned activities to the objectives.

- Road traffic injury information in Thailand is still very incomplete due to there being many sources of data collection, each done with different purposes. The Injury Prevention Unit, Bureau of NCD, MoPH, which is one partner to this workplan, has done major work on the road safety information system by collecting and analysing data from different sources, both within and outside the MoPH.

- Although several activities were implemented by 4 major implementing agencies, ThaiHealth, the WHO CC for Trauma Care, the MoPH and the Police in 2013–2014, these activities were implemented independently by each agency and some of the activities were not part of the workplan.

- The lead agency does not have legal authority or the power to implement programmes, regulations, and activities across the participating ministries, departments, and other stakeholders. This undermines coordination.

- Although one of the main stated objectives was to reduce the motorcycle-related injury and death rate, there was not a clear and systematic approach to fulfill this objective. Most activities focused on campaigns in a few localities and were not visible and continuous in nature and were not large enough to yield a measurable effect on mortality.

- The governance structure did not work particularly well. Meetings consisted mainly of activity reports with minimal guidance or corrective action taken.

- The WHO CC used the same committee that monitored the ThaiHealth supported programmes to serve as the subcommittee for CCS. It is reasonable
to decrease the number of different committees having similar functions but there was a problem to call members from different parts of the country for meetings so CCS oversight suffered.

- The change from the Steering Committee to the Executive Committee and changes to who chaired various committees caused some feeling of confusion and concerns about a lack of policy consistency.

The RTG, in 2010, assigned the Department of Disaster Prevention and Mitigation, which is the Secretariat to the Road Safety Operating Centre or RSOC, to be responsible for developing the Road Safety Master Plan 2011–2020. There is limited or no linkage of the CCS for road safety with the National Road Safety Master Plan.

Progress made after the midterm review includes:

- With support from WHO, ThaiHealth and the Bloomberg Philanthropies, the Injury Prevention Unit, BNCD of the MoPH, has been working to develop computerized software for more accurate analysis and estimation of road traffic injury data. Information from this programme will be used as a single national reference source of road traffic injuries (RTI). The software has been finalised and is ready for field testing.

- From May–December 2016 at DDC request, WHO provided an expert to support the implementation of the “Strengthening Road Traffic Injury Investigation Project” in the areas of training, monitoring, and evaluation of local traffic injury investigation teams. Investigation teams were established in 20 localities in different parts of the country. The programme, however, does not have enough competent staff to follow up the teams’ performance in the field.

- During 2013–2014, the WHO CC implemented four important activities: a) Workshop on Road Safety Law Enforcement for the Police, b) Pilot Project on Child Restraint and the Workshop on Child Safety Seat in Khon Kaen Hospital, c) Training on Road Traffic Injury Surveillance for Health Personnel using TEACH-VIP curriculum, and d) a second Workshop on Capacity-Building for Law Enforcement. 79 police inspectors from 76 provinces of Thailand participated in the second workshop.

The Injury Prevention Unit of the BNCD of the MoPH is the office responsible as a core authority to set the traffic injury prevention framework for the health sector nationwide. The unit, however, is small and short of technical staff. The WHO CC, on the other hand, has a main role in capacity-building and research on injury prevention, including road safety and trauma care. The WHO CC has considerable capacity but limited authority to implement road safety measures outside Khon Kaen province. The multisectoral working methods of the current WHO CCS has not yet succeeded in bringing the authority and capacity together as smoothly as would be ideal.
Conclusion and Recommendations

Considering the extent of road traffic injuries in Thailand, the inclusion of road safety as one of the CCS priority programmes is highly relevant. Road safety is an element of WHO Leadership Priorities 2014–2019 on “Addressing the challenge of noncommunicable diseases and mental health, violence and injuries and disabilities” and links to the WHO 12th General Programme of Work (GPW)\(^\text{42}\) outcomes as well as to the regional strategic plan. Although the road safety programme did not achieve its stated objectives it did achieve a set of planned and useful activities. The workplan was geared towards activity-based planning and failed at effective coordination among partners. Also the objectives were too broad and too ambitious. There are a number of activities that likely led to the reduction of risk factors for road traffic injuries but their impact cannot be measured.

The workplan was developed under the responsibility of ThaiHealth and the WHO CC with consultation with some key partners. Available knowledge based evidence and WHO guidelines on road safety were used to guide the planning process. During the first 2 years of the CCS, direct technical input to the programme was limited because WHO did not have technical staff in the field of road safety. A staff member who was assigned to monitor this programme played a coordinating role rather than provision of technical input.

In 2015, WHO was able to use the Thailand road safety programme to mobilise resources from the Bloomberg Initiative to provide programme implementation support in RTI information systems and law development.

The lead implementing agency should have authority and convening power to coordinate effective implementation of the workplan with stakeholders nationwide. A fulltime programme manager is highly desirable.

The workplan development process should ensure that objectives, targets, strategies, activities, indicators, responsible agencies and budget lines are consistent. Monitoring and evaluation mechanisms should be part of the workplan. The work planning process can benefit from the input of experienced planners and from full consultation with all stakeholders.

The programme did not achieve its stated objectives, but the implemented activities are useful and need periodic follow-up, e.g., the capacity-building on law enforcement, implementation the RTI information system, and the road traffic injury investigation.

\(^{42}\) Twelfth General Programme of Work, World Health Organization; can be accessed at http://apps.who.int/iris/bitstream/10665/112792/1/GPW_2014-2019_eng.pdf?ua=1
There should be closer collaboration in planning and implementation with the Road Safety Operation Centre (RSOC) which is a central national authority on road safety. The workplan should link to the National Road Safety Master Plan, 2011–2020.

Currently the RSOC plays only a coordinating role and has no authority and power to execute the National Master Plan. It is beyond the scope of this evaluation to comment or recommend, but some have proposed the establishment of a Road Safety Institute with full authority to implement the National Master Plan.

For the next round of work planning, more attention should be given to building systems with clearer coordination mechanisms in road safety rather than planning based on a series of activities. One of Thailand’s weakest pillars out of the five road safety pillars that requires more collaborative action with responsible partners is “Safer roads and mobility”.

Thailand has a policy of decentralization. The country should explore methods to decentralize implementation of road safety policy to local authorities, especially at District and Tambon levels. This would reduce substantially the financial burden on the central administration.

WHO should ensure having one technical staff attached to the Thailand Country Office to work closely with national counterparts throughout the term of the CCS and beyond if road safety remains a priority programme.

For the next round CCS, whether road safety is selected as a CCS priority programme or not, WHO should continue its advocacy role and use its convening power to strengthen the skills and position of national managers in coordination among the various national authorities and other stakeholders.

The role and capacity of the national Road Safety Operation Centre (RSOC), which was assigned by the government as a central body to execute the Road Safety Master Plan, 2010–2020 is unclear. WHO should consider using its convening and brokering capacity to assist the government of Thailand to clarify this issue and thereby help in moving the Master Plan forward more effectively.
Annex 11 - Tuberculosis Control

Background

TB in Thailand has been mistakenly understood as a communicable disease that is less of a public health problem for some time. National resources have been shifted towards other areas of public health. The annual WHO Global Tuberculosis Report 2000 categorized Thailand as one of 22 Global High TB Burden Countries (TB HBC). Since that time the government started to realize the extent of the TB problem. In the most recent report of 2015, the number of high burden countries has increased to 30 and Thailand remains on the list. The Thai situation is more worrisome as it is one of 14 countries on all 3 lists, documenting severe problems with TB, namely the TB HBC grouping, the TB/HIV grouping, and also multidrug resistant TB (MDR TB). This is not in line with the advances Thailand has made in other aspects of health systems and communicable disease control.

There have been several attempts to improve TB programme management to meet WHO standard requirements and eventually to reduce TB morbidity and mortality. However, due to the complexity of the management structure of the national programme and with poor cooperation of hospitals outside the Ministry of Public Health (MoPH) achievements are not satisfactory. A Joint International Monitoring Mission Review (JIMM) in 2013 identified several important issues and made detailed recommendations. WHO Thailand and the RTG decided to include the National TB Programme under the umbrella of the CCS priority programmes, 2012–2015.

Findings

The Bureau of Tuberculosis Control (BTB) of the MoPH is responsible for policy development, supervision, monitoring and evaluation; training down to the regional level; surveillance and laboratory reference issues; some clinical and laboratory services; and research. Administratively the BTB is under the Department of Disease Control but it is geographically located in South Central Bangkok. The BTB provides technical and supervisory support functions to the 12 Regional Offices of Disease Prevention and Control (ODPC). It has no direct line of administrative command to health facilities beyond that. From Regional ODPCs there are lines of supervision through Provincial Health Offices, Provincial Hospitals, District Health Offices, General Hospitals, Health Promotion Hospitals and PHC centres. University hospitals, Bangkok Metropolitan

45 Mid-term review of the WHO Country Cooperation Strategy Thailand 2012-2016; can be access at http://www.searo.who.int/thailand/areas/ccs-midterm-review-2012-2016-tha.pdf?ua=1
Administration (BMA) hospitals and private hospitals are independent from both administrative and supervisory lines from BTB, a fact that many consider unfortunate for TB control in Thailand.

There are three main sources of funding support for the National TB Programme (NTP), the government budget, the National Health Security Office (NHSO) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). WHO direct financial support is small in comparison, about US$ 190 000 for the 3 bienniums. One TB/HIV Medical Officer within the Thailand Country Office has been assigned to provide technical support.

GFATM is the second largest source of funding for the NTP after the government. From 2003–2015 Thailand has received US$ 70 465 000 from the GFATM for TB control. The latest round provided US$ 30 819 000 with the period of implementation from October 2011–2015. It has been used for a) expansion and enhancing high quality DOTS, b) addressing TB/HIV, MDR-TB and other challenges, c) harmonizing the work of all public and private TB care providers in Bangkok and d) empowerment of people with TB and communities. The National TB Programme (NTP) is facing a big challenge in how to continue to improve or even maintain programme performance after GFATM termination.

To ensure quality and standardization, about 75% of anti-TB drugs and laboratory reagents have been procured through the Government Pharmaceutical Organization (GPO). All anti-TB drugs for all government health facilities were supplied by the NHSO while BTB had a stock of drugs for migrants. The GFATM filled the gaps of second line drugs and drugs for multidrug resistant TB (MDR) and extensively drug resistant TB (XDR).

Gaps and challenges identified by the JIMM in 2013 are the following:

- Low case notification: Not all hospitals, especially those from the BMA, university and private sector, report their TB cases to the BTB. The priority for the recording and reporting is to respond to the demands of the health insurance schemes rather than the BTB.
- Insufficient reporting and surveillance system: There are many systems, both paper and electronic used in parallel. Current systems for registering and following cases are not efficient enough and consume the time of staff. The computerized system, called TBCM, does not synergize with the National Health Security Office (NHSO) data collection system.
- Treatment outcomes are not satisfactory: In 2012, Thailand’s treatment success rate was only 82% among the new Thai smear-positive cases and in some private hospitals the success rate was lower than 73%. There was a high fatality rate in many areas, especially among the elderly. DOTS is working only in a few provinces.
Insufficient provision of suitable care for all migrants in need: There are about 3 million migrants concentrated near the country’s border and in and around Bangkok. Migrants have reduced access to health services, including TB care. They have higher default rates and a greater risk of developing drug resistance.

To follow up JIMM’s recommendations the Green Light Committee undertook a review mission in 2014. Their findings show some progress while several issues still need to be resolved.

The following progress was achieved after the JIMM review in 2013:

- The National Strategic Plan for Tuberculosis Prevention, Treatment and Care 2017–2021 was developed and is waiting to be submitted to the Cabinet for approval. This covers the budget and human resource requirements, as well as establishment of coordinating and technical committees for TB Control. The budget requested is also planned to minimize programme interruption after the phasing out of the GFATM
- A chapter on multiple drug resistant TB is included in the 2013 NTP treatment guidelines and these were distributed widely and are now in use
- Inclusion of algorithms, treatment regimens, and integrated new WHO definitions and reporting framework
- A National Expert Committee on Drug Resistance-TB (DR-TB) established in 2013 with the purpose of providing technical guidelines related to approval of developed guidelines and making decision on the changing of recommended second line drugs
- Improving collaboration with civil society
- Strengthening knowledge on programme management
- Improving laboratory services for TB diagnosis
- Streamlining case registration and notification so that only one system is used and can be accessed online by all offices concerned (BTB, NHSO, provincial and district offices). With the GFATM support, software is being developed that will be field tested soon and it is expected to be launched by the end of this year. The new system will integrate the TBCM and NHSO systems and it is web-based so it can be accessed by all levels of health personnel. The new system is called TBCM Online
- In order to prepare for the phasing out of GFATM support the NTP is going to submit the National Strategic Plan for TB Control, 2017–2021 to the Cabinet for approval. The MoPH is also planning to establish the TB Foundation as a source of funding to subsidise the government budget.
A National TB Prevalence Survey was completed in 2012 and is still waiting for publication. This is an unusual delay. Some data has been extracted for use by the NTP.

Some Outstanding issues remain:

- Drug management: Availability of second line drugs, paediatric formulations and pre-packing the drugs for patients is still inadequate.

- The BTB has yet to be strengthened sufficiently to face challenges in the near future (e.g. transition from Global Fund towards government support, greater decentralization, management of outbreaks).

- Insufficient supervision to staff looking after MDR-TB patients and staff supervision is challenged by the shortage of personnel with appropriate authority/expertise and funding for transportation. Supervision is replaced by irregular meetings.

- There has been limited engagement of the private/non-MoPH sector and insufficient networking between government and nongovernment laboratories.

- Only 24 out of 77 provinces are covered by the Programme Management of Drug-resistant TB (PMDT) training.

- The data registration system is in transition: It shows little progress from the 2013 reviews, is still not primarily case-based, has a multiplicity of overlapping systems, none of them complete, with several inefficiencies including parallel paper/electronic methods, little leverage on the private sector, and lack of good information on certain important issues, e.g. paediatric TB and outbreaks.

- Increasing TB prevalence has been observed among migrants with higher rates of MDR and lower cure rates.

- DOTS is not widely applied for the treatment of TB with the impression of the TB control staff that this method of treatment is not practical.

- Problems of TB among migrants include access to and quality of services. Outbreaks of MDR continue to exist although several measures have been applied to minimize problems. High default rates are also found because of their high mobility and fear of losing jobs after being diagnosed as having TB.

- There was a report of a large stock of fixed dose combination drugs (which the GPO purchased from a WHO pre-qualified manufacturer) with degradation of quality before the expiry date. This happened with stocks in some southern provinces. GPO had to collect all of this stock and replace it with single entity rather than combination tablets.

- The ASEAN Economic Community (AEC) was established in 2015 at the same time the GFATM is phasing out. More labour workforce is expected to
flow into Thailand from other ASEAN countries. It is a great challenge for the country to deal with the increased tuberculosis in non-Thai population groups.

- The cost of anti-TB drugs procured through the GPO is rather high compared to the costs of drugs in neighbouring countries.

The NTP has been trying to address these issues. But technical support from WHO is felt to be needed, particularly in planning and advocacy to high-level decision-makers to ensure strong commitment to TB control as one of the country’s priorities. The comprehensive programme review every 4 years is considered useful for programme development.

**Conclusions and recommendations**

Inclusion of the TB programme as one of the strategic priorities is highly relevant. It aligns to the national development plan and also closely links to the HIV/AIDS and Border and Migrant Health programmes. It aligns with the WHO 12th Global Programme of Work (GPW)\(^{46}\) and regional WHO strategies.

There are some important areas that the NTP has not yet achieved fully, namely: a) an efficient and effective case notification, reporting and information system, b) quality of TB case management, c) multidrug resistance (MDR) management, d) procurement of anti-TB drugs and supplies and quality control. Reasons for nonachievement in these areas are mainly due to nonstandardized case reporting systems, inappropriate application of the rapid diagnostic technology, weak supervisory systems and multiple channels within the health-care provision system.

The impact of the CCS on NTP implementation is seen as an improvement in programme management in some areas as mentioned above. However, an impact on disease morbidity and mortality has yet to be seen. This depends on how well Thailand can address the following main issues: a) standardization for quality PMDT implementation, b) sustainability of BTB performance after withdrawal of GFATM, c) improvement of the supervisory system, d) case registration systematization, e) coverage and quality of TB case identification and management for migrants, and f) countrywide application of DOTS.

The inclusion of the TB Workplan is a good example of flexibility and responsiveness of the CCS to the changes of the health situation of the country. WHO provided technical support by appointing one TB Medical Officer in the Thailand Country Office to work closely with the national programme manager.

Although several issues in the TB programme implementation were found by the review mission, Thailand has worked hard to correct them. Many things have been

\(^{46}\) Twelfth General Programme of Work, World Health Organization; can be accessed at http://apps.who.int/iris/bitstream/10665/112792/1/GPW_2014-2019_eng.pdf?ua=1
rectified, others are in the process of being improved and some of them have yet to work out a best solution. Those include appropriate services for migrants, cooperation from the BMA, university and private hospitals, increased coverage of the advanced laboratory service, and programme supervision and monitoring. The inclusion of the TB programme in the CCS umbrella by WHO is relevant and timely. To improve and sustain programme performance, the NTP requires continuous technical support, particularly in the areas of programme management skills and coordination with other stakeholders. The effectiveness of the support is high as evidenced by improvements in several areas addressed by the JIMM review and GLC mission reports.

While most of the JIMM recommendations are still relevant, the following are an addition from the final CCS evaluation report.

In order for Thailand to be free from the list of Global TB Burden Countries and further reduce disease morbidity and mortality, the NTP has to strengthen its human resources in both quality and quantity, at the central as well as regional level. Training on programme management, coordination and advocacy skills is required.

The transition plan before the termination of GFATM support has to be made as soon as possible. While waiting for a workable transition plan, the BTB should try to expedite approval of the National Strategic Plan by the Cabinet.

Advocacy efforts to seek full cooperation from BMA, university and private hospitals to improve case notification and reporting and to follow the national TB management guidelines should be strengthened. A high-level authorities meeting and discussion may be required to seek their commitment to cooperation. The summary of the JIMM evaluation report (in Thai) should be published and widely distributed to high-level administrators and to all facilities with TB care services.

Invest more to ensure availability of advanced diagnostic technique (HTB/rif) as a first line test in all hospitals, and not just limited to high-risk groups.

Since DOTS is the recommended strategy for TB Control but is not widely implemented in Thailand, the NTP should try to explore workable models in order to widely apply this strategy in all provinces and difficult areas.

WHO should negotiate with the RTG to continue considering TB as a health priority programme and give continuous support to the country. Advocacy work may also be required to mobilize external resources to ensure that implementation of the programme will not be interrupted.

Funding support from WHO should give more attention to building capacity of the national TB staff, particularly in areas of plan development, programme management, coordination and advocacy skills.

Continue to support the 4-year cycle of JIMM Evaluation.
This final evaluation of the World Health Organization (WHO) Country Cooperation Strategy (CCS) 2012-2016 was conducted in June 2016 by a four-member team consisting of Dr Sawat Ramaboot, Dr Kumnuan Ungchusak, Mr Stéphane Rousseau and Dr Dean Shuey.

The evaluation found the CCS to be relevant to the health needs of Thailand, and WHO is widely acknowledged as a valuable partner. The WHO normative functions are well recognized and appreciated.

The following are the key recommendations of the final evaluation:

1. Have a clear development process for the next CCS;
2. Have clear criteria for lead agency selection;
3. Continue to foster multisectoral work but perhaps involve the MoPH more;
4. Recognize that multisectoral work requires specific technical skills;
5. Explore lighter management processes;
6. Move the oversight committee towards more sustainable funding over time;
7. Slow down the rate of turnover of key personnel; and
8. Continue pushing multisectoral working methods in spite of obstacles.

The evaluation concludes that the WHO CCS 2012-2016 was well aligned with Thailand’s health priorities and has directed most resources towards the priority programmes. Most of the priority programmes have been implemented successfully and have contributed to the stated objectives.