The World Health Organization (WHO) Country Cooperation Strategy (CCS) is WHO's key instrument to guide its collaboration in and with a country, in support of its national health agenda. The WHO Country Cooperation Strategy Thailand 2012–2016 was developed through an extensive and broad consultation process. This was the fourth WHO CCS for Thailand but a very different, innovative approach was proposed for working in five priority areas. The CCS called for WHO to undertake a mid-term review of the CCS, which was agreed by the Ministry of Public Health. This document presents the findings and recommendations of this mid-term review.
Mid-term review of the
WHO Country Cooperation Strategy
Thailand
2012–2016
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<tbody>
<tr>
<td>AC</td>
<td>assessed contribution</td>
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<tr>
<td>AEC</td>
<td>ASEAN Economic Community</td>
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<td>APW</td>
<td>award for performance for work</td>
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<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<tr>
<td>BPHER</td>
<td>Bureau of Public Health Emergency Response</td>
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<tr>
<td>BPS</td>
<td>Bureau of Policy and Strategy</td>
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<tr>
<td>CEO</td>
<td>chief executive officer</td>
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<tr>
<td>CHSD</td>
<td>Community Health Services Development</td>
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<td>CHSDP</td>
<td>Community Health Service Development Programme</td>
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<td>DFC</td>
<td>direct financial contribution</td>
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<tr>
<td>DOTS</td>
<td>directly observed treatment – short-course</td>
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<td>EMIT</td>
<td>Emergency Medical Institute of Thailand</td>
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<td>FTA</td>
<td>Free Trade Agreement</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 Program (Thailand)</td>
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<td>IUHPE</td>
<td>International Union for Health Promotion and Education</td>
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<tr>
<td>MDP</td>
<td>Myanmar displaced person</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NESAC</td>
<td>National Economic and Social Advisory Council</td>
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<td>NESDB</td>
<td>National Economic and Social Development Board</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<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>
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<td>RTG</td>
<td>Royal Thai Government</td>
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<td>RTI</td>
<td>road traffic injury</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>TB</td>
<td>tuberculosis</td>
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<td>ThaiHealth</td>
<td>Thai Health Promotion Foundation</td>
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<td>THL</td>
<td>Thailand Healthy Lifestyle</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNPAF</td>
<td>United Nations Partnership Assistance Framework</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>US CDC</td>
<td>United States Centers for Disease Control and Prevention</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

Background
The (World Health Organization) WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) is WHO’s key instrument to guide its collaboration with the Royal Thai Government (RTG), in support of the national health agenda. The CCS called for WHO to undertake a mid-term review of the CCS.

The CCS identified five priority areas:

1. community health system
2. multisectoral networking for noncommunicable disease control
3. disaster preparedness and response
4. international trade and health
5. road safety.

An innovative partnership programme approach was proposed for each of these areas, using the following modalities: a steering committee to oversee implementation, a subcommittee for each priority area to oversee and direct, a lead agency to facilitate, a programme manager to manage the one plan per priority area implemented through multiple partners, and an agreed pool of funds.

WHO’s role was to provide technical expertise, facilitate the convening of partners and contribute financial resources.

The CCS also incorporated other components, including major public health challenges, WHO’s normative work, and support for Thailand’s work beyond its borders.

The objectives and methodology of the review
The objectives of the review were to review the progress, outputs, outcomes and impact of the five partnership priority programmes; identify lessons learnt from planning and implementation; propose potential changes; and assess the balance between the five priority programmes and other components of the CCS.

A team of eight persons conducted the review, with one reviewer per priority programme, one reviewer for each of the two programmes included from the major public health challenges, namely communicable disease control and border and migrant
health, and a team leader. Separate reports were prepared for each of the programme areas reviewed, which have been included as Annexes 5–11. Documentation was reviewed, key informants interviewed using semi-structured interviews, and findings analysed and discussed before finalizing the final and programme reports.

**Context**

Since the finalization of the CCS, Dr Pradit Sintavanarong took office as the Minister of Public Health in Thailand, on 2 November 2012. On 15 February 2013, an executive committee was established to set up policies and directions to manage collaboration between the RTG and WHO. This committee has also taken over the functions of the steering committee.

On 1 June 2013, Dr Yonas Tegegn assumed the post of WHO Representative for Thailand.

**Conclusions**

1. The implementation of the five partnership priority programmes shows promise in making a significant contribution to the RTG’s objectives.
2. The five priority programmes are all relevant and addressing public health priorities.
3. The five priority programmes have not been planned optimally, which has contributed to difficulties in implementation.
4. There have been issues in implementation of some of the priority programmes.
5. The priority programmes have improved the partnership and collaboration in the programme area but have been less effective in promoting multisectoral partnership.
6. There is scope for the Ministry of Public Health to play a greater role in the priority programmes and ensure linkage to policy-making.
7. The outputs of the activities have been significant and relevant but not always coherent. It is too early to determine the outcomes and potential impact of the programmes.
8. Some programmes have been able to leverage funds but it is too early to say whether the programmes are considered good value for money.
9. The monitoring and evaluation frameworks for the programmes were not able to provide a basis for monitoring and evaluating the programmes.
10. The WHO contribution, both technical and financial, has been useful but the technical input could be improved.
(11) The concept of a partnership programme to tackle health priorities appears to be a valid approach; however, more monitoring and evaluation is required to determine the added value and to learn lessons from implementing the approach.

(12) Changes to the priority programmes are possible; however, a more rigorous process is required in deciding whether to employ this approach and for what purpose.

(13) The priority programmes should have an end date, which as a default should be 2016.

(14) The CCS should not restrict the ability of the Ministry of Public Health and the WHO Country Office for Thailand to collaborate in new priority areas, either through other modalities of cooperation or through the partnership priority programme.

(15) The CCS Thailand 2012–2016 provides a sound strategic framework for collaboration with the RTG, is a good approach for the use of WHO resources, offers good value for money and is consistent with the core functions of the Organization.

Lessons learnt

(1) It is necessary to have a robust planning process that involves all partners and has an internal and external review process where adequate time is given for partners to reach consensus on the plan.

(2) It is necessary to provide more guidance and support for developing strategic and operational plans

(3) It is important to ensure that there are institutional linkages with the Ministry of Public Health for all priority programmes and that the Ministry of Public Health is actively involved in the programmes.

(4) A sound monitoring and evaluation framework is an essential requirement for each programme.

Recommendations

1. Internal reviews by priority programmes in 2013

In 2013, as part of the process for development of their plans for 2014, the partnership priority programmes should undergo an internal review process with the involvement of the partners, using their monitoring and evaluation frameworks. The Ministry of Public Health and WHO can provide support. The findings of the Mid-term review of the WHO Country Cooperation Strategy Thailand 2012–2016 can inform these exercises.
2. **The importance of continuing evaluation**

Continuing evaluation of the priority programmes is important, in order to assess the value of these programmes and learn from their implementation. Best practices should be shared with partners and counterparts both globally and in Thailand.

3. **The Ministry of Public Health should be more actively involved in priority programmes**

There is much scope for the Ministry of Public Health to be more actively involved in the priority programmes, especially in ensuring that there are institutional linkages with the programmes. If implemented, these actions would be expected to contribute to improved sustainability and a greater impact of the partnership programmes, and better contribution of the priority programmes to national policy.

4. **Application of the priority programme approach**

There is a need to be selective when this approach is used. The approach may be particularly useful in emerging issues, such as ageing, which is a relatively new health challenge, where there are no existing mechanisms to bring together a wide range of potential partners in the health sector and other sectors.

5. **The WHO Country Office for Thailand should take a flexible approach to the Country Cooperation Strategy**

WHO should continue to be strategic in the collaboration with the RTG, utilizing the strengths of the Organization and providing high-quality technical cooperation. However, if new priorities emerge or there is a change in priorities, these should be accommodated in the CCS framework.
1 — Introduction

The World Health Organization (WHO) Country Cooperation Strategy (CCS) is WHO’s key instrument to guide its collaboration in and with a country, in support of its national health agenda. The *WHO Country Cooperation Strategy Thailand 2012–2016* (1) was developed through an extensive and broad consultation process. This was the fourth WHO CCS for Thailand but a very different, innovative approach was proposed for working in five priority areas. The CCS called for WHO to undertake a mid-term review of the CCS, which was agreed by the Ministry of Public Health.
2 — Background

The CCS was developed with the recognition that Thailand, a middle-income country, had made remarkable health gains over the last few decades but faced challenges such as the rise of noncommunicable diseases (NCDs), as well as increased demand by the public for high-quality health services. In addition, diseases such as HIV/AIDS and other communicable diseases also continued to be on the health agenda. Over the last decade in particular, the health sector had become more complex, with more agencies and institutions having defined mandates. Innovation, as well as greater collaboration and cooperation, was required within the health sector, as well as with other sectors, to address the challenges in the health sector.

WHO is a major partner of the Thailand Ministry of Public Health and has a long-standing programme of technical cooperation and collaboration with the Ministry. Previously, WHO technical cooperation to Thailand has largely consisted of many small projects, covering a broad range of programme areas, administered through contracts that have often been based on ad hoc unplanned requests, which did not utilize the strengths of the Organization or lead to substantive outcomes. The process of joint strategic planning and prioritizing was not optimal, partly because WHO funds were minor in comparison to government funding, but also because the strengths of WHO were not utilized in a well-planned manner. These strengths are considerable – WHO is the leading authority on health and has convening authority; it is neutral; and it is able to draw on expertise not only in the Country Office for Thailand but from the region and globally.
3 — Description of the Country Cooperation Strategy

WHO has developed the *Country Cooperation Strategy Thailand 2012–2016* (1) to provide a longer-term, more focused and strategic framework for the collaboration.

The CCS under review identified five priority areas, which were selected by representatives from major public health agencies in Thailand. The areas were:

1. community health system
2. multisectoral networking for noncommunicable disease control
3. disaster preparedness and response
4. international trade and health
5. road safety.

In addition, two other areas – communicable disease control and border and migrant health – were included in the list of major public health challenges and also reviewed, along with part of the unfinished agenda in the CCS.

For the priority areas, the CCS was expected to result in a “profound change” in the collaboration between the Royal Thai Government (RTG) and WHO, “using a participatory and evidence-based approach for a more innovative collaboration in terms of setting strategic priorities for greater impact”, as well as proposing modalities that include a greater multisectoral approach (1).

The modalities of implementation in the five priority areas were:

- a high-level steering committee for overall governance
- a steering subcommittee for each priority area
- a lead agency designated for each priority area
- appointment of a programme manager
- implementation of the programmes through multiple partners, with a degree of pooled funding.
The strategic and operational plans were reviewed by an internal and external review process, before approval in the two committees.

WHO’s role was to provide technical expertise and contribute funds but WHO’s convening power and the independent authority of the Organization as a whole to contribute to the programmes would also be utilized. Alignment with the Thai National Health Development Plan (2), as well as with the United Nations Partnership Assistance Framework Thailand 2012–2016 (3), would be a requirement.

The modalities proposed in the CCS, Annex 4 (1), were expected to contribute to increased coordination and collaboration of involved agencies in the particular programme areas. It was envisaged that other interested agencies would join the partnership and pool their funding for the programme. However, it was not envisaged that all funds would be pooled, as it was felt that separate management of resources may be more appropriate in some cases.

In 2010, the development process for the CCS took place and in 2011 the priority programme approach was trialled in selected programmes. In 2012, the CCS formally commenced as the basis for WHO’s collaboration with the RTG. In mid-2012, a quality assurance review was undertaken by WHO, which resulted in actions to improve the management of the programmes. Details of the chronology are given in Annex 1.

In a broader context, as countries, especially in Asia, graduate to the status of middle-income country, WHO’s country cooperation with them has been an ongoing challenge. The Thai CCS was seen as an innovative approach to collaboration with a middle-income country, which may hold lessons for WHO in its cooperation with other countries.
4 — Objectives, scope and methodology of the review

The CCS review had four objectives:

1. to review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
   - the leverage that the five CCS priority programmes have created for channelling other funds into the programme
   - the quality of the activities performed by the five priority programmes and value for money
   - the relevance and WHO support to communicable disease control (the unfinished agenda) and border and migrant health

2. to identify the lessons learnt from planning and implementation of the five priority programmes

3. to propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

4. to assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

In developing the methodology, questions were developed based on the terms of reference that the review should address. However the two overriding questions were:

1. Is implementation of the CCS making a significant contribution to the achievement of the RTG’s, including the Ministry of Public Health’s, objectives and adding value?

2. Is the CCS a good approach for the use of WHO resources, good value for money and consistent with the core functions of the Organization?

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using
semi-structured interviews. The initial list of key informants was developed by the WHO Country Office for Thailand; some additional names were suggested by the International Health Bureau and Ministry of Public Health, and the reviewer identified additional informants from the documentation and from information gathered from key informants during the review process.

Summaries or recordings of the interviews were made. The programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

The final report was prepared after analysis and discussion of the programme reports and the findings of the team leader, who reviewed the overall CCS as well as reviewing the implications for WHO and the concept of the new programme approach.

One limitation of the review was that most programmes had only commenced implementation in early 2012 and had not yet produced substantive outcomes or had an impact, since the strategic plan was for a 5-year period. If this was the case, the reviewer attempted to make an assessment of potential outcomes and impact from the programme.

The framework used for the review of the priority programmes is included as Annex 3. Annex 4 presents a list of persons interviewed.
5 — Results/findings

5.1 General findings

The five priority programmes of the WHO Country Cooperation Strategy Thailand 2012–2016 (1), along with communicable disease control and border and migrant health, were reviewed and separate reports for each programme area are included as Annexes 5–11.

The preparation of the CCS was given high-level support and commitment from the Ministry of Public Health and WHO. This has continued through the implementation of the CCS. The scope of the seven programmes reviewed was broad and it was difficult in the limited time of the review to capture all the elements of the programmes and to interview all the key informants that were identified.

5.2 Context

Important developments in Thailand since the finalization of the CCS have been the appointment of a new Minister of Public Health, Dr Pradit Sintavanarong, who took office on 2 November 2012. On 15 February 2013, an executive committee was established. Some of the responsibilities of this committee are to set up policies and directions, to manage collaboration between the RTG and WHO, in accordance with the Ministry of Public Health policies and country needs, and to report the outcome of the meetings of the executive committee to the international health committee chaired by the Minister of Public Health. The steering committee that was previously responsible for the five priority programmes was replaced by the executive committee. The international health committee is an internal committee in the Ministry and coordinates and oversees the international health activities of the Ministry. The Ministry of Public Health has also embarked on a process of health reform.

On 1 June 2013, a new WHO Representative for Thailand, Dr Yonas Tegegn, commenced his duties.

In 2013, the World Health Assembly approved the 12th General programme of work of WHO (4), which has guided the development of the WHO Programme budget 2014–2015 (5) and will guide the preparation of the country programme budget for the biennium 2014–2015.
5.3 The process for developing the Country Cooperation Strategy and identifying the five priority programmes

The consultative process for development of the CCS had broad participation, involving, besides the Ministry of Public Health and WHO, the engagement of major public health agencies and institutes. The five criteria used for prioritization areas were agreed, then concept papers of potential priority areas were drafted and a workshop was held, involving a deliberative process to rank priority areas. The criteria agreed upon for a priority area were that each area should:

1. be of interest to all stakeholders
2. have a good potential for success
3. be challenging and include intersectoral issues
4. fill gaps in knowledge and interventions, and avoid duplicating existing efforts
5. be an area that provides benefit to others, both regionally and globally.

Implicit were the public health importance and the alignment with The 11th national health development plan (2). The criteria adopted for the priority areas were broad and subjective.

Twenty-one concept papers were submitted by a number of national agencies as well as MoPH departments, which were reduced to 12 areas, and these were voted upon by 17 major public health organizations and agencies. The four areas that received the highest number of votes were selected, with road safety, which was tied for fifth place, being selected by WHO.

Once the priority areas had been identified, lead agencies were selected for each area. However, the process for selection of the lead agencies was not transparent and did not involve WHO. The role of the lead agency was “to plan, coordinate, convene, and communicate as well as facilitate and monitor implementation using a participatory and inclusive approach which would define agreed upon objectives, plans and proposals. An agreed upon action plan would serve as the basis for implementation” (terms of reference, as approved by the steering committee in mid-2012 (see ref. 1, Annex 4)).

The lead agencies selected were: the Health Systems Research Institute (HSRI); the Thai Health Promotion Foundation (ThaiHealth); the Emergency Medical Institute of Thailand; the WHO Collaborating Centre for Injury Prevention and Safety Promotion, Khon Kaen Hospital; and the International Health Policy Program (Thailand) (IHPP), Ministry of Public Health. The role of the lead agency was to act as a facilitator and also to host the secretariat (programme manager) for the subcommittee. The only institute or programme from the Ministry of Public Health was IHPP, which was also the only candidate for international trade and health.

As this was a new approach, it was considered important to have commitment from all stakeholders; hence, the process was conducted in stages over several months in 2010. The process was thorough but slow.
5.4 The five Thailand–WHO partnership priority programmes

5.4.1 Planning: the process and the plans

Once the priority areas had been selected, the lead agencies were asked to develop a strategic plan. The plans were developed through a consultative process and then subjected to both an internal review process conducted by ThaiHealth and an external review process managed by WHO, with participation from recognized global and regional experts. Both the consultative process and the review process were demanding and time consuming. There was minimal guidance provided for the preparation of the plans, except that they should contain a results hierarchy.

For the external review, plans were sent to experts in the area, who made comments. In some areas, such as international trade and health, the plans were modified to take on the comments; in others, such as disaster preparedness and response, they were not. The internal review process in some programmes was not sufficient to achieve a consensus on the plan or indeed to agree a satisfactory plan as an end-product.

The result was that not all partners had a shared vision of what some priority programmes were trying to achieve, nor did some partners agree with the final plans, which created difficulties in implementation, as well as affecting their level of engagement.

Some findings on the plans and processes for the five programmes

Community health system: HSRI developed the plan after extensive consultation. The reviewer considered it relevant and appropriate. However, a partner had reservations and did not agree on the objectives of the programme. A contributing factor to the lack of agreement was that the period for the internal review was short and not adequate to achieve consensus.

The scope of the plan was ambitious; the target was to expand the community health programme to 2000 subdistricts by the end of 2013 and 4000 by the end of 2015.

Multisectoral networking for NCD control: the strategic plan was well formulated with an ambitious scope, but the action plans did not align with the strategic goal and objectives of the programme but were rather related to the individual agencies’ intervention programmes. The strategic plan has continued to evolve over the 2 years of implementation. The action plans have supported a fragmented project-type approach, rather than a coherent programme approach.

Disaster preparedness and response: the original strategy document was reviewed by two external reviewers, who both concluded that the plan had significant weaknesses in its conceptual design and required major revision. However, the final approved plan contained minimal change to the original document. Partners recognized that the plan was not appropriate, so in July 2011 a revised strategic plan was developed in consultation with stakeholders, indicating that the initial internal review process was inadequate.
International trade and health: IHPP developed the plan through stakeholder meetings. Most comments arising from the external review were incorporated. There was stakeholder agreement with the plan.

Road safety: the scope of the plan was very broad without a clear vision. Also, the plan led to the programme being implemented in an activity-focused project mode rather than a coherent programme approach.

All the programme areas were complex, especially community health system, NCD control and road safety; hence, the direction and objectives of the plan needed to be well defined, which did not happen for some plans, resulting in difficulties in implementation. In addition, the scope and objectives for community health system, NCD control and road safety were very ambitious.

The operational plans did not always match the strategic plans and the indicators were also often poor and unmeasurable; hence, they did not provide a basis for monitoring and evaluation. This was also an important finding of the quality assurance review of 2012. Revision of plans occurred in 2012 in some programmes, for example disaster preparedness and response. However, this review has found that the monitoring and evaluation frameworks for most programmes continued to be weak and were not always used for monitoring, as in the case of the disaster preparedness and response programme. In some programmes, the operational plans were fragmented and not coherent, which was not in line with the concept of the programme approach to have one integrated plan. Rather, partners continued to implement their activities in a vertical project mode.

5.4.2 Governance

The steering committee met once in 2011, three times in 2012 and once in 2013. The committee reviewed the progress of the programmes. Programmes were required to report every 6 months; however, following the quality assurance review in mid-2012, a reporting format for 3-monthly reports was agreed in February 2013.

The executive committee was established in February 2013 and had its first meeting on 27 March 2013. This was well attended by department heads or their representatives, who expressed much interest in the work of the priority programmes and a desire for departments to be more involved in these programmes.

For priority programmes, the subcommittees were found to have overseen the programmes and also to be a useful mechanism for sharing information, discussing issues, promoting understanding and changing views. Subcommittees were multisectoral and appear to have promoted multisectoral collaboration in some programmes but not active engagement of ministries or agencies outside of the health sector in any of the programmes. The work of the subcommittees would have been facilitated if good
reporting systems had been adopted earlier. However, once the executive committee had been formed, the status of the subcommittees was unclear and most ceased to meet.

The chairpersons were very prominent in the field and their role varied, with strong involvement in some programmes. The only chairperson from the Ministry of Public Health was for international trade and health.

Some programmes established a core group of major partners that met more frequently or, in the case of NCD, of experts to advise and provide direction. In the case of international trade and health, the partners were presented at a less senior level and could discuss practical matters related to the programme. The core group was a useful innovation; however, for NCD, the core group had no agreed mandate from the subcommittee and so there was some confusion over its role.

It has taken time for programmes to come to a common understanding of the role of the different bodies involved in stewardship – the subcommittee, the core group if established, the lead agency, and the secretariat or programme manager. Since agencies also had other programmes in the same area, there was sometimes confusion over the role of the partnership priority programme and other programmes in the same area.

5.4.3 Progress

The achievements have been variable, largely being confined to outputs but often with potential for outcomes and impact in the future. There are many positive examples from the programmes of significant outputs covering a wide range of activities. However, in some programmes, the achievements have fallen below the level expected from some partners. The reviewers found it difficult to assess the quality of the activities, although there was general satisfaction from stakeholders over the quality of most of the activities.

A primary aim of the programme approach has been to promote interagency networking and collaboration, including multisectoral collaboration. The programmes should be a vehicle to bring agencies and existing networks together to collaborate. Programmes have held meetings and seminars, which are important in strengthening networking and improving collaboration, but the impact was difficult to assess and not considered as an outcome at this time.

In the area of NCD, it was felt that some progress has been achieved to some extent, especially around specific areas, for example in addressing salt as a risk factor, but the programme has been less successful in bringing agencies outside the health sector into the partnership. In international trade and health, a major group of activities was on network strengthening, involving workshops, seminars and meetings. For this programme, the capacity-building was multisectoral, with ministries from other sectors also benefiting.

However, there have been difficulties in implementing activities in some programmes and many have fallen behind schedule. In the community health system
programme, implementation has fallen behind schedule and the lead agency, HSRI, has recently withdrawn. Contributing factors included the lack of an agreement of all partners on the plan, which was very ambitious; the choice of lead agency as HSRI; the failure to develop a prototype model district; and programme management. However, the programme did attract major partners, who committed funds. The subcommittee worked hard, along with the programme manager, to make the programme a success.

Leverage of funds has occurred. The community health system partnership and plan attracted significant funding. Also, in the NCD control programme, the training for policy advocacy attracted financial support from the United States Centers for Disease Control and Prevention (US CDC), in collaboration with the International Union for Health Promotion and Education (IUHPE).

### 5.4.4 Programme management,

Programme management was an important factor in implementation of the programmes. The quality assurance review conducted in mid-2012 drew attention to the variation in practices between the programmes in relation to workplans, the need for quantitative indicators, common reporting formats, and programmatic fragmentation that occurred in the implementation.

The reviewers found that the programme managers and secretariat had worked hard in trying to ensure the success of their programmes. In some cases, this was an additional responsibility; in others, the programme manager did not have the relevant experience or background in managing a multipartner programme. If the programme manager was not from the lead agency, this was also a constraint in managing the programme. The programme manager and team were recognized in all programmes as being very important to the success of the programme.

### 5.4.5 Significant changes that have impacted or may impact upon a programme

On 15 February 2013, a Ministerial Order was issued, establishing an executive committee, which would have responsibility to manage the overall collaboration between the RTG and WHO and replace the steering committee, which had oversight of only the five priority programmes. There were also some changes to the membership, with a stronger representation from the Ministry of Public Health in the executive committee. In 2013, the subcommittees of the steering committee also stopped meeting formally; however, in most programmes, informal meetings have continued to occur.

The Ministry of Public Health is undergoing a reform process, which is expected to impact upon the collaboration between the RTG and WHO. In addition, the incoming minister has given high priority to international health, including establishing an international health committee, which meets monthly and also addresses Thailand’s role beyond its borders.
5.4.6 The Ministry of Public Health

The development process for the priority programmes was led by the Ministry of Public Health, through the Permanent Secretary. However, departments of the Ministry of Public Health have not played an important role in the partnerships, with the exception of IHPP.

In 2012, the Ministry of Public Health provided 1 million baht (approx. US$ 30 000) per priority programme to the pool of funds to fund activities.

In the Thailand–WHO Partnership Priority Programme for Multisectoral Networking for Noncommunicable Disease Control, a working group, including key persons from the Department of Disease Control, was established to work on aligning Thailand’s national NCD control target and indicators with the Global monitoring framework approved by the World Health Assembly (6). This has proceeded well and was expected to affect Thailand’s national NCD framework. However, the reviewer noted that, overall, for the NCD control programme, collaboration between the Ministry of Public Health and the network has been limited to mid-level management and individual linkages rather than institutional linkages.

Similarly in some other programmes, the institutional linkages with the Ministry of Public Health were lacking; hence, the ability to influence the work of the Ministry of Public Health, including setting policy, was weak. However, for international trade and health it was noted that a representative from the Bureau of Policy and Strategy would attend meetings.

5.4.7 WHO contribution to the priority programmes

The establishment of the priority programmes with their multisectoral partnerships drew upon WHO’s stature and convening power. WHO staff played an important role in some programmes, in the initial setting-up phase of programmes, and have continued to support the revision of strategic and operational plans. In disaster preparedness and response, international trade and health and road safety, the WHO country staff have played a more active role in supporting the programmes, including provision of expertise. However, after the staffing changes in the WHO Country Office for Thailand, WHO has not played a significant role in the community health system and NCD control programmes. A contributing factor has been that the post of national professional officer with responsibility for NCD has been vacant for some time, despite efforts to fill it.

WHO support to the partnership priority programmes has fallen largely under the following core functions:

(1) providing leadership on matters critical to health, and engaging in partnerships where joint action is required
2) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

3) providing technical support, catalysing change and building sustainable institutional capacity.

There has been little support for policy development, as this has not been a significant objective of the programmes to date; a factor in this is the lack of institutional linkages with the relevant departments of the Ministry of Public Health in the programmes. The Thailand–WHO Partnership Priority Programme on Disaster Preparedness and Response is an exception, in that the programme developed the Health Sector Disaster Risk Management Framework, although it is not certain that this has been fully endorsed by the Ministry of Public Health.

The CCS stated that the five priority areas “will receive a minimum of 50% of the financial (AC [assessed contribution]) and human resources available from WHO” (1). For the programme budget 2012–2013, the AC funds spent and committed for the five partnership priority programmes to 28 June 2013 was 58% of the funds available for technical activities, or 38% of the total non-human-resource funds. For the WHO staff, 37% of total AC spent on human resources was for the five partnership priority programmes. In addition, US$ 630 000 of voluntary contributions was spent on the five partnership priority programmes.

5.5 Major public health challenges: two programmes

5.5.1 Communicable disease control

The strategic agenda of the WHO Country Office for Thailand, as stated in the CCS (1), presents the major public health challenges, including the unfinished agenda where a list of eight areas is included, three of which relate to communicable disease control.

WHO support for communicable disease control has covered a large number of diseases and the technical cooperation has come in many forms. Of note is the support for policy development through high-level consultations and quality research and analysis in selected areas such as HIV treatment. Also noted was the importance of intercountry collaboration where WHO has played an important role, including the hosting of subregional, regional and global meetings in Thailand. The reviewer identified a range of areas where support was requested and a number of recommendations were made for WHO support.

5.5.2 Border and migrant health

“Ensuring equitable access to health services among migrants and mobile populations” is listed in the CCS (1) as one of the eight areas under major public health priorities.
The review of this programme area confirmed its public health importance to the RTG, and increasing relevance in light of regional economic developments and demographic trends. WHO’s work in this area was much appreciated by government and other informants, with WHO playing an important technical role in incorporating border and migrant concerns into other health programmes, as well as ensuring that migrant health concerns were raised in multisectoral forums.

In addition, WHO was able to convene meetings that provided a platform for open dialogue for representatives from ministries of health of countries of migrant origin and destination, as well as facilitating the sharing of experiences between the RTG and other governments.

Migrant health is an important priority of the Ministry of Public Health and there will need to be dialogue between the Ministry of Public Health and WHO on how WHO can best support the Ministry in the development and implementation of related Ministry of Public Health policies, and how the WHO programme can be adapted for a more strategic and focused role.

5.6 Normative functions and support to Thailand’s role beyond its borders

WHO has continued to provide support for Thailand related to WHO’s normative role. The activities have covered a broad range of areas and have been appreciated by the Ministry of Public Health, as well as institutions and academia. The activities have included knowledge management, as specified in the CCS (1).

WHO has continued to support Thailand’s work beyond its borders. This has included facilitating Thailand’s collaboration with other governments, its work in multicountry partnerships such as the Mekong malaria initiative, and the regional stockpile initiative. The WHO Country Office for Thailand hosts WHO subregional staff for the Mekong malaria programme, vaccine safety and emergency response.

Representatives from the Ministry of Public Health indicated that there were emerging priorities for the Ministry of Public Health, such as ageing, which would require WHO support.

5.7 WHO commitment to the Country Cooperation Strategy and its impact on ways of working

5.7.1 Other commitments in the Country Cooperation Strategy

In the CCS (1), WHO made commitments in relation to the strategy. These commitments are presented below, along with the progress made in implementing them.

• Widely disseminate: achieved
• Revise existing workplans and guide future ones: for the Programme Budget 2012–2013 it guided the preparation of the workplans

• Map CCS priorities to existing medium-term strategic plan strategic objectives as a basis for subsequent WHO operational plans: completed

• Use the CCS to shape and define the United Nations Partnership Assistance Framework (UNPAF): WHO contributed to the development and implementation of UNPAF; in particular, the ways of working are in line with the WHO CCS

• Use the CCS for advocacy and resource mobilization: the CCS has been used for resource mobilization and advocacy

5.7.2 Impact on ways of working

Strategic focus

The WHO Country Office for Thailand has been much more focused on fewer programme areas, including the priority programmes, and has tried to work more upstream – that is, supporting policy development and norms and standards. WHO’s convening power and its neutrality have been well used. WHO’s funding has also been important in some programme areas.

Human resources

Since 2010, three additional technical international staff posts have been established, with a decrease of four fixed-term national professional officer posts. General service support staff have increased by one post. These changes have been in line with the role for WHO identified in the CCS (1), which called for the establishment of a post for a full-time senior professional health officer and also for a review of the human resource profile of the WHO Country Office for Thailand, so that it would be better equipped to support the CCS.

Programme modalities for funding the programmes

The number of awards for performance for work (APWs) and direct financial contributions (DFCs) has been tabulated over the last three biennia. The number of APWs has markedly decreased but the number of DFCs has not increased. There was an increase in the average value of DFCs from 2008–2009 compared to 2006–2007 but this was not sustained into the current biennium.

The reduction in APWs would result in a decrease in technical and administrative workload for staff; however, the programmatic and administrative workload associated with implementing the country programme is still substantial.
6 — Conclusions and lessons learnt

1. The implementation of the five partnership priority programmes shows promise in making a significant contribution to the RTG’s objectives.

The conclusion of the review team was that this partnership programme approach shows promise as a way to achieve important outcomes through multipartner participation in the tackling of health priorities. The programmes are achieving outputs and have the potential to achieve further outcomes and make an impact. The team considered that the approach should be continued but measures should be taken to improve implementation of the existing programmes.

2. The five priority programmes are all relevant and addressing public health priorities.

The five priority programmes were all addressing major public health problems and have been able to establish multipartner partnerships with a “pool” of funds. In some programmes, the scope was quite limited, whereas in others, for example, NCD control and road safety, the scope was very broad.

3. The five priority programmes have not been planned optimally, which has contributed to difficulties in implementation.

Since this was a new approach, it has been a learning experience for all programmes. Much attention was given to the planning process, which was designed to be robust. However, there were issues with the plans, which included that they were too ambitious; did not always achieve partner consensus on the plans; did not promote coherence but rather a vertical project-type approach; and nearly all did not provide a basis for monitoring and evaluation. One factor was that sufficient time was not allowed in the internal review process for the development of a good-quality plan that was achievable and could gain the support of all partners. The operational plans in some programmes did not match the strategic plans.

Lesson learnt: it is necessary to have a robust planning process that involves all partners and has an internal and external review process where adequate time is given for partners to reach consensus on the plan. The strategic plan should provide the vision and have clear objectives. There should be a phased approach that is not overly ambitious initially but rather includes activities that strengthen networking and
collaboration, as well as those that can build confidence between partners. There needs to be coherence in the activities of the partners towards common objectives – that is, to pursue a programme approach.

4. **There have been issues in implementation of some of the priority programmes.**

Implementation has proceeded, but most programmes are behind schedule in some or a number of their activities. The activities being implemented are producing a range of outputs but it was considered too early in the implementation to determine the outcomes and potential impact.

It has been a learning experience, particularly in programme management, which, in the quality assurance review of 2012, was considered to be weak. However, the programme management has improved considerably in some programmes. The choice of the programme manager, the linkage of the programme manager to the lead agency, and the level of support for the programme manager are all important factors to consider in establishing programmes in the future.

*Lesson learnt:* it is necessary to provide more guidance for developing strategic and operational plans, including monitoring and evaluation frameworks. In setting up programmes, there needs to be more attention paid to the reporting systems, which provide the basis for accountability of the partners and for monitoring progress.

5. **The priority programmes have improved the partnership and collaboration in the programme area but have been less effective in promoting multisectoral partnership.**

A multipartner partnership was formed in all priority programmes, which has promoted a good collaboration between the partners and an improved understanding of the roles of other partners. This has been a significant achievement of the programmes and many partners stated that WHO’s participation has influenced their participation, although in some programme areas partners were already collaborating. However, an aim was to promote multisectoral partnership and this has been less successful, with other ministries playing a minor role in subcommittees, if they participate at all. The relative lack of active involvement in the partnerships by the Ministry of Public Health was a missed opportunity.

6. **There is scope for the Ministry of Public Health to play a greater role in the priority programmes and ensure linkage to policy-making.**

The Ministry of Public Health has played a major role in overseeing the development of the partnership priority programmes and setting up of the governance structures. The Ministry of Public Health, through the steering committee chaired by the Permanent Secretary, and, more recently, the executive committee, which has continued to be chaired by the Permanent Secretary, has provided the direction and oversight for the implementation process. However, the only lead agency from the Ministry of Public
Health was IHPP and there was only one chairperson from the Ministry of Public Health. Some programmes have not established institutional linkages with the relevant departments in the Ministry of Public Health. This has affected their ability to influence policy and there is a risk that the Ministry of Public Health will set up alternative or duplicate programmes and structures.

The Ministry of Public Health has not been a lead agency for any programme other than international trade and health. It could be a lead agency for other programmes, since the role of the lead agency is largely one of facilitating and coordinating.

Lesson learnt: it is important to ensure that there are institutional linkages with the Ministry of Public Health for all priority programmes and that the Ministry is actively involved in the programmes. This will help to ensure that the programmes contribute to national policy as well as lead to sustainable national mechanisms for some programme areas.

7. The outputs of the activities have been significant and relevant but not always coherent. It is too early to determine the outcomes and potential impact of the programmes.

A very large range of activities have been implemented across the programmes, which have generally met the standards expected by the partners and have been relevant to the programmes. Some are expected to lead to significant outcomes and impact in the future. In some programmes, such as NCD control and road safety, there was a lack of coherence across the activities, as the programmes were implemented more in a project mode than a coherent programme mode.

8. Some programmes have been able to leverage funds but it is too early to say whether the programmes are considered good value for money.

The programmes have generally been well funded and able to attract good support from partners, with the result that WHO funds are generally only a small portion of the budgets. The CHS was able to have a large pool of funds for their programme and this was considered a good example of leverage of funds. Also, the NCD control programme was able to attract the US CDC in collaboration with IUHPE to support the training for policy advocacy. However, some programmes are not meeting the expectations of some partners. If programmes do not achieve significant outcomes and are not considered value for money, it is expected that some partners will withdraw from contributing funds to the programmes.

9. The monitoring and evaluation frameworks for the programmes were not able to provide a basis for monitoring and evaluating the programmes.

As stated already, a major weakness of the programmes was their weak monitoring and evaluation systems. This has affected the ability of the executive committee, previously the steering committee, and subcommittees to monitor the programmes through valid quantitative indicators. No baselines have been established; hence, there will not be a sound basis for evaluation and monitoring of the programmes.
Lesson learnt: a sound monitoring and evaluation framework is an essential requirement for each programme. Attention needs to be paid to this in establishing programmes, and it is important to have advice from experts in this field, who should also review the frameworks.

10. The WHO contribution, both technical and financial, has been useful but the technical input can be improved.

The WHO Country Office for Thailand made a very important contribution to establishing the programmes and supporting their implementation; however, this has been variable across programmes. Greater use could be made of WHO expertise, and the resources of the Organization could also be drawn upon to a larger extent. For example, in establishing the monitoring and evaluation frameworks, better use could have been made of WHO’s expertise in the Organization as a whole.

The financial contribution has reached the target of 50% of the AC budget. However, the importance of the financial contribution to a priority programme was variable and this does not appear to be an important target. Indeed, it restricts the ability of the WHO Country Office to provide support to emerging new priorities of the Ministry of Public Health.

11. The concept of a partnership programme to tackle health priorities appears to be a valid approach; however, more monitoring and evaluation is required to determine the added value and to learn lessons from implementing the approach.

The concept of the programme approach to tackle health issues was innovative; hence, this initial stage has been a learning phase for the programmes and the governance structures. From the findings of the review, the concept appears to be valid and have good potential. Critical success factors and lessons learnt have been identified, which will contribute to improving the implementation of the existing programmes and any new ones.

12. Changes to the priority programmes are possible; however, a more rigorous process is required in deciding whether to employ this approach and for what purpose.

It is possible that one or more programmes may cease to function before the 5-year period is finished. The lead agency for the Thailand–WHO Partnership Priority Programme on Community Health System has withdrawn and the future of this programme is uncertain. If the programme were to cease, the executive committee would need to determine whether a new programme would be established or only four programmes would continue.

There would need to be a more rigorous process in determining whether this approach would be useful in being applied to a new priority area.
13. **The priority programmes should have an end date, which as a default should be 2016.**

The Thailand–WHO partnership priority programmes developed 5-year strategic plans and the expected date of completion for the programmes is 2016. The view of the team was that the programmes should finish at that date. Some possible end results by 2016 are that the programmes have achieved their objectives, or structures or mechanisms with a government mandate have been established to continue the collaborative partnerships. If there were a willingness from the executive committee and the subcommittee for a programme to continue, then the composition of the subcommittee, lead agency and secretariat should all be reviewed.

14. **The CCS should not restrict the ability of the Ministry of Public Health and the WHO Country Office for Thailand to collaborate in new priority areas, either through other modalities of cooperation or through the partnership priority programme.**

The CCS is “an Organization-wide reference for country work, which guides, planning, budgeting, resource allocation and partnership” (1), usually for a 5-year period. However, it is recognized that country priorities may change. This may lead to changes in the collaboration, or in some cases to a new CCS. The team found that there was flexibility in the CCS to incorporate new priorities – either a Thailand–WHO partnership priority programme, or in the major public health challenges and normative work.

It is suggested that it may be useful to consider the partnership priority programmes as “partnership priorities”, and other major areas of focus, such as communicable disease control and border and migrant health, as “other priorities”. Emerging priorities for the Ministry of Public Health and RTG, such as migrant health, would be then be considered as priorities and receive the recognition that is required, by focusing attention on the area and mobilizing the resources required to address it.

15. **The CCS Thailand 2012–2016 provides a sound strategic framework for collaboration with the RTG, is a good approach for the use of WHO resources, offers good value for money and is consistent with the core functions of the Organization.**

As a result of the CCS, the work of the WHO Country Office for Thailand was much more strategic and focused. The WHO Country Office should continue to support the priority programmes but should also ensure that adequate support and resources are allocated for the other programmes addressing major public health challenges, the normative work, and Thailand’s work beyond its borders.

The WHO Country Office should continue to have a mix of senior international staff and national professional officers, with the work of the office focusing on upstream work as much as possible, such as supporting policy development, facilitating high-level consultations, supporting relevant research and analysis, and developing policy briefs.
7 — Recommendations

1. **Internal reviews by priority programmes in 2013**

   In 2013, as part of the process for development of their plans for 2014 (and 2015), the partnership priority programmes should undergo an internal review process with the involvement of the partners, using their monitoring and evaluation frameworks if they are adequate. Attention should be paid to the adequacy of the strategic plan, in view of the experience and achievements to date, with the involvement of the Ministry of Public Health and WHO in the reviews. A set of minimum standards should be established for the review exercise, under the direction of the executive committee, so that programmes can improve their monitoring framework if it is not adequate. The strategic plan should be modified as necessary, with the agreement of partners; operational plans should prepared for 2014 (and 2015); and monitoring and evaluation frameworks should be thoroughly reviewed, so that they meet good quality standards and provide a basis for monitoring and evaluation. The Ministry of Public Health and WHO can provide support if required, but should, as a minimum, verify the frameworks. The findings of the *Mid-term review of the WHO Country Cooperation Strategy Thailand 2012–2016* can inform these exercises.

2. **Continuing evaluation important**

   Continuing evaluation of the priority programmes is important, in order to assess the value of these programmes and learn from their implementation. Best practices should be shared. The evaluations should occur yearly or two yearly, depending upon the partners’ requirements. If the internal reviews are of a good standard, then external reviews are not recommended. However, support may be required for the review or evaluation frameworks.

3. **The Ministry of Public Health should be more actively involved in priority programmes**

   There is much scope for the Ministry of Public Health to be more actively involved in the priority programmes, especially in ensuring that there are institutional linkages with the programmes. This will be of benefit to both the partnership priority programme and the Ministry of Public Health. The Ministry of Public Health can also play a more direct role by having a senior member of staff as the chairperson or co-chairperson. Departments
could also take on the role of lead agency where appropriate. If implemented, these actions would be expected to contribute to improved sustainability, a greater impact of the partnership programmes, and better contribution of the partnership programmes to national policy.

4. **Application of the priority programme approach**

In determining which health areas would be amenable to this approach, it is important that, once an area of public health importance has been selected as a possible candidate, an analysis is done to determine the gap that needs to be addressed, and whether there are any existing mechanisms or programmes that could be used to address this gap. If not, it should be determined whether the gap is likely to be amenable to this type of programme, where a primary aim is to achieve the collaboration of multiple and multisectoral partners working in the area. There is a need to be selective when this approach is used. The approach may be particularly useful in emerging issues, such as ageing, which is a relatively new health challenge, where there are no existing mechanisms to bring together a wide range of potential partners in the health sector and other sectors.

5. **The WHO Country Office for Thailand should take a flexible approach to the Country Cooperation Strategy**

The *WHO Country Cooperation Strategy Thailand 2012–2016* (1) is a reference document that has been very successful in providing the framework for WHO to have a much more strategic and focused approach to collaboration with the RTG. WHO should continue to be strategic in the collaboration with the RTG, utilizing the strengths of the Organization and providing high-quality technical cooperation. However, if new priorities emerge or there is a change in priorities, these should be accommodated in the CCS framework.
Acknowledgements

The review team wishes to acknowledge the generous cooperation and support that was received from the Ministry of Public Health, as well as officials and staff of all the other ministries, institutions and agencies that are involved in the programmes that were reviewed by the team. Particular thanks go to Dr Samlee Pliabanchang, the Regional Director, for his support and encouragement; and to Dr Yonas Tegegn, the WHO Representative for Thailand; Dr Monir Islam, Director Health System Development and Special Adviser to the Regional Director; and all the WHO staff from the Country Office for Thailand, who cooperated and provided support to the team.
References


2009

February: Advice and encouragement from both within the World Health Organization (WHO) and the Royal Thai Government (RTG) to move away from many small projects scattered thinly across many areas and innovate a more prioritized, consolidated way of working, given Thailand’s status as a middle-income country

2010

February: Discussion on the Country Cooperation Strategy (CCS) began with informal consultation with many stakeholders, including the Permanent Secretary of the Ministry of Public Health, and the Director of the Regional Office for South-East Asia

March: Concept paper drafted and endorsed by the Permanent Secretary of the Ministry of Public Health and the heads of the other government-funded public health agencies

High-level focal points in each agency established

April: Meeting among focal points to agree on criteria for prioritizing

Definition of five criteria used for prioritization areas agreed

May: Concept papers of potential priority areas drafted

June: Workshop involving deliberative process to rank priority areas (4+1)

Lead agencies identified for each area

July: Formulation of the five proposals

August: High-level meeting held to review and endorse priority areas and modalities of collaboration

September: Meeting of chief executive officers (CEOs), lead agencies and funding organizations

Governance and further implementation steps agreed
October–November: Plans submitted, peer reviewed and endorsed

22 October: Ministerial Order 1962/2553 establishing steering committees with membership and terms of reference

December: First meeting of steering committee and governance arrangements endorsed

2011

CCS approach trialled in selected programmes

December: Financial audits of lead agencies

2012

January: CCS commenced

May: Quality assurance review of the five priority programmes

June: Meeting of CEOs to discuss the RTG–WHO collaboration

2013

15 February: Ministerial Order 272/2556 appointment of executive committee on the RTG–WHO collaboration (for all collaboration between the RTG and WHO) replacing the steering committee of five priority programmes

March: First meeting of new executive committee of the RTG–WHO collaboration, endorsed the mid-term review and requested to expand to include communicable disease control and border and migrant health

June: Mid-term review of WHO CCS

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<th>Area of work</th>
<th>Name</th>
<th>Title and position</th>
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<td>Thailand–WHO Partnership Priority Programme on Disaster Preparedness and Response</td>
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<td></td>
<td>• Former National Programme Manager, trade-related capacity</td>
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<td>Area of work</td>
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| Thailand–WHO Partnership Priority    | Dr Gururaj Gopalakrishna      | • Professor and Head, Department of Epidemiology, WHO Collaborating Centre for Injury Prevention and Safety Promotion Centre for Public Health, India,  
• Former Public Health and Epidemiology Research and Advocacy for Injury Prevention and Care and Noncommunicable Disease Prevention and Control |
| Programme on Road Safety             |                               |                                                                                     |
| Communication Disease Control        | Dr Wiwat Rojanapithayakorn    | • Team leader, Joint United Nations Programme on HIV/AIDS, Asia Pacific Intercountry Team, Bangkok, Thailand,  
• Former WHO Representative, Mongolia,  
• HIV/AIDS team leader and senior adviser, WHO China |
| Programme                            |                               |                                                                                     |
| Border and Migrant Health Programme  | Ms Jacqueline Weekers         | • Senior Health Assessment Programme Coordinator, International Organization for Migration, Bangkok, Thailand,  
• Former senior public health officer, WHO, Geneva, Switzerland |
Mid-term review of the WHO Country Cooperation Strategy 2012-2016

Annex 3: Framework used for the review of the priority programmes

Five priority programmes

- Community health system
- Multisectorial networking for noncommunicable disease control
- Disaster preparedness and response
- International trade and health
- Road safety

Governance

Multisectoral coordination

Collaboration

Lead agency + Other partners

Executive committee

Steering subcommittee

Health sector Other sectors

Programme manager

Resources management

Human resources + Pooled funding

Planning

Implementation

Strategic operational plans

Activities → Outputs → Outcomes → Impact

Peer review process

Internal – Thai health
External – experts

Reporting and monitoring

Audits and controls

Annex 3: Framework used for the review of the priority programmes

Community health system

Multisectorial networking for noncommunicable disease control

Disaster preparedness and response

International trade and health

Road safety
Annex 4: List of persons interviewed

Interviewed by the Team leader – Dr Richard Nesbit

Dr Nima Asgari
Public Health Administrator, WHO Thailand

Dr Maureen Birmingham
WHO Representative to Mexico, former WHO Representative for Thailand

Dr Brent Burkholder
Team Leader, Communicable Disease and Border and Migrant Health Programme Coordinator, WHO Thailand

Dr Sopida Chavanichkul
Director, Bureau of International Health, Ministry of Public Health, Thailand

Dr Monir Islam
Director Health System Development and Regional Director’s Special Adviser, WHO Regional Office for South-East Asia

Dr Amphon Jindawatthana
Secretary-General, National Health Commission Office, Ministry of Public Health, Thailand

Dr Wilawan Juengprasert
Director-General, Department of Medical Services, Ministry of Public Health, Thailand

Ms Barbara Ortandini
Chief, Office of the United Nations Resident Coordinator, Thailand

Mr Angus Pringle
Global Service Centre, WHO former Administrative Officer, WHO Thailand

Dr Supakit Sirilak
Senior Adviser on Preventive Medicine, Health Technical Office, Ministry of Public Health, Thailand

Dr Porntep Siriwanarangsun
Director-General, Department of Disease Control, Ministry of Public Health, Thailand

Dr Viroj Tangcharoensathien
Senior Adviser, International Health Policy Programme, Ministry of Public Health, Thailand

Dr Yot Teerawattananon
Senior Researcher, Health Intervention and Technology Assessment Program, Ministry of Public Health, Thailand

Dr Chanvit Tharathep
Deputy Permanent Secretary, Ministry of Public Health, Thailand

Dr Suwit Wibulpolprasert
Senior Adviser in Disease Control, Office of Permanent Secretary Ministry of Public Health, Thailand
Thailand–WHO Partnership Priority Programme on Community Health System

Interviewed by Dr Supachai Kunaratnpruk

Dr Narongsakdi Aungkasuvapala  Thaipin Coordinator, member of the steering subcommittee, Ministry of Public Health, Thailand

Ms Orajit Bamrunsakulsawas  Community Health Service Development (CHSD) Focal Point, National Health Security Office, Thailand

Dr Pranom Cometieng  Public Health Supervisor, member of the steering subcommittee, Ministry of Public Health, Thailand

Ms Duangporn Hengboonyapan  CHSD Focal Point, Thailand Health Promotion Fund

Ms Suthathip Jantarak  CHSD Focal Point, Department of Health Service Support, MOPH, Thailand

Dr Pongpisut Jongudomsuk  Acting Director, Health System Research Institute (lead agency), Ministry of Public Health, Thailand

Ladda Damri Kamlert  Formerly CHSD Programme Officer, Health System Research Institute, Thailand

Dr Chai Kritayapichatkul  Former WHO member of the steering subcommittee

Ms Mathuraporn Parkprot  CHSD, Programme Manager Assistant, Office of Mahidol University, Thailand

Dr Somchai Peerapakorn  Former WHO member of the steering subcommittee and central management committee

Dr Nitas Raiyawa  Deputy Permanent Secretary, Ministry of Public Health (Supervising Primary Care Development), Thailand

Dr Suvaj Siasiriwattana  Inspection General, Ministry of Public Health, Thailand

Dr Supattrra Srivanichakorn  CHSD Programme Manager, Ex-Director Office of Community Based Health Care Research and Development, Mahidol University, Thailand

Dr Kanitsorn Sumriddetchkajorn  CHSD Programme Officer, Health System Research Institute, Thailand

Ms Tassanee Ya  CHSD Programme Manager Assistant, Office of Mahidol University, Thailand
Thailand–WHO Partnership Priority Programme for Multisectoral Networking for Noncommunicable Disease Control

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Thailand–WHO Partnership Priority Programme on Disaster Preparedness and Response

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Thailand–WHO Partnership Priority Programme on International Trade and Health

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Thailand–WHO Partnership Priority Programme on Road Safety

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Communicable Disease Control Programme

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Border and Migrant Health Programme

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Annex 5: Report for the review of the Thailand–WHO Partnership Priority Programme on Community Health System

Objectives and method of the Country Cooperation Strategy review

The review of the WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) had four objectives:

1. to review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
   - the leverage that the five CCS priority programmes have created for channelling other funds into the programme
   - the quality of the activities performed by the five priority programmes and value for money
   - the relevance and World Health Organization (WHO) support to communicable disease control (the unfinished agenda) and border and migrant health

2. to identify the lessons learnt from planning and implementation of the five priority programmes

3. to propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

4. to assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using semi-structured interviews. Summaries or recordings of the interviews were made; the programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

One limitation of the review was that most programmes had only commenced implementation in early 2012 and had not produced substantive outcomes or had an impact, since the strategic plan was for a 5-year period. If this was the case, the reviewer attempted to make an assessment of the potential outcomes and impact from the programme.
Background

Primary health care has been a core health policy in Thailand since 1978. The programme has shifted from a service-oriented approach to a development approach. Numerous community health development programmes have been launched by the Ministry of Public Health and other autonomous health agencies, particularly at the subdistrict level, which is the lowest administrative structure recognized by law.

Each agency has run a programme according to its own mission and course. The Ministry of Public Health has continuously developed village health volunteers along with the self-managed subdistrict programme. The National Health Security Office (NHSO) has supported establishment of the Community Health Fund. The Thai Health Promotion Foundation (ThaiHealth) has launched the Healthy Subdistrict programme nationwide. The National Health Commission Office (NHCO) has supported the Local Health Assembly, while the national Health Systems Research Institute (HSRI) is supporting community research, in addition to different Community Health Service Development (CHSD) programmes financed by WHO in each biennium.

Therefore, under the CCS, the Community Health Service Development Programme, or CHSDP, has been developed to integrate all health development programmes created by these agencies, to be more responsive to the local needs, have less redundancy and be better value for money. Lessons learnt from the programme are expected to be used in the future, to foster policy for Thailand and each agency.

Programme description

The partners and objectives

The Ministry of Public Health, NHSO, ThaiHealth, NHCO, HSRI and WHO/Thailand agreed to fund and jointly run this programme. These health agencies have assigned HSRI to coordinate the plan and operate as lead agency. The objectives of the programme are to:

- promote collaboration of all community health development programmes run by health agency partners in subdistricts, to create a model subdistrict health development system
- encourage establishment of a local community information system that is specific to each community
- enhance the efficiency of local community organizations (primary care unit, local administration and civil community) in performing new roles
- develop a framework of key health partners, in a drive to create a community health development system.
The strategies

Strategies to meet the objectives are listed next.

**Strategy 1:** Development of prototypes area  
**Goal:** Target area has strong development network, responds effectively to local problems and becomes the learning site for other areas

**Strategy 2:** Research to generate knowledge  
**Goal:** Knowledge and practice experience of the community is adopted as a best practice model and forms the basis for policy formulation at the national and organizational level

**Strategy 3:** Policy development  
**Goal:** Development of a community health development policy that meets specific community needs

**Strategy 4:** Social movement and expanding network  
**Goal:** Public support of the community health development programme and nationwide coverage of the community health development system network

**Target areas:**

1. Start with 80 model subdistricts
2. Expand to 2000 subdistricts in 2013
3. Cover 4000 subdistricts by the end of the programme in 2015

**Programme funding**

The health agency partners have pledged to contribute funds for the implementation of the programme (exclusive of funds for their own operational plans) as follows:

- HSRI – 1.5 million baht (approx. US$ 46 000)
- Ministry of Public Health – 3 million baht (approx. US$ 92 000)
- NHCO – 1.5 million baht
- NHSO – 45 million baht (approx. US$ 1.4 million)
- ThaiHealth – 30 million baht (approx. US$ 920 000)
- WHO – 7.77 million baht (approx. US$ 237 000)
- Total – 88.77 million baht (approx. US$ 2.7 million).
Programme management

HSRI was the agency that first proposed the CHSDP to the CCS priority-setting forum. As the organization has recognized expertise in grant management, as well as neutrality (no existing CHSD programme implemented in the community), it was assigned by the partners to be the lead agency of the programme.

HSRI entered into a contract with the Office of Community Based Health Care Research and Development, affiliated with Mahidol University, to be the programme manager.

CHSD programme manager structure

Context

The community health system programme area was unanimously ranked top among the five priority CCS programmes, by all parties concerned, reflecting the programme’s importance to the development of national health. According to the decentralization law, the subdistrict local administration authority elected by the people has the responsibility to provide basic health services, including primary care, to meet the needs of local people. The management of local health centres, currently under the Ministry of Public Health, would be gradually transferred to the responsibility of the subdistrict authorities, according to the readiness of individual localities. It is also required by law that at least 25% of the national budget is given to the local administration authorities to discharge their duties.
Results/findings

The plan and planning process

By the assignment from related partners, HSRI developed the strategic plan, with extensive consultations with these partners. After that, the strategic plan was reviewed by external experts assigned by WHO, endorsed by related agencies and finally approved by the steering committee.

All parties conducted the planning process prudently. However, some interviewees mentioned that the planning process was pushed by the steering committee to finish quickly, and the programme and budgeting approval processes required by the related agency were not fully completed. Therefore, in the implementation phase, there were some reservations from concerned partners.

As a whole, the strategic plan was relevant and appropriate. The aim was to solve the important problems of current community health system development. However, this review found that the large number of subdistricts included in the target of the programme, namely 2000 subdistricts in the first phase and 4000 subdistricts at the end of the 5-year programme, caused confusion and misunderstanding among related parties as to whether the objective of the programme was to develop a model subdistrict, with lessons learnt, and to develop policy advocacy, or to implement another community health development programme nationwide.

Progress

From the beginning, the steering subcommittee and lead agency recognized the necessity to integrate all the parties’ experiences into the programme and to strengthen their collaboration; therefore, key CHSD programme operators from all agencies were brought together to form “the central management team”, to oversee the detailed operation plan and supervise programme management. This team has met monthly. Despite this initiative, the mid-term progress of the programme is still delayed, for the reasons detailed next.

Lack of an agreed prototype

None of 80 areas selected since the beginning of the programme, to be developed as a model subdistrict, have been approved by the stakeholder partners to be the prototype area with the lessons learnt synthesized to advocate national or organizational policies. However, there was recently an attempt to intensively study six subdistricts to use as a prototype; this needs to be followed up.

As a parallel move, attempts have been made to expand the number of subdistricts to be developed to meet the set target, without waiting for a clear prototype. The programme has funded subdistricts to develop human resources in health and manage
knowledge in their localities. Some partner agencies questioned the value for money of this approach, since indicators for outcome were not available. However, even though the programme managers have tried very hard, the number of subdistricts covered at the time of this review was only 232, which is quite a long way from the set target of 2000 subdistricts.

**Conducting research to generate knowledge**

Since the first year of the programme, two research projects under this programme have been completed:

- “Community Health System Research”, which analysed the critical success factors for implementing the community health programme in subdistricts before entering into this CHSD programme
- “Assessment of tools and approaches for community assessment”.

Apart from these two research projects, there was no clear result from any other research undertaken, which might be a result of the delay in developing a prototype area. However, as a result, research topics could not be formed to conclude the lessons learnt and foster policy in the community health system.

**Policy development**

There were 10 seminars on various topics related to experiences and best practices in community health system management, led by Dr Prawase Wasi and held in Mahidol University. The seminars were temporarily withheld for review, as the majority of the audience were scholars in the university. The communities had less active engagement in the seminars. The reports and recommendations from these seminars were being prepared for wider access. It will be interesting to follow their impact on national health policy on community development, after their publication.

**Social movement, communication, advocacy and networking**

Public media materials have been developed. There was an interactive website that presented the database of CHSD area mapping. However, this activity was not promoted as there was, as yet, no clear prototype area.

**Governance, collaboration and financing the programme:**

This CHSD programme was regarded as a good governance programme. The structure of the programme was outlined clearly. There were clear responsible parties and terms of reference, ranging from the steering committee, the steering subcommittee, the lead agency, the central management team and the programme manager. The criteria for using funds were also set. Staff who were responsible for finance had been assigned and a good system was in place.
In the aspect of fund leverage, this programme was very successful. Up until this mid-term review, out of the pledged financial contribution of 88.77 million baht, the partner agencies have pooled funds to the programme for a total of 26.995 million baht, ThaiHealth contributed 11.226 million baht, NHSO 11.149 million baht, NHCO 1.42 million baht, HSRI 0.5 million baht and WHO 2.7 million baht (see Figure 1).

The subcommittee has shown strong leadership. It gave direction for the operations, advised and monitored the progress closely. However, the subcommittee has sometimes given directions that were different from those of the steering committee. The subcommittee pressed to expand the target area, while the steering committee wanted to limit the area to see the result first.

The most important factor to success of this programme was collaboration of its partner agencies. The programme has made an attempt to promote collaboration at all levels, ranging from chief executive officer of the responsible agencies to operators. The central management team was created to respond to this attempt. However, this programme experienced ongoing collaborative problems, as each agency had its own objective, methodology and organizational culture. They all wanted to ensure their own success and the programme manager could not build up the level of trust required to get their full support.

**Programme management, including reporting and monitoring**

This programme has assigned HSRI to be the lead agency. Despite their long-term experience and expertise on research management, HSRI was not a core agency in developing the community health system and had no personnel in this field. Therefore, from the beginning, management was the biggest problem of this programme. Initially, HSRI hired a full-time programme manager but she did not pass the probation period.
The agency then outsourced and contracted a programme manager from the Office of Community Based Health Care Research and Development affiliated with Mahidol University. However, the collaboration could not be retrieved and target dates were not achieved. Some partner agencies reasoned that the programme manager may not have had enough time for the programme and the staff did not have the required knowledge and skills.

**Significant changes impacting the programme**

- The Ministry of Public Health issued the Ministerial order 272/2526, dated 10 February 2013, which effectively cancelled the steering committee of the Royal Thai Government (RTG)–WHO CCS, and established the new executive committee to oversee the CCS. HSRI was not included in this committee.

- The Office of Community Based Health Care Research and Development was being transformed to a new status, no longer affiliated with Mahidol University. Therefore, the contract to be the programme manager of the CHSD programme with HSRI was rendered invalid.

- HSRI has notified WHO that it would like to terminate the contract signed with WHO, effective as of 1 July 2013.

- Under these developments, ThaiHealth considered that their commitments to the CHSD programmes were void.

**WHO contribution**

WHO’s convening power helped to integrate the visions and strategies of existing autonomous health agencies and build up a partnership. WHO also provided technical contribution, through the extensive international peer review process, for the CHSDP strategy plan, and through the WHO participation in the steering committee meetings and other related meetings from time to time. During the first several months of the CHSDP, the WHO Country Office for Thailand assigned a national professional officer to regularly participate in the monthly meetings of the central management team. However, owing to subsequent changes in the human resources of the WHO Country Office for Thailand, the focus of WHO participation with the programme was seemingly changed towards more financial accountability and fund management, while technical advice was diminished. To ensure that the WHO technical contribution is provided in a timely fashion and at a proper level, WHO may need reconsider and see whether increasing the technical contribution to the CHSDP, through increasing the time available from individual technical staff and quality interaction with Thailand’s lead agency team, would be feasible.
Lessons learnt

- Strong leadership is crucial for getting different stakeholders with diverse mission, organization cultures and legal obligations to come together. However, extensive consultation to reach a common understanding of the nature of the programme and the expectations and limitations of different stakeholders is important for long-lasting cooperation and needs to be given plenty of time. The plan developed should be agreed by all partners, setting a clear direction with indicators to monitor progress.

- Proper programme management is the most important factor for success. The lead agency and programme manager should be identified based upon the organization mission, technical and managerial skills, and full-time commitment.

- Fostering collaboration by bringing key CHSD stakeholding partners to form the central management team, though helpful, is not enough. Confidence and trust should be built through joint efforts in the deliberate development of a few prototypes of model subdistricts, before expanding to other areas.

- Adequate attention should be paid to the existing and functioning primary health-care infrastructures in the community, e.g. a provincial health office, district and subdistrict health office, regional primary health-care training centres and village health volunteers, which have all been set up for a long time in this country.

Conclusions

High priority of the community health system programme area

The community health system programme area was top-ranked among the five common-priority CCS programmes, by the forum setting the priority areas, reflecting its high priority for the development of national health. The undertaking of this programme has been unprecedented in terms of its visionary integrative approach, and inclusion of, and ownership by, all independent national public health agencies in Thailand and by WHO.

Implementation challenges

The huge challenges in pooling funds and integrating efforts from all parties to implement the CHSDP were identified from the start of the programme. These challenges arose from the differences of legal and administrative requirements, technical approaches, expertise and available human resources of each party. However, despite the fact that all parties concerned pledged to solve the challenges mutually and cooperatively, when required, and that the central management team, comprising key operation staff from every agency partner, was created to foster strong and closer collaboration, the challenges remained unresolved. Hence, the programme deliverables were delayed compared to the aims of the plan.
Factors impacting implementation

The major factors impacting on implementation were: the recent change initiated by the Thai Ministry of Public Health on the composition of the executive committee for the Thailand–WHO collaborative programmes based upon the CCS for 2012–2016 (thus, among others, removing the membership of HSRI); the subsequent withdrawal of HSRI from being the assigned lead agency for the Partnership Priority Programme on Community Health System; and termination of its contract with the programme manager.

Potential contribution to policy development

Taking into account the lack of agreement on the approach to develop the prototype model subdistrict, the lack of active engagement by policy-makers of the stakeholder partners in the development process in the field, and the technical seminars (as mentioned in “Policy development”), which were implemented by the CHSDP as part of its contribution for policy development, the programme was not powerful enough to draw attention and commitment from the policy-makers of relevant national programmes. The CHSDP hence has made little contribution, if any, to the national policy development regarding community health systems. There is an urgent need to redesign a better mechanism and process to ensure that deliverables from the CHSDP will contribute to national policy development.

The role of WHO

The role of WHO was substantially reduced following change in staffing but there is scope for a greater technical input into the programme by WHO, for example facilitating policy dialogues or policy briefs, and organizing consultation meetings.

A way forward

On the occasion of the mid-term review of the WHO Country Cooperation Strategy Thailand 2012–2016, and after taking into account the history of development, current situation and context of the programme implementation as discussed above, it is recommended that a serious and timely effort should be made to improve the implementation of the Partnership Priority Programme on Community Health System by all stakeholders.

Recommendations

A set of specific actions as listed below for the Partnership Priority Programme on Community Health System is suggested, with the aim to nurture the unprecedented visionary integrated approach for all national public health agencies and WHO to work together on the five priority programme areas as identified under the CCS exercise:

1. WHO should facilitate the organization of meeting(s) or informal consultation(s) among all parties concerned in the Partnership Priority Programme on
Community Health System, including HSRI, to explore whether working together on this priority area is still feasible and, if so, how to proceed.

(2) All involved national public health agencies need to contribute by suggesting actionable and agreed ways to implement this programme further, especially in relation to identification of a new lead agency, a revised proposal with a list of realistic programme deliverables and budget (for instance, only synthesis of the desirable community health system model with no scale-up part for the remaining time frame, etc.), and an improved business model for pooling of funds and expertise among the parties concerned.

(3) Meanwhile, existing deliverables (such as technical reports and notes, etc.) from the Partnership Priority Programme on Community Health System should continue to be documented and made available to all parties concerned, for their further consideration and necessary action within their mandate and mission.

(4) The recent failure of the Partnership Priority Programme on Community Health System to thrive deserves a more detailed analysis of the lessons learnt in comparison to the success and/or failure of the other four CCS programmes. Insights from a careful study should contribute to the next CCS development of the preferred approach for WHO to work in and with Thailand, a middle-income country with diverse independent public health agencies in its national health system.

**List of steering subcommittee for the CHSD programme**

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Mr Vichai Aswapak  
Mr Somporn Chaibangyang  
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Mr Chatchai Luengsaroen  
Ms Kanitta Nanthabutr  
Mr Kittisakdi Sindhuvanich  
Mr Leuchai Sringernyueng  
Dr Narongsakdi Ungkasuwapala  
Dr Suwit Wibulpholprasert

Adviser  
Chairman  
Member  
Member  
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<td>Permanent Secretary, MOPH or Representative</td>
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<tr>
<td>Chief Executive Officer (CEO), Thailand Health Promotion Fund or Representative</td>
<td>Member</td>
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<td>Secretary General, National Health Security Office or Representative</td>
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<td>CEO, Health System Research Institute or Representative</td>
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<td>WHO Office for Thailand Representative</td>
<td>Member</td>
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<td>CHSD/HSRI Programme Officer</td>
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Objectives and method of the Country Cooperation Strategy review

The review of the WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) had four objectives:

1. To review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
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2. To identify the lessons learnt from planning and implementation of the five priority programmes

3. To propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

4. To assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using semi-structured interviews. Summaries or recordings of the interviews were made; the programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

One limitation of the review was that most programmes had only commenced implementation in early 2012 and had not produced substantive outcomes or had an impact, since the strategic plan was for a 5-year period. If this was the case, the
reviewer attempted to make an assessment of the potential outcomes and impact from the programme.

**Background**

Overwhelming evidence suggests that noncommunicable disease (NCD) remains the priority problem in Thailand. The Royal Thai Government (RTG) recognizes the importance of involvement of both health and non-health sectors to meet the challenges of NCD prevention and control. Correspondingly, the Ministry of Public Health, under the leadership of the Bureau of Policy and Planning, with close collaboration with the National Economic and Social Development Board (NESDB), successfully placed the Thailand Healthy Lifestyle (THL) strategic plan 2011–2020 (1) on the national agenda, with approval from the Thai Parliament. The main aim of THL was to synergize the various organizations that have been involved in the NCD prevention and control effort, as well as to galvanize collaboration from non-health sectors. Therefore, this foundation conceptually paves the way for the Thailand–WHO Partnership Priority Programme on Multisectoral Networking for Noncommunicable Disease Control.

**Programme description**

The strategic agenda prescribed by the WHO CCS focuses on building up networks for implementing integrated NCD control, and leads to development of the RTG–WHO NCD, emphasizing collaboration and partnership among health and non-health sectors. It addresses control of five main NCDs and four risk factors. Based on this framework, the RTG–WHO NCD network proposes the objectives and goals listed next.

**Main objectives:**

- to promote collaboration, partnership and integration among various sectors, to attack the problems of NCD, including both health-related and non-health-related sectors in Thailand;
- to strengthen national policies, plans and interventions for prevention and control of five main NCDs, including cardiovascular diseases, hypertension, diabetes, cancers and chronic respiratory diseases;
- to strengthen monitoring and evaluation for the policies and programmes for prevention and control of NCDs, e.g. establishing an information system related to NCD, and access to essential care and quality of treatments.

**Sub-objectives:**

- to promote healthy lifestyles and cost-effective interventions to reduce the main risk factors for NCDs, including tobacco use, unhealthy diets, physical inactivity, obesity and harmful use of alcohol;
- to promote research related to NCD control and reduction of risk factors.
Goals:

- to support movements to raise awareness of the problems of NCDs, as a priority of the national agenda on social and human development;
- to control five main NCDs, including cardiovascular diseases, hypertension, diabetes, cancers and chronic respiratory diseases;
- To control unhealthy lifestyles, including tobacco use, unhealthy diets, physical inactivity, obesity, and harmful use of alcohol, focusing on primary and secondary prevention.

Context

The context in which the RTG–WHO NCD network has been implemented may be considered as both a threat and an opportunity. The changes in high-level management in the Ministry of Public Health pose uncertainty about the governance process for the RTG–WHO NCD network, since the subcommittee as a functioning unit is officially suspended but with minimal effects on the implementation of this programme, at least at present. Moreover, the continued operation of THL remains uncertain and its position at the Ministry of Public Health may change, which will affect the RTG–WHO NCD, since its main strategy involves aligning with THL.

However, opportunities exist that may pave the road for the RTG–WHO NCD network to implement its programmes effectively. The recent resolutions at the 2012 United Nation General Assembly and the 2013 World Health Assembly highlight the importance of Member States putting this issue forward on their national agenda. The Prime Minister of Thailand endorsed these resolutions, which may lead to political commitment. Moreover, there exists substantial social capital, as well as systems and structures in NCD prevention and control; therefore, the RTG–WHO NCD disease network already has a solid foundation and resources to capitalize.

Results/findings

General findings

The results of this mid-term review were based on information obtained through examining available documents in both English and Thai, provided by staff of the WHO Country Office for Thailand and the secretariat of the RTG–WHO NCD network, as well as in-depth interviews with key informants, such as various subcommittee members, core team members, the RTG–WHO NCD network secretariat team, and others who have been involved in a specific capacity.

The plan and planning process

To achieve the goals and objectives of the RTG–WHO NCD network, and through a series of brainstorming meetings among various partners, the first strategic plan was
developed in early 2011 by the RTG–WHO NCD network secretariat team, composed of the head of the secretariat and a small number of 5–7 staff. Adhering to the modalities of implementation proposed by the WHO CCS, the subcommittee for this priority programme reviewed and provided guidance in shaping up the strategic plan, which has continued to evolve after almost 2 years in operation. Although the four main strategies outlined in the strategic plan reflected the mandates of the RTG–WHO NCD network, the challenges lay in development of these strategies into detailed action plans and their implementation.

Those interviewed formed similar views that the strategic plans were well formulated; however, the action plans did not align with the goals and objectives of the RTG–WHO NCD network. The main mandate of the network in supporting and strengthening the collaboration among various health and non-health partners and stakeholders was circumvented, with activities being more focused on implementing individual intervention programmes. Consequently, most of the respondents concluded that the detailed action plan lacked coherent direction and the RTG–WHO NCD network became an implementer of programmes rather than a catalyst in connecting networks and stakeholders working in the area of NCD prevention and control. This may have been due, in part, to the limitations in capacity of the RTG–WHO NCD network head secretariat and his team, who recognized their limitations in managerial skills and ability to network, both within Ministry of Public Health and in other non-health sectors.

Activities

Although it did not meet the expectations of most respondents, the accomplishments of the RTG–WHO NCD network may be highlighted in a few areas, namely in strengthening the NCD network and collaboration, and supporting research and knowledge management for NCD control; and evaluation and reduction of risk factors in health – two of the four strategies in the CCS strategic plan. However, these strategies may have been achieved at a level below the expectations of most respondents, and challenges remained, as indicated by most respondents.

Training for policy advocacy

In responding to strengthening the NCD network and collaboration, a NCD policy advocacy training programme became an important effort, which aimed to create a critical mass of policy advocates who work at various organizations, with the expectation that they will drive the policy movement in NCD prevention and control at their workplace. Since its inception, three groups of participants, mostly from the health sector, have enrolled in the training programme. The subcommittee agreed on the value of this mechanism as a strategy to strengthen the NCD network and collaboration. In fact, this effort attracted the US Centers for Disease Control and Prevention (US CDC) in co-funding the first training session, with collaboration from the International Union for Health Promotion and Education (IUHPE).
The curriculum of the NCD policy advocacy training programme has been evolving with each group of participants, which strengthened the relevance and quality of the programme, especially in emphasizing the integration of risk factors for NCD, through cross-cutting issues. The main challenges in this effort, as expressed by most respondents, lay in the selection of the trainees; monitoring and evaluating the expected outcomes, so that the participants function as advocates for NCD policy and form networks of policy advocates in their communities; and, equally importantly, expanding to include the non-health sector.

**Risk factors for noncommunicable disease**

Strengthening the NCD network by involving collaboration among stakeholders around an issue in risk factors for NCD, the secretariat of the RTG–WHO NCD network formed a partnership with the Royal College of Physicians of Thailand to develop a network of stakeholders, named Salt Net, to work on reducing consumption of salt, through various activities. Salt Net employed various mechanisms to achieve its objectives, from developing campaigns, media and communications, to supporting research to produce evidenced-based strategies. Review of the progress reports indicates that the secretariat of the RTG–WHO NCD network allocated considerable time and resources to this effort, which was supported by most respondents. Evaluation of the outcomes and impact of this effort requires time, and since the programme only commenced in 2012, the subcommittee agreed on its continuation, and it has been included in the 2012–2013 strategic plan.

**Organization of the forum and meetings**

One main outcome of the RTG–WHO NCD network that derived from reviewing the various progress reports was organization of forums and meetings with various networks and key stakeholders, which has constituted the majority of the activities in the past 2 years. While many respondents viewed this effort as output with minimal achievements toward the mandate of the RTG–WHO NCD network, these meetings brought some key players and networks to the same table, which may serve as building blocks in establishing a working relationship between the RTG–WHO NCD network and other networks and stakeholders, and form a bridge for future collaboration. This may eventually lead to the RTG–WHO NCD network becoming the critical driver of connecting partners and policy movement in NCD prevention and control.

**Research and knowledge management**

In terms of the RTG–WHO NCD network’s strategy of supporting research and knowledge management for NCD control, evaluation and reduction of risk factors in health, the highlight of this effort lay in the proactive response of the secretariat of the RTG–WHO NCD network to the 2013 World Health Assembly resolution of setting out a comprehensive global monitoring framework for NCDs, including a set of indicators and targets, which country members were urged to adopt as their own
national framework. The secretariat of the RTG–WHO NCD network mobilized relevant key stakeholders to instigate Thailand meeting its obligations. As a result of this effort, this working group headed by the secretariat of the RTG–WHO NCD network was composed of key persons within the Ministry of Public Health and others who may have the technical expertise and relevant responsibilities, such as managing national databases. This group identified the national targets and indicators for NCD control, as well as developing mechanisms to integrate data from various sources of information. At present, this initiative has focused on aligning the global health indicators with Ministry of Public Health national health indicators, which may not support the global framework in its entirety; however, the potential for achieving the comprehensive global framework may be realized in the coming years.

**WHO contribution**

One particular member of WHO staff made significant contributions to the implementation of the RTG–WHO NCD network, by active involvement in drafting the strategic plan and providing guidance and technical input to the secretariat team, until he left the Organization. He served as a key stimulator during the implementation process. As a Thai national with extensive experience and networks within the Ministry of Public Health, he was a great asset to this programme. Most respondents endorsed and saw the value of WHO involvement in the RTG–WHO NCD network. The respondents expressed that WHO’s presence and visibility highlighted to the stakeholders, including high-level management, the importance of this programme at the global arena.

**Major challenges for the programme**

Most respondents recognized that the RTG–WHO NCD network faced many challenges, owing to the complexity of NCDs and the numerous players in their prevention and control, as well as the uncharted road for the RTG–WHO NCD network, since this new strategy of the WHO CCS has not been implemented elsewhere and it was a new transformative direction in Thailand. The results of the interviews with key informants pointed toward the major challenges presented next, which may also constitute lessons learnt from the past few years of programme implementation.

*Continual alignment of the main strategy of the RTG–WHO noncommunicable disease network with the Ministry of Public Health Thailand Healthy Lifestyle strategic plan 2011–2020*

Although the THL strategic plan was established under a favourable political environment within high-level management of the Ministry of Public Health, resulting in successful leverage in drawing in non-health sectors and a large amount of budget (100 million baht), the changes to the high-level management in the Ministry of Public Health, with different priorities, profoundly affected the advancement of THL. Subsequently, this lack of continued commitment from high-level management in the Ministry of Public Health, which was reflected in the limited investment of resources and involvement within Ministry of Public Health key organizations, resulted in stagnation, which
impeded the achievement of the Royal Thai Government–WHO NCD network’s goals and objectives. Moreover, the broadness and complexity of the THL strategic plan, of which the RTG–WHO NCD network’s mandate is only a small part, requires strategic alignment and collaboration with the THL secretariat. Most key informants have expressed the opinion that failure of the network to do so will mean the efforts of the secretariat of the RTG–WHO NCD network may be circling without direction.

The governance process and structure of the RTG–WHO noncommunicable disease network, including the capacity of the secretariat team

The challenges lay not in the governance process and structure but rather in establishing a common understanding of the key roles and expected time commitment of the subcommittee and lead agency; the qualifications and capacity of staff of the secretariat of the RTG–WHO NCD network; and periodic contradictory advice between the subcommittee and core group, which was established to assist the secretariat of the RTG–WHO NCD network on specific matters.

Role of the secretariat

All respondents considered the secretariat of the RTG–WHO NCD network to be the critical actor in the success of the network. In order to achieve the mandate, specific qualifications and capacity may be required, especially for the head secretariat, such as skills in management, lobbying, negotiation, networking and conceptualization, as well as extensive experience and knowledge in NCD prevention and control, and staff who are senior enough to connect with high-level management at the various partner organizations. In addition, the staff of the RTG–WHO NCD network secretariat should have technical skills and knowledge in NCD, to assist the head secretariat.

All respondents recognized that it may be a challenge to recruit candidates who possess the required qualifications and skills and can offer a full-time commitment. Acknowledging the difficulties of the responsibilities expected of the secretariat, one key member of the subcommittee suggested that, in addition to the prescribed role of the subcommittee, coaching may be added as a critical role that the subcommittee must play, as well as allocating adequate time commitment, in order to move the RTG–WHO NCD network forward.

The core group

On the advice of the subcommittee, the secretariat of the RTG–WHO NCD network established a core group composed of experts in various areas of NCD prevention and control, to advise and provide direction in implementing the action plan. The head secretariat of the RTG–WHO NCD network considered this mechanism to be beneficial in expediting the work of the action plan, without channelling through the approval process of the subcommittee, as well as for receiving the necessary technical inputs. However, on several occasions, views differed between the subcommittee and core group on the value of activities implemented by the secretariat team of the RTG–WHO
Involvement with the Ministry of Public Health, particularly high management level and other non-health sectors, as well as integration of work between the RTG–WHO noncommunicable disease network and relevant organization

Although the RTG–WHO NCD network should involve active collaboration and participation from various organizations within the Ministry of Public Health, the involvement has been limited to mid-level management and individual collaboration, rather than institutional linkages. The most relevant organization within the Ministry of Public Health that shared a similar mandate to that of the RTG–WHO NCD network developed their organization plan in isolation, with little collaboration with the network. This may be attributed to the limited involvement from the higher-level management of the Ministry of Public Health; without their tangible commitment, it remains a challenge to establish a sustainable collaboration.

The challenge of involving stakeholders within the health sector alone posed difficulties for the RTG–WHO NCD network to achieve its mandate. With the time constraint of less than 2 years, expansion to include the involvement of the non-health sector appeared a formidable challenge. However, the secretariat of the RTG–WHO NCD network recognized this shortfall and has highlighted this effort in next year’s strategic plan.

Monitoring and evaluation

Most respondents formed similar views that realizing the outcomes and impact within the short time period presented challenges for the RTG–WHO NCD network. This may be attributed to the work of the RTG–WHO NCD network being more output oriented during the past years. However, there are opportunities to measure the outcomes and impact through systematic monitoring and evaluation based on the activities that have been carried out during recent years. For example, determining the outcomes and impact of NCD policy advocacy training programmes may be instituted through a systematic follow-up of the trainees and evaluation of their involvement in the policy advocacy.

Conclusions

The challenge of implementing the RTG–WHO noncommunicable disease network

All respondents concurred that the concept of the RTG–WHO NCD network was well conceived but implementing it effectively, since its inception, continued to be a challenge. The main obstacle was the effort of the network to align its work with that of the THL strategic plan. The initial supportive environment and political commitment
for this strategic plan warranted such an approach for the RTG–WHO NCD network. However, the change of high-level management in the Ministry of Public Health led to a decline in the commitment, which resulted in a shift in the Ministry’s priority for the THL strategic plan. This impeded the advancement the RTG–WHO NCD network mandate, once the resources and activities of the THL strategic plan waned over time.

The role of the RTG–WHO noncommunicable disease network

Most respondents recognized the complexity of NCD and the intricacy of interrelationships between risk factors and diseases, as well as the need to involve both health and non-health sectors in NCD prevention and control. All respondents agreed that the RTG–WHO NCD network can, conceptually, potentially become an effective instrument in responding to the complexity of NCD prevention and control. Representatives of the lead agency for this WHO CCS priority programme, the Thai Health Promotion Foundation (ThaiHealth), welcomed the initiative of integrating risk factors with diseases; this is a new direction for ThaiHealth and may be introduced into their work. However, most respondents concluded that the RTG–WHO NCD network has not reached their expectations for achievement of its goals and objectives. They envisioned that the RTG–WHO NCD network was well placed to support and synergize the existing NCD networks, to collaborate and partner in a more comprehensive and cohesive manner; however, the accomplishments of the RTG–WHO NCD network have been dominated by implementation of specific intervention programmes. Most respondents expressed that the RTG–WHO NCD network became an implementer of programmes rather than a catalyst in connecting networks and stakeholders working in NCD prevention and control.

The importance of the subcommittee and secretariat

The drivers of the RTG–WHO NCD network must have the knowledge and capacity necessary to continue its implementation. The subcommittee members consisted of key individuals who have extensive knowledge and experience, as well as respect in the community of NCD prevention and control. These qualifications extended to the secretariat team of the RTG–WHO NCD network, and the head secretariat should be skilful in management, lobbying, networking, and conceptualizing, as well as being of a senior rank, in order to connect with high-level management in the health and non-health sectors. The challenge lay in recruiting persons with these qualifications who were able to serve full-time in this position.

The achievements

Most respondents acknowledged that some accomplishments have been made that align with the mandate of the RTG–WHO NCD network, such as the successful collaborative effort with various key networks and stakeholders in forming Salt Net, which aimed to reduce salt consumption among Thailand’s population. However, the majority of work by the RTG–WHO NCD network has been concentrated on organizing meetings and forums; while these may not be specific outputs, they have merits in building
a working relationship between the RTG–WHO NCD network and other networks and stakeholders. This may serve as a foundation for continued effort in promoting collaboration and partnership, and eventually lead to the RTG–WHO NCD network becoming the critical driver of strengthening national policies, plans and interventions in NCD prevention and control.

**The future**

All respondents, including the lead agency, acknowledged the potential contribution of the RTG–WHO NCD network in NCD prevention and control, and endorsed the continuation of this programme. They expressed their commitment and anticipated re-examination of the strategic plan and direction of the RTG–WHO NCD network, upon reviewing this mid-term assessment report.

**Recommendations**

(1) In lieu of the diminishing interests and commitment of high-level management of the Ministry of Public Health to support THL, re-evaluation of the value of aligning the RTG–WHO NCD network strategic plan with THL, as well as the entire strategic plan, may be warranted. The original strategic plan may be well formulated, but perhaps too broad and ambitious to fully achieve the mandate of the RTG–WHO NCD network within the limitations posed by the constraints of time and capacity of the network secretariat team. The new direction of the strategic plan should be based partly on the evidence that has been gathered by the secretariat team of the RTG–WHO NCD network during the past few years, namely mapping of networks and stakeholders and gap analysis. Moreover, since NCD is complex, with intricate interrelationships between risk factors and diseases, in addition to the need to involve both health and non-health sectors in NCD prevention and control, the strategic plan may be developed in stages where the scope of the initial stage is more limited and tactical, in order to slowly build sustainable collaboration with strategic partners and stakeholders.

This may be achieved through first linking with an entity that has similar functions and plans, such as the Bureau of Noncommunicable Disease, in the Ministry of Public Health, which plans to develop a coordinating centre in NCD, chaired by the Director of Department. The roles of this coordinating centre fall in line with the work of the RTG–WHO NCD network, with the strategy of capitalizing on the existing systems and mechanisms within the Ministry of Public Health, at both the central and provincial levels. The chairing of this coordinating centre by the Director of the Disease Control Department signifies a potentially strong political commitment, which is a critical factor for its success and sustainability. Moreover, the Department of Health and other organizations within the Ministry of Public Health may make similar efforts.
(2) Re-identify the roles of the five lead agencies to function beyond granting funds to support the five priority programmes: the RTG–WHO NCD network may explore utilization of the strength of each partner, its social capital, and its capacity to drive the mandate. For example, NHCO’s strength lies in driving the community participation process and it has an extensive network with local stakeholders in health and non-health sectors. In addition, NHSO has funding sources that are in line with the work on NCD, through community funds.

(3) Capitalize on existing networks and structure in a cross-cutting collaboration: there exists substantial social capital, as well as systems and structures in NCD prevention and control; therefore, the RTG–WHO NCD network already has a solid foundation and resources on which to capitalize. For example, the Tobacco Research and Knowledge Management Center, and the Center of Alcohol Policy Research have extensive networks with various sectors throughout Thailand, in which the RTG–WHO NCD network could not only use their connectivity but synergize the integration of their work in a cross-cutting collaboration.

(4) Capture an ongoing, or initiation of a, national movement with strong political interests: for example, the RTG–WHO NCD network may explore integration of NCD prevention and control with the national interest in ageing, which has gained momentum in policy movement and support. Many sectors place importance on ageing at the policy level, which may serve as a mechanism to collaborate with non-health sectors.

(5) Position the RTG–WHO NCD network to be a state policy with sustainable political commitment, instead of a special interest group movement: past experiences suggest that individually derived policy may evolve into state policy; a notable example is the universal-coverage health insurance scheme. Another health-related example is tobacco control. Thailand’s achievements in tobacco control exceed those of many countries globally, partly due to its position as a state policy sustained through the changing political climate over the years. This accomplishment is attributed to Thailand’s obligations under the WHO Framework Convention on Tobacco Control (2).

(6) Although no such treaty exists for NCD prevention and control, the recent United Nations Assembly, as well as the World Health Assembly, highlighted and raised the importance of NCD globally. WHO may consider taking on a proactive role in bridging high-level policy-makers in the Ministry of Public Health with Thailand’s commitment as a Member State to the United Nations and WHO. In addition to providing technical expertise and functioning as a convener and supporter, WHO, through various platforms, may create mechanisms and visibility to maintain commitment among high-level policymakers. Having had a presence in Thailand for numerous years, WHO has the ability to navigate through various channels within the Ministry of Public Health, non-health sectors and other international organizations, in order to position the strategies of the RTG–WHO NCD network to become state policy.
References


Annex 7: Report for the review of the Thailand–WHO Partnership Priority Programme on Disaster Preparedness and Response

Objectives and method of the Country Cooperation Strategy review

The review of the WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) had four objectives:

1. to review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
   - the leverage that the five CCS priority programmes have created for channelling other funds into the programme
   - the quality of the activities performed by the five priority programmes and value for money
   - the relevance and World Health Organization (WHO) support to communicable disease control (the unfinished agenda) and border and migrant health

2. to identify the lessons learnt from planning and implementation of the five priority programmes

3. to propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

4. to assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using semi-structured interviews. Summaries or recordings of the interviews were made; the programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

One limitation of the review was that most programmes had only commenced implementation in early 2012 and had not produced substantive outcomes or had an impact, since the strategic plan was for a 5-year period. If this was the case, the reviewer attempted to make an assessment of the potential outcomes and impact from the programme.
Background

Thailand has experienced two major natural disasters during the last decade, with major loss of lives and substantial economic impact. The Indian Ocean Tsunami hit the west coast of Southern Thailand on 26 December 2004, affecting major tourist destinations. There were 4812 confirmed deaths, 4499 missing and huge economic losses. Governments in the region, including the Royal Thai Government (RTG), recognized the need to strengthen disaster risk management after this tsunami. Subsequent reviews of the response suggested that the RTG, through activating its existing Civil Defense Act Emergency System, successfully mobilized and directed the human and financial resources of relevant line ministries in the affected areas. This made the Thai response more appropriate and efficient than that of the other countries affected, including Indonesia, Maldives and Sri Lanka. In the first and second phases of the emergency, the strong national-level coordination temporarily bolstered the capacity of district authorities to deal with the search and recovery tasks. However, the national tsunami response has not necessarily had a lasting impact on local capacity in management of disasters (1).

In 2011, Thailand experienced its worst flooding in half a century; it affected 65 provinces, resulting in severe impairment to the country’s economy and industrial sector. There were 815 confirmed deaths, 21 000 km$^2$ of farmland were damaged, and estimated economic losses were 1440 billion baht. The flooding was attributed to heavy precipitation, 35% higher than average, high tides and a storm surge in the Gulf of Thailand, but the impact was exacerbated by soil erosion caused by deforestation (2). The scale of the disaster highlighted the reality that the responsibilities and authorities of national and local government units were not clearly defined. The follow-up recommendations also emphasized the need for well-organized planning systems that could control the use of land, and the development of drainage systems to control flood levels.

In 2012, the Prime Minister of Thailand declared that disasters and emergencies are priority areas for her government and asked all of Thai society to develop their capacities according to their designated areas of responsibility. The 11th national health development plan 2012–2016 (3) highlights the focus on developing systems for monitoring, warning and management of disasters and health threats.

The World Health Assembly passed a resolution in the aftermath of the Indian Ocean Tsunami (4), 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. This resolution included building on the Hyogo framework for action 2005–2015 (5), stemming from the World Conference on Disaster Reduction. Another World Health Assembly resolution was passed in 2011, calling upon Member States to strengthen all-hazards
health emergency and disaster risk-management programmes as part of national and subnational health systems (6). This included integrating all-hazards health emergency and disaster risk-management programmes into national or subnational health plans, and institutionalizing capacities for coordinated health and multisectoral action.

Consequently, there is a strong commitment and mandate from the RTG, Ministry of Public Health and WHO to develop a more effective disaster preparedness and management system within the health sector.

**Programme description**

The programme is based on the Framework for health sector disaster management (7), a revised strategic plan that was developed in July 2011 as an initial activity of the programme (for further details, see the section “The plan and planning process”). The objective was to bring all ongoing and planned activities together within one systematic strategic framework. This has three main strategic directions:

1. mainstream disaster risk reduction into health sector planning and development
2. strengthen the disaster management system in the health sector of Thailand, through emergency preparedness activities
3. foster collaboration with other countries to support the health sector disaster response in Thailand.

The main areas of work involve establishing coordination and management structures in the health system of the country. The programme has five key areas of work:

1. health system (health facilities, health workforce and health service delivery)
2. strategy, policy and legal framework
3. community readiness preparation
4. information management
5. operation and logistics management system.

The National Institute for Emergency Medicine (NIEM) was selected as the lead agency for the programme, which involves coordinating and managing the programme activities. NIEM was established under the Emergency Medical Act B.E.2551 (2008). It is responsible for administrative management and coordination between relevant agencies, in both public and private sectors, including the promotion of local governments to play a role in the management of emergency medical services. This means that NIEM does not have within its mandate all aspects of disaster preparedness and response, but is mainly concerned with emergency medical services, specifically pre-hospital care.

A subcommittee was established to have oversight of the programme. This committee, chaired by Dr Bichit Rattakul, has members from key partners such as
the Department of Disaster Prevention and Mitigation, Ministry of Interior, Ministry of Defense, Thai Health Promotion Foundation (ThaiHealth) and Thai Red Cross. A list of the members of the subcommittee is included in Annex 4.

**Context**

The Disaster Prevention and Mitigation Act in 2007 is the national law for disaster prevention and mitigation. The organization with primary responsibility is the Department of Disaster Prevention and Mitigation under the Ministry of Interior. The Act requires that each of 17 ministries, including the Ministry of Public Health, be prepared to respond to all kinds of disasters and hazards. As described in the section “Changing institutional environment”, in March 2012, the Ministry of Public Health established a new Bureau of Public Health Emergency Response (BPHER) under the Permanent Secretary’s office.

Operating in a decentralized system, the provinces under the provincial governors and administrations and the district administrations will have the main responsibility to respond to major emergencies and disasters. The provincial health offices will provide support, in cooperation with the rest of the provincial administration.

**Results/findings**

**The plan and planning process**

The original strategy document, *Multi-stakeholder approach to Royal Thai Government (RTG)–WHO collaboration, thematic area: “disaster management”*, was reviewed by two external reviewers, who both concluded that the document had significant flaws in both structural and conceptual issues and needed major revisions. In spite of this, the strategy document was approved by the steering committee, without taking the advice from the external reviewers into consideration. This is recognized as a major weakness in the planning process and contributed to a significant delay in the planning and implementation of the programme.

Recognizing the shortcomings of the original strategy document, a revised strategic plan, *Framework for health sector disaster management*, was developed in July 2011, in consultation with key stakeholders (7). The document is technically sound and in line with recommended international best practices in disaster preparedness and risk management. The process of development of the new strategy document is perceived as a key achievement, because it brings the partners together for a common vision and strategy for the programme. It would be an advantage if this document were printed as an official document, and also recognized by the Ministry of Public Health as the key strategy document.

An analysis of the objectives and approaches in the CCS and the current strategy document suggest that there has been a shift in focus, from establishing a well-
functioning agency network for maximum coordination, cooperation and collaboration in disaster health emergency management, to mainstreaming disaster risk reduction into health sector planning and emergency preparedness activities. This shift in orientation is considered to be feasible if it is the result of an agreement by all stakeholders involved, including the Ministry of Public Health. However, previous assessments have suggested that coordination and collaboration are weak at the national level but strong at the subnational level.

The operational plan, with a monitoring framework, is well aligned with the Framework for health sector disaster management (7). The monitoring framework is reasonable, but (as mentioned in the section on “Reporting”) has yet to be used for progress reporting.

**Programme implementation and achievements**

Overall programme implementation seems satisfactory, with a financial implementation of 82.6% as of June 2013 (see Table 1).

**Table 1: Financial implementation (2011 to present)**

<table>
<thead>
<tr>
<th>Funder</th>
<th>Income</th>
<th>Expenditure</th>
<th>Committed</th>
<th>Balance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thai Health</td>
<td>15 900 000.00</td>
<td>8 295 040.48</td>
<td>2 399 742.00</td>
<td>5 205 217.52</td>
<td>Many projects were extended to June 2013, so the budget of 2012 will be withdrawn completely in June 2013.</td>
</tr>
<tr>
<td>WHO</td>
<td>4 500 000.00</td>
<td>4 500 000.00</td>
<td>0</td>
<td>0</td>
<td>The budget of 2 years (2011 and 2012)</td>
</tr>
<tr>
<td>MOPH</td>
<td>1 000 000.00</td>
<td>1 000 000.00</td>
<td>0</td>
<td>0</td>
<td>Budget of 2012 was pending</td>
</tr>
<tr>
<td>HSRI</td>
<td>900 000.00</td>
<td>900 000.00</td>
<td>100 000.00</td>
<td>-100 000.00</td>
<td>HSRI will allocate budget after terminating the activity.</td>
</tr>
<tr>
<td>NIEM</td>
<td>5 817 079.90</td>
<td>5 282 137.04</td>
<td>0</td>
<td>534 942.86</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27 217 079.90</strong></td>
<td><strong>19 977 177.52</strong></td>
<td><strong>2 499 742.00</strong></td>
<td><strong>5 640 160.38</strong></td>
<td>The balance budget will be paid for the activities within 2013.</td>
</tr>
</tbody>
</table>

HSRI: Health Systems Research Institute; MOPH: Ministry of Public Health; NIEM: National Institute for Emergency Medicine; ThaiHealth: Thai Health Promotion Foundation.

Many of the activities are outsourced to institutions and individuals and there have been delays, as some of the subcontractors have not been able to meet the set deadlines.

Examples of programme achievements include a joint task force to manage and review the disaster response plan for the health sector in five pilot provinces, and a training package, *Incident Command System*, for middle managers and executives and mobile medical teams. NIEM has also developed a website as an information source. The website could be expanded further to serve as a knowledge base and portal on
emergency medicine and disaster risk management, with links to international sources of best practices.

Various media and information, education and communication materials specifically targeting children have been developed as part of the community preparedness toolkit. The immediate impression is that the material is of high quality, but without any information of outcome from pretesting. This is meant to be a pilot with initial printing of $300 \times 12$ puzzles, a board game and playing cards, to be tested in 10 schools. The plan is to scale this up to 60 provinces, although there is currently no clear funding for scaling up this activity. Furthermore, it was suggested by another government agency that this may be beyond the mandate of the current programme and could be a possible duplication of what is being done by other stakeholders.

Several technical reports and studies in Thai have been produced under the programme but, because of the language, the reviewer could not assess the quality of the reports. One key informant suggested that there is too much focus on studies and research, while more attention should be given to curriculum development, training and practical approaches within the health services. Limited time did not permit a review of the actual content and quality of most of the other activities, including the training programmes carried out. The assessment, therefore, is based mainly on the interviews with key informants.

**Reporting**

NIEM is reporting on the progress of programme implementation through regular PowerPoint presentations to the subcommittee – the most recent was in June 2013. However, most of this reporting is at activity and output levels, often indicating that an activity has been completed, but with limited specificity and details. For example, a report on training courses indicated that the *Incident Command System* and *Major Incident Medical Management and Support* were completed, but there was no information on the number of training courses, the number of participants or the cost of the activity.

Further reporting according to indicators and set targets in the agreed monitoring framework would be an advantage. The Ministry of Public Health in particular has requested further support from WHO to enhance skills in designing general monitoring and evaluation frameworks for the programme.

So far there is limited documentation on potential outcomes and impacts of the programme. More systematic efforts are needed to document outcomes through reporting on the indicators, and to conduct simple feedback surveys from training programmes and monitoring the effectiveness of interventions targeting the public (e.g. number of listeners on the weekly radio programme *Hotline 1669 Prepare for Disaster*, followers on Facebook, Twitter).
Since the programme has been running for about 2 years, it may be useful to prepare a comprehensive report at the end of 2013, on activities, budget and achievements. This could also be an opportunity to see whether adjustments in the programmes are needed, based on the lessons learnt so far, considering the gaps identified through assessment of national emergency preparedness using the benchmarks report of the WHO Regional Office for South-East Asia (8) and the new institutional environment after the establishment of BPER.

**Coordination through a lead agency**

The programme has been able to attract funding from various stakeholders. WHO’s financial contribution (excluding the technical officer) is only about 33.0% of the total programme. It has been suggested that the pooled funding has created more national ownership of the programme and is perceived as more sustainable compared to the traditional way of WHO-supported programme implementation. The programme can continue, even if eventually there will be less or no funding from WHO. However, having WHO as a key partner for the programme is considered essential to get the buy-in of the participating agencies. As stated by one agency representative: “Without WHO there would not be a programme …”.

Having an autonomous lead agency such as NIEM implementing the programme provides more flexibility in pooling of resources and outsourcing activities than having the programme under a Ministry of Public Health department. According to the view of NIEM, the WHO funding through the direct financial contribution mechanism implies less strict rules on use of the funds compared to other mechanisms for financial support from WHO.

The work of the subcommittee has been affected by discontinuity, as the chairperson has not been able to attend every meeting. Having a high-level experienced chairperson provides the advantage of stronger leverage in bringing the stakeholders together, but it must be recognized that it might be more difficult for such a chairperson to attend all meetings. The existence of a second coordination committee with NIEM has also created some confusion. The chairperson has suggested that the two subcommittees could merge and, furthermore, that the Ministry of Public Health could serve in the capacity as co-chairperson of the subcommittee, to ensure closer linkage of the programme to the Ministry of Public Health and its various departments. For example, the Department of Medical Services in the Ministry of Public Health has so far not been involved, despite the focus using a health-system approach in disaster risk management.

It was also suggested that a greater involvement of partners such as the Thai Association for Emergency Medicine, Ministry of Education, media and the private sector would be an advantage. Stronger links to media could help to scale up the activities of the communities and general public. Expanding the network should be done in close cooperation with Department of Disaster Prevention and Mitigation, to avoid overlap and duplication.
Changing the institutional environment

The Ministry of Public Health established a new Bureau of Public Health Emergency Response (BPHER) in March 2012, under the Permanent Secretary’s office, and this has been operational since August 2012. There was previously a cluster in the Bureau of Health Administration dealing with public emergencies and disasters. The establishment of the new BPHER signifies the increased priority that the RTG and Ministry of Public Health are giving to disaster preparedness and response and public health emergencies, particularly in the aftermath of the floods in 2011.

BPHER has a threefold mandate, covering emergency medical services, disasters and outbreaks of public health significance. Further details of the mission of BPHER are given in Box 1. BPHER currently has 30 staff and increased its budget from 1 million baht (approx. US$ 31,000) in 2012 to 40 million baht (approx. US$ 1.23 million) in 2013.

Box 1: Mission of the Bureau of Public Health Emergency Response

- BPHER is the secretarial body of the Ministry of Public Health for driving disaster prevention/preparedness and response in the field of medical and public health, at the national, policy, management and operational level.

- It is the main contacting body of the governmental offices at the central, provincial and district level, and for various networking organizations, including connection for taking care of patients under the role and responsibility of the Emergency Medical Institute of Thailand during disaster situations.

It is also responsible for:

- preparation of a strategic plan, action plan, policy and guideline for implementation, including monitoring and evaluation of the implementation under the strategy of public health disaster management by the network of functioning agencies, at both national and international level, under the terms of the national policy and development plan;

- resource planning and management of medical and health-care services, to provide a cost-effective operation and result for emergency crises;

- support and development of information technology systems, expertise and innovation in relation to administration, services and academia

- development of a networking agency for real-time communication linkages for public health disaster prevention preparedness, and response to disaster situations.

The observations from the review suggest that there is still a need for further clarification among the stakeholders of the roles and responsibilities of BPHER and
NIEM. However, the establishment of BPHER provides an opportunity for greater focus on public health and health-system response in disaster risk management. NIEM has more focus on, and experience of, emergency medical services and pre-hospital care. Joint work of BPHER and NIEM would therefore be complementary and can provide a good foundation for developing disaster preparedness and response and emergency medical services in Thailand.

Since BPHER is newly established and is currently building up its technical and administrative capacity, it could benefit from more focused technical support from WHO.

**WHO contribution**

WHO contributed 6.9 million baht to the programme during 2011–2013. Another major contribution has been the support of the WHO technical officer. The support by the technical officer has been much appreciated by the key partners, who perceive it is of high quality and good value. In addition, some technical and financial support has been provided by the WHO Regional Office for South-East Asia, for example for the Assessment of National Emergency Preparedness in Thailand using benchmarks of the WHO Regional Office.

The major contribution by WHO is that, with limited financial resources but good technical support, it has created a momentum in engaging the Ministry of Public Health, NIEM and other stakeholders in enhanced focus and work on disaster preparedness and response. This, in itself, represents good value for money.

**Conclusions**

1. After an initial delay because of an originally weak strategic paper, the programme area on disaster preparedness and response is being implemented effectively overall, and has been able to attract various stakeholders and additional financial resources.

2. The programme is in line with the high priority given by the RTG to capacity for disaster preparedness and response and the focus on developing systems for monitoring, warning and management of disasters and health threats in *The 11th national health development plan* (3).

3. The completion of the *Framework for health sector disaster management* (7) for Thailand, with the objective of bringing all ongoing and planned activities together within one systematic strategic framework, is commendable and perceived as a key achievement of the programme.

4. The CCS strategy, and the subsequent programme, have created a momentum for engaging the Ministry of Public Health, NIEM and other stakeholders in work on disaster preparedness and response.
(5) The current programme modality, with a lead agency and pooled funding, has provided ownership among the stakeholders and is perceived as more sustainable compared to the traditional way of WHO programme implementation. However, this may be perceived as a project approach rather than as regular support for a national programme.

(6) The establishment of BPHER has contributed to some ambiguity among stakeholders in understanding the different roles and responsibilities of BPHER and NIEM in disaster preparedness and response.

(7) The new BPHER provides an opportunity for greater focus on health-system response to disaster risk management.

**Recommendations**

(1) Further clarification is needed of the roles and responsibilities of BPHER and NIEM, to achieve more effective coordination and targeting of resources.

(2) Closer cooperation with the Ministry of Public Health and its departments (e.g. Department of Medical Services) in applying a health-system approach to disaster risk management: make capacity for management of emergencies and disasters one of the building blocks of the health system.

(3) Report according to indicators and set targets in the monitoring framework and improve the documentation of the outcome and impact of the activities and the programme.

(4) WHO to enhance the knowledge and capacity in designing a monitoring and evaluation framework for the programme.

(5) Readjust the programme for 2014–2015, based on the lessons learnt so far and the new institutional environment after establishment of the BPHER.

(6) Re-examine the governance structure and members of the subcommittee and the possibility of having a co-chairperson from the Ministry of Public Health.

**References**


Annex 8: Report for the review of the Thailand–WHO Partnership Priority Programme on International Trade and Health

Objectives and method of the Country Cooperation Strategy review

The review of the WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) had four objectives:

1. to review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
   - the leverage that the five CCS priority programmes have created for channelling other funds into the programme
   - the quality of the activities performed by the five priority programmes and value for money
   - the relevance and World Health Organization (WHO) support to communicable disease control (the unfinished agenda) and border and migrant health

2. to identify the lessons learnt from planning and implementation of the five priority programmes

3. to propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

4. to assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using semi-structured interviews. Summaries or recordings of the interviews were made; the programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

One limitation of the review was that most programmes had only commenced implementation in early 2012 and had not produced substantive outcomes or had

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1 The list of persons interviewed is provided at the end of this annex. Interviews with the officials from Department of Trade Negotiation, one of the key stakeholders, with the Director, Madhihol University Global Health, were not possible, owing to other prior commitments of the interviewees.
an impact, since the strategic plan was for a 5-year period. If this was the case, the reviewer attempted to make an assessment of the potential outcomes and impact from the programme.

**Background**

Consistent with the National economic and development plan (1), progressive economic and trade liberalization has been the Royal Thai Government’s (RTG’s) core strategy in international trade. Since economic growth is driven primarily by exports (2), Thailand has been actively engaged in trade negotiations at multilateral, regional and bilateral levels, to attract foreign investment and increase market access opportunities. However, such opening of trade and assumption of obligations under multilateral, regional and bilateral trade agreements and their rules may have widespread impact, not only on trade, but also on social, health and other issues (3). Five specific issues covered by the World Trade Organization and regional or bilateral trade agreements have important implications for public health. These are: protection of intellectual property rights, including patents, copyrights, trademarks and industrial design; measures to protect human, animal and plant life; production, labelling, packaging and quality standards of pharmaceutical products, equipment, biological agents and foodstuffs; liberalization of health services through the movement of consumers and service providers across borders to receive and supply health care; direct foreign investment in health and emerging areas of e-health; and reduction of tariff on health-related products. The RTG, as well as nongovernmental organizations, technical groups and academics, have been working on the implications of trade on public health for a long time; however, before implementation of the CCS, these works were ad hoc, scattered and non-continuous (2). Consequently, the support of WHO was also a one-off event.

**Programme description**

In line with the strategic agenda and approach of the CCS, the programme aims to build up and strengthen institutional capacities, in order to generate and manage knowledge on international trade and health for evidence-based policy decisions and to make coherent policies between international trade and health; to strengthen the evidence-based, transparent and participatory trade negotiation processes and mechanisms related to health; to build capacity of all the partners to understand the implications; and to advocate the knowledge and policy recommendations generated by the programme. In order to achieve these goals and objectives, the programme has adopted the strategies of strengthening collaboration with multiple stakeholders and their active participation and ownership, targeting the negotiation process with synergistic contributions from technical groups, academics, civil society and negotiators/policy-makers, through knowledge generation and management, social movement and policy decisions.
The programme has identified activities in three focus areas: knowledge generation, management and sharing; network strengthening; and capacity-building. The activities under knowledge generation, management and sharing include knowledge mapping and generation in the area of intellectual property rights, so-called “sin products” (tobacco/alcohol), health services and food; formulating and implementing relevant priority research packages on the impact of various trade agreements, to be used by trade negotiators and policy-makers; and establishment of an international trade information clearing house, with management and dissemination of the knowledge generated. Under network strengthening, the focus has been on strengthening various natural networks of concerned agencies, holding regular meetings of Journal Club members and workshops, as well as networking between local networks and other north–south and south–south international collaboration. The capacity-building component includes research capacity-building of individuals and implementing partners, organization of and participation in training/workshops, and technical and financial support to postgraduate students. In addition, the programme also provides technical support to the National Committee to Support Study and Monitoring of International Trade Negotiation related to Health and Healthy Policy. The identified programme activities also follow the RTG–WHO policy on filling the gap and not to compete with existing organizations and their functions.

The programme has been implemented with multistakeholder collaboration led by the International Health Policy Program (Thailand) (IHPP). Other supporting agencies in specific activities are the Bureau of International Health, Bureau of Policy and Strategy (BPS), Department of Trade Negotiation, Food and Drug Administration, Health Systems Research Institute (HSRI), National Food Committee, National Health Commission Office (NHCO) and the WHO Country Office for Thailand.

Context

As the RTG aggressively pursued trade liberalization through multilateral, regional and bilateral free trade agreements, it has been recognized that the government must protect Thailand’s national interests in the conduct of her international economic policies. The urgent need for research studies to assess the impact of trade liberalization on health and health services has also been acknowledged (4). The reactions from transnational companies, their governments and other organizations to the RTG decision on the use of compulsory licensing for seven drugs (two antiretroviral, one anticardiovascular and four anticancer), as well as the emergence of health-related issues such as Trade-Related Aspects of Intellectual Property Rights (TRIPs)-plus in the agenda of ongoing negotiations on the Thailand–EU Free Trade Agreement (FTA) and Thailand–US (United States) FTA, among others, have also provided impetus to the generation of knowledge, network strengthening and capacity-building on the impact of trade policy on public health. In addition, various resolutions of the World Health Assembly (5–7) have urged Member States to consider linkages of trade-related policies with health policies. The Eleventh
general programme of work 2006–2015 of WHO (8) also provided a broad direction of work as shaping the research agenda, stimulating the generation and dissemination of valuable knowledge, and providing leadership on matters that are critical to health.

Results/findings

The plan and planning process

Development of the strategic framework document and identification of goals, objectives and activities were based on the unified planning framework for all the relevant stakeholders. There appears to be coherence in the process, through involving the key stakeholders in the design and implementation of the activities. Under the leadership and coordination of the Ministry of Public Health, various meetings were held among concerned public health agencies, independent public health agencies and WHO, and it was decided to address jointly the issue of international trade and health. The IHPP, BPS and HSRI were assigned to coordinate all stakeholders to formulate the programme. A series of stakeholders’ meetings were convened with the participation of representatives of the Ministry of Foreign Affairs, Ministry of Commerce, Ministry of Public Health, academics, professional councils, civil society representatives and the private sector. The meetings sought opinions on the proposed objectives, conceptual framework, working process and expected outcomes of the programme. The draft document was also sent to independent experts for review and most of the reviewers’ comments on factual and analytical parts of the documents were incorporated. However, suggestions on the composition of the steering subcommittee, and the issue of “specificity” of activities and outcome of the programme do not seem to be addressed in the document.

Progress

Activities

The programme has carried out two types of activities: one as planned in the strategic documents and another unplanned, upon the request of concerned agencies and for the benefit of the overall programme. The broad picture of the status of the activities performed is provided at the end of this annex. Most of the knowledge-generation and management activities have not been completed in the scheduled time. The reasons could be inadequate human resource in the programme-management unit, lack of availability of competent experts in the identified areas, and conflicting interests among the stakeholders. Apart from these, instituting the system of quality assurance that each research study requires, both in-house and outsourced, going through the process of review by external reviewers, and making presentation in a consultative meeting with key stakeholders, may also have resulted in delays. However, most of the activities related to networking and capacity-building have been carried out as planned and scheduled.
Output

To date, the programme has not produced any tangible output under knowledge-generation and management activities. However, it has been able to identify the trade-related issues that have significant implications for public health and health policies. With regard to networking, a functional Journal Club – a platform for discussion of trade and health issues by major stakeholders, including policy-makers, academics and members of civil society organizations – has been established, where knowledge and experiences are exchanged regularly. Establishment of the International Trade and Health Information Clearing House has helped disseminate timely and accurate information on trade and health. It has also helped build the capacities of stakeholders. The programme also provided experts’ views on various policy-related issues, to different government agencies, including the Ministry of Commerce and the trade negotiation team. In addition, training sessions, seminars and workshops have been organized, which have directly contributed to capacity development of programme staff, as well as stakeholders, including the Ministry of Commerce and the Ministry of Justice.

Outcome

The major outcome of the programme was collaborative engagement of health and non-health government officials and policy-makers, in assessing the impact of opening trade on public health, and enhanced understanding of trade negotiators on the implications of the negotiation agenda for the health sector. The second outcome of the programme has been enhancement of the capacities of all partner organizations and stakeholders, including trade negotiators, related to the interface between international trade and health.

Governance and financing

A steering committee has been established for oversight, and to monitor the achievement and progress in all five priority programmes identified by the CCS. For closer oversight in the International Trade and Health Programme, a 15-member subcommittee, chaired by the Deputy Permanent Secretary and comprising representatives from government, independent public health agencies, civil society organizations and academics, and a representative from the WHO Country Office for Thailand, was established to provide guidance and advice to the programme, to approve the specific programme plan and activities and financial matters, as well as to monitor and evaluate the programme. The meeting agenda and minutes indicate that the steering subcommittee satisfactorily discharged its responsibilities of overall guidance, approval of the plan and activities and monitoring of the programme, with its regular meetings, despite the fact that the representative from the Ministry of Commerce – the government agency entrusted for

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2 Information has been already uploaded to the IHPP website; once this website has been reconstructed and become operational, all the information will be able to be retrieved by users.

3 See end of this annex for the composition of the steering subcommittee.
trade negotiations – has never attended a meeting. The steering subcommittee also provided written feedback to the programme team on various issues. However, the steering subcommittee has been inactive for about the last 6 months. Nonetheless, the core team has been providing general guidance to the programme in the absence of the steering subcommittee.

The financial resources required for the programme have been pooled by government agencies, autonomous government bodies and WHO. The Thai Health Promotion Foundation (ThaiHealth) and the National Health Security Office (NHSO) are the major contributors, funding 39.4% and 33.9%, respectively, of the programme budget. Other government ministries, such as the Ministry of Commerce and Ministry of Foreign Affairs, could contribute to the resource pool, as the activities of the programme overlap with the mandate of these ministries.

**Programme management**

The lead agency for the programme is IHPP, and major supporting agencies are the WHO Country Office for Thailand, HSRI, NHSO, NHCO and ThaiHealth. Under the guidance and supervision of the steering subcommittee and core group, the programme activities were implemented by a full-time programme manager, appointed by IHPP and supported by researchers and other administrative staff. Although there is a requirement for a progress report to be submitted to the steering subcommittee on a half-yearly basis, as well as to the funding agencies, there was no established format for the reports. In addition, targets and indicators were not well articulated and lacked baselines and units of measurement. Similarly, the timeline provided in the workplan was on a yearly basis and multiple “lead agencies” have been identified for most of the activities. Although, the core group has attempted to refine the indicators and output, this was far from satisfactory.

**Significant changes impacting the programme**

The recent change at the institutional level – in the composition of the subcommittee – as well as potential change at the policy level, particularly with regard to the conclusion of ongoing bilateral trade negotiations, may directly impact the implementation of the programme. Once the FTAs are concluded, the whole rationale of some of the activities of the programme will be brought into question.

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4 This information was provided by some of the members of steering subcommittee, but it could not be independently verified with the officials from the Ministry of Commerce, since no meeting with the Ministry of Commerce could be arranged.

5 See the end of this annex for the composition of the core team.

6 Information based on the financial statement of the programme.

7 International Trade and Health Programme management core team meeting, 19 June 2013.

8 One of the interviewees reported that conclusion of bilateral FTAs is the top priority of the RTG and the issue of public health in trade negotiation may be relegated to a secondary place.
**WHO contribution**

Despite the fact that the financial contribution of the WHO Country Office for Thailand to the programme was about 15%, the Country Office has been able to provide leadership and engage in partnership with the RTG on the critical issue of trade and health. The non-tangible contributions, such as assisting IHPP in coordinating other stakeholders in programme implementation, establishing linkages with international experts and organizations, and mobilizing individual experts, are of more critical value to the programme than the financial contribution. However, engagement of the WHO Country Office was not as intensive as demanded by the programme.9

**Conclusions**

**General conclusions**

The programme was designed, developed and implemented as a collaborative venture of multistakeholders and guided by a clear strategic document with a simple unambiguous hierarchy of results. Although implementation of the majority of the activities has been delayed, it is recommended that the programme should be continued, as it directly contributes to the essence of the social and economic development plan and health policies of the RTG, and the global mandate of WHO as spelt out in the *Eleventh general programme of work 2006–2015* (8).

**Linkage to government policy**

The CCS has identified building national capacity in trade and health negotiation as the main area of focus, and one of the objectives of the programme was to strengthen trade negotiation capacity. However, there seemed to be no effective and direct mechanism to feed in the knowledge generated by the programme to the negotiators, except through the participation of representatives of the Ministry of Commerce, the Ministry of Foreign Affairs and the National Committee to Support Study and Monitoring of International Trade Negotiation related to Health and Health Policy in the Subcommittee. The established linkages were at the horizontal and technical levels, and there was a lack of effective vertical linkages with the highest policy-making bodies and in articulating negotiating positions.

**Potential impact**

Since the programme was in the second year of implementation, it was difficult to assess its impact on the health system. If programme activities are implemented as planned, one would anticipate that multilateral, regional and bilateral trade negotiation processes would become more transparent and the negotiated outcomes, as well as national trade policies, would be consistent with health policies and plans.

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9 Many interviewees complained about lack of “quality man-hours” of work from WHO staff for the programme.
**Financing of the programme**

The financial contributions of the existing partner organizations seemed adequate to implement the identified activities. There is a theoretical, as well as a pragmatic, rationale to include the Ministry of Commerce, Ministry of Finance and Ministry of Foreign Affairs in the funding mechanism, as programme activities directly contribute to their respective mandates. It may also contribute to enhancing the intensity of ownership of the programme by these agencies.

**Advocacy and dissemination**

Despite the fact that stakeholders were aware of the positive and negative implications of trade liberalization and FTAs on the health sector, there was little understanding of the range of available policy options and their trade-offs.

**The role of WHO**

The coordinating role of WHO was well recognized in the programme activities and the voice of WHO was well respected among the stakeholders.

**Recommendations**

It is recommended to take the following actions in order for the programme to have greater impact.

**Governance**

Include a representative from the Ministry of Finance and upgrade the status of the representative from the Ministry of Commerce (Director General of Department of Trade Negotiation) to the position of vice chair of the steering subcommittee. This will contribute to enhancing ownership of the programme by the Ministry of Commerce and help establish direct communication to the negotiators (responsible authority: steering committee).

**Monitoring and evaluation**

Refine indicators of the activities, with a clear timeline, unit of measurement, baseline and target values, and prepare a standard reporting format. The report should include an executive summary in English and be circulated at least one week before the steering subcommittee meeting (responsible authority: steering subcommittee and programme implementation unit).

**Funding**

Leverage funding from the Ministry of Finance and the Ministry of Commerce, to enhance the ownership of the programme (responsible authority: Ministry of Public Health, steering committee, WHO Country Office for Thailand).
**Management**

Do away with multiple lead agencies in the implementation of programme activities and increase the number of professional staff in the programme (responsible authority: steering subcommittee and international health policy programme).

**Advocacy and dissemination**

Develop an advocacy and dissemination strategy and strengthen dissemination of information on the programme activities, and also information on trade and health (responsible authority: international health policy programme office).

**WHO contribution**

Initiate a dialogue between WHO and the programme on what, how and when WHO should support the programme, including the expertise and networking support, within the available resources of WHO (responsible authority: steering subcommittee and WHO Country Office for Thailand).

**References**


### Progress in activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timeline</th>
<th>Planned/Unplanned</th>
<th>In house/outsourced</th>
<th>Status</th>
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<tbody>
<tr>
<td>1. Knowledge management</td>
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<tr>
<td>a. Research</td>
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<tr>
<td>1.1 Research on overall international trade</td>
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<tr>
<td>1.1.1 Policy process analysis: the comparison of Medical Hub and World Kitchen</td>
<td>Jan–Dec 2012</td>
<td>Planned</td>
<td>In house</td>
<td>Final draft prepared</td>
</tr>
<tr>
<td>1.1.2 Export–import value of products related to health</td>
<td>June–Sep 2012</td>
<td>Planned</td>
<td>Outsourced</td>
<td>Ongoing, knowledge mapping completed (as part of the Thai–EU [European Union] project in 1.2 because of the focusing on EU, not all trade partners)</td>
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<tr>
<td>1.1.3 Impact of policy incoherence between international trade and domestic law and legislation on health</td>
<td>May 2012–May 2013</td>
<td>Planned</td>
<td>Phase 1: outsourced Phase 2: in house</td>
<td>Phase I of knowledge mapping completed, phase II ongoing</td>
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<tr>
<td>1.1.4 The analysis of trade agreements and their issues on health</td>
<td>May 2012–Sept 2013</td>
<td>Planned</td>
<td>In house</td>
<td>Preliminary literature review completed</td>
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<tr>
<td>1.1.5 Foreign direct investment in health-related business</td>
<td>Aug 2012–July 2013</td>
<td>Planned</td>
<td>Partially in house and outsourced</td>
<td>In the process of developing concept paper</td>
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<tr>
<td>Activities</td>
<td>Timeline</td>
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<td>In house/outsourced</td>
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<tr>
<td>1.2 Intellectual property and health products</td>
<td>Aug 2012–Dec 2013</td>
<td>Planned</td>
<td>Outsourced</td>
<td>Ongoing</td>
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<tr>
<td>1.2.1 Border measures and intellectual property enforcement on health products</td>
<td>Aug 2012–Dec 2013</td>
<td>Planned</td>
<td>Outsourced</td>
<td>Ongoing</td>
</tr>
<tr>
<td>1.2.2 Increase in market competition and product quality</td>
<td>June 2012–Dec 2013</td>
<td>Planned</td>
<td>Outsourced/in house</td>
<td>Assigned lower priority</td>
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<tr>
<td>1.2.3 The impact of government procurement on trade agreement on drugs system</td>
<td>June 2012–Dec 2013</td>
<td>Planned</td>
<td>In house</td>
<td>Ongoing</td>
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<tr>
<td>1.2.4 Data exclusivity and technology transfer</td>
<td>Unplanned</td>
<td>In house</td>
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<tr>
<td>1.3 Products that are harmful to health (tobacco and alcohol)</td>
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<tr>
<td>1.3.1 Tariff reduction and impact on market access</td>
<td>Jan–Dec 2012</td>
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<tr>
<td>1.3.2 Burden of diseases and health and societal losses</td>
<td>July 2012–2013</td>
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<tr>
<td>1.3.3 Economic value in health from law enforcement</td>
<td>July 2012–June 2013</td>
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</table>

ITH was recommended by the ex-steering subcommittee to pass this research area to lead agencies, i.e. (1) Center for Alcohol Studies, and (2) Tobacco Control Research and Knowledge Management Center

Not initiated (see details in 1.3)

Not initiated (see details in 1.3)

Not Initiated, (see details in 1.3)
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<th>In house/outsourced</th>
<th>Status</th>
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<tr>
<td>1.4 Health services</td>
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<tr>
<td>1.4.1 Demand-supply of health system to health need of Thai and foreign patients</td>
<td>July 2012–June 2013</td>
<td>Planned</td>
<td>Outsourced</td>
<td>Knowledge mapping completed, research yet to be initiated</td>
</tr>
<tr>
<td>1.4.2 Equitable sharing on income distribution from Medical Hub</td>
<td>Aug 2012–July 2013</td>
<td>Planned</td>
<td>Outsourced</td>
<td>Knowledge mapping completed, research yet to be initiated</td>
</tr>
<tr>
<td>1.4.3 Tracking on the movement of medical and health professionals</td>
<td>Sep 2012–June 2013</td>
<td>Planned</td>
<td>In house/outsourced</td>
<td>Knowledge mapping completed, research yet to be initiated</td>
</tr>
<tr>
<td>1.4.4 Case-studies on the impact of Free Trade Agreement on the movement of health professionals</td>
<td>Sep 2012–June 2013</td>
<td>Planned</td>
<td>In house/outsourced</td>
<td>Knowledge mapping completed, research yet to be initiated</td>
</tr>
<tr>
<td>1.4.5 ASEAN Mutual Recognition Arrangements on health professionals, phase II</td>
<td>Aug 2012–July 2013</td>
<td>Planned</td>
<td>In house</td>
<td>Knowledge mapping completed</td>
</tr>
<tr>
<td>1.5 Food</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5.1 Food</td>
<td>Jan 2012–Dec 2013</td>
<td>Planned</td>
<td>In house/outsourced</td>
<td>Development of conceptual framework and literature review completed, yet to select the research topics and their prioritization and development of concept paper for prioritized topics</td>
</tr>
<tr>
<td>b. Information Clearing House</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Information Clearing House</td>
<td>Jan 2012–Dec 2013</td>
<td>Planned</td>
<td>In house</td>
<td>Uploaded information on IHPP website, but IHPP website is under construction</td>
</tr>
</tbody>
</table>
## Activities Timeline Planned/Unplanned In house/outsourced Status

### 2. Network strengthening

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timeline</th>
<th>Planned/Unplanned</th>
<th>In house/outsourced</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Annual conferences</td>
<td>Decr 2012–Dec 2013</td>
<td>Planned</td>
<td>Co-team with network</td>
<td>Draft proposal and scheduled for the last quarter of 2013</td>
</tr>
<tr>
<td>2.2 Journal Club</td>
<td>July 2012–Dec 2013</td>
<td>Planned</td>
<td>Carried out as planned</td>
<td></td>
</tr>
<tr>
<td>2.3 Stakeholders’ meeting in each area</td>
<td></td>
<td></td>
<td>In the process of conducting research and research quality assurance</td>
<td></td>
</tr>
</tbody>
</table>

### c. Capacity-building

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timeline</th>
<th>Planned/Unplanned</th>
<th>In house/outsourced</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2 Short course training</td>
<td>July 2012–Dec 2013</td>
<td>Planned</td>
<td>Network/in house</td>
<td>Priority is based on the topics, timeline</td>
</tr>
<tr>
<td>6.3 Technical work presentation in conference/meeting/ seminar</td>
<td>July 2012–Dec 2013</td>
<td>Planned</td>
<td>Network</td>
<td>Priority is based on the topics, timeline</td>
</tr>
<tr>
<td>6.4 Publication in national and/or international journal</td>
<td>July 2012–Dec 2013</td>
<td>Planned</td>
<td>Network/in house</td>
<td>Depending on the potential of the research and researchers</td>
</tr>
<tr>
<td>6.5 Application for research scholarship and/or overseas study scholarship</td>
<td>July 2012–Dec 2013</td>
<td>Planned</td>
<td>Network/in house</td>
<td>Selection process completed</td>
</tr>
</tbody>
</table>

## Composition of steering subcommittee

1. Mr Siriwat Tiptaradol                            Chair
2. Mr Suwit Wibulpolprasert                         Vice-Chair
3. Mr Viroj Tangcharoensathien                      Member
4. Mr Yupin Lawanprasert                            Member
5. Director-General or Representative of Department of Health Support Service  Member
6. Ms Chutima Bunyapraphasara                      Member
7. Representative of Ministry of Foreign Affairs    Member
8. Representative of WHO Country Office for Thailand Member
9. Director of Health Systems Research Institute     Member
(10) CEO or representative of ThaiHealth Member
(11) Secretary-General or representative of the National Health Commission Member
(12) Secretary-General or representative of the National Health Security Office Member
(13) Ms Niyada Kiatiyong-Angsulee Member
(14) Director or representative of Economics and Finance Research Institute Member
(15) Ms Churnrurtai Kanchanachitra and Secretary Member
(16) Mr Phusit Prakongsai and Assistant Secretary Member

Composition of core team (as per attendance on 20 June 2013)

(1) Dr Soriwat Tiptaradol, Adviser, National Health Commission Office
(2) Dr Phusit Prakongsai, Director, International Health Policy Program (IHPP), on behalf of the Secretariat of the International Trade and Health Programme steering subcommittee
(3) Dr Nima Asgari, Public health administrator, WHO Thailand
(4) Ms Orpan Srisookwatana, Deputy Secretary-General, National Health Commission Office
(5) Dr Chutima Akaleephnan, Manager and senior researcher, International Trade and Health Programme, IHPP
(6) Dr Tipicha Posayanonda, Expert, Global Collaboration Development Program, National Health Commission Office
(7) Ms Aree Wadwongtham, Expert Bureau of Policy and Strategy
(8) Ms Saowapa Jongkittipong, Director, Committee on Medical Hub, Department of Health Service Support
(9) Dr Cha-aim Patchanee, Senior researcher, International Trade and Health Programme
(10) Ms Hathaichanok Sumalee, Research assistant and coordinator, International Trade and Health Programme
(11) Ms Bhimbhasu Juabkwamsuk, Researcher, International Trade and Health Programme
(12) Mr Channarong Sungayuth, Research assistant, International Trade and Health Programme
(13) Ms Chadsuree Waiyarattana, Research assistant, International Trade and Health Programme
## Action matrix

<table>
<thead>
<tr>
<th>Issues</th>
<th>Recommendation</th>
<th>Responsible authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Include a representative from the Ministry of Finance and upgrade the status of the representative from the Ministry of Commerce (preferably Director-General of Department of Trade Negotiation) to the position of vice-chair of the steering subcommittee, as it enhances the ownership of the programme and helps establish direct communication with the negotiators</td>
<td>Steering committee</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>Refine indicators of the activities with clear timeline, unit of measurement, baseline and target values, and prepare reporting format</td>
<td>Steering subcommittee and Programme Implementation Unit</td>
</tr>
<tr>
<td>Funding</td>
<td>Leverage funding from the Ministry of Finance and the Ministry of Commerce to enhance ownership of the programme</td>
<td>Ministry of Public Health, steering committee, WHO Country Office</td>
</tr>
<tr>
<td>Management</td>
<td>Do away with multiple lead agencies in the implementation of programme activities and increase the number of professional staff in the programme</td>
<td>Steering sub-committee and IHPP</td>
</tr>
<tr>
<td>Advocacy and dissemination</td>
<td>Develop an advocacy and dissemination strategy and strengthen dissemination of information of the programme activities, and also information on trade and health</td>
<td>ITH Programme Office</td>
</tr>
<tr>
<td>WHO contribution</td>
<td>Focus on non-financial support and increase the “quality man-hours” of work from the staff to the programme; provide technical expertise on specific issues through WHO staff or external experts</td>
<td>WHO Country Office</td>
</tr>
</tbody>
</table>
Objectives and method of the Country Cooperation Strategy review

The review of the WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) had four objectives:

1. to review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
   - the leverage that the five CCS priority programmes have created for channelling other funds into the programme
   - the quality of the activities performed by the five priority programmes and value for money
   - the relevance and World Health Organization (WHO) support to communicable disease control (the unfinished agenda) and border and migrant health

2. to identify the lessons learnt from planning and implementation of the five priority programmes

3. to propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

4. to assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using semi-structured interviews. Summaries or recordings of the interviews were made; the programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

One limitation of the review was that most programmes had only commenced implementation in early 2012 and had not produced substantive outcomes or had an impact, since the strategic plan was for a 5-year period. If this was the case, the reviewer attempted to make an assessment of the potential outcomes and impact from the programme.
**Background**

According to data available from the Disease Burden ranking in Thailand, road traffic injuries (RTIs) are an important public health problem. The mortality rate for RTIs was 18.2 per 100,000 population in 2008 and has remained high over time, as has the number of hospitalizations as a result of RTIs (1100/100,000 population in 2006). RTIs are the second-leading contributor among males for disability-adjusted life-years and seventh among females. Around 80–85% of fatalities and injuries occur among motorized two- or three-wheelers and these are the most significant vulnerable groups. The majority of people killed and injured are young men in the productive age groups of 15–44 years. Significant regional variations of mortality and morbidity in RTIs are clearly seen in Thailand. Risk factors such as drinking and driving, inappropriate and excessive speeds and non-use of helmets, seat belts or child restraints pose a major threat for people’s safety, in addition to safety issues associated with vehicles and road environments.

Despite the significant importance given to the safety of road users at different levels by several stakeholders, it is reported that the mortality rate associated with RTIs in Thailand has not changed much, from 22.2 per 100,000 of population in 2003 to 16.9 per 100,000 in 2009. Research data from the Ministry of Transportation indicated that in 2007 RTIs resulted in economic losses to the extent of 282,355 million baht, or 2.8% of gross domestic product.

**Response to the road traffic injury problem in Thailand**

Road safety in Thailand is undertaken as an independent and joint activity by several stakeholders, without significant coordination, with each organization pursuing its own independent agenda. The central and lead coordinating agency for road safety in Thailand is the Department of Disaster Management and Prevention in the Ministry of Interior and is the coordinating ministry designated by the Royal Thai Government (RTG). Following the *World report on road traffic injury prevention* in 2004 (1), the high-level ministerial meeting in Moscow in 2008, release of the first *Global status report on road safety* in 2009 (2) and launch of the Decade (2011–2020) of Road Safety in 2010, Thailand developed the National Master Plan on Road Safety, which has been approved by the RTG and all stakeholders (a summary of the master plan is provided at the end of this annex).

In view of increasing numbers of RTIs and the huge impact on Thai society, road safety was included as a priority area of the CCS in Thailand in 2011. Major reasons for inclusion of road safety were based on several factors, such as the availability of knowledge-based evidence, the role of cost-effective and sustainable solutions, lessons from the global experience and the fact that RTIs are predictable and preventable (also discussed in detail later in this report).
Programme description

The partners

The Thai Health Promotion Foundation (ThaiHealth) was identified as the lead agency, with WHO as the collaborating centre in Khon Kaen. The Ministry of Public Health and other ministries were identified as partners for implementation. ThaiHealth, being the lead agency for the programme, provided managerial support and funding for the programme. The WHO collaborating centre was the implementing arm of the programme. WHO provided technical inputs, supported activities and provided funding, while the Ministry of Public Health facilitated a number of activities. Other ministries were involved in discussion and to formulate other activities. For all agencies, this was a new component added into their existing and ongoing activities.

The strategies and objectives

Setting goals

In a high-level meeting of all stakeholders in August 2010, concept papers were prepared and discussed by relevant stakeholders, which also included modalities of collaboration. The first steering committee meeting was held on 2 December 2010 and the proposal was approved at the highest level. The significant point of this approval was that road safety would be addressed through a coordinated programme of work that would seek to harness the potential strengths of various agencies and stakeholders in Thailand. The concept paper prepared for road safety had the overall goals of:

- developing Thailand as a gateway for international coordination and strengthening Thailand’s road safety network
- reducing the death rate from road traffic accidents by half over the next 5–10 years.

The goals were realistic and the first goal was found to be extremely broad and unclear, while the second one was focused and clear.

Objectives

- Establish international coordination and knowledge sharing on strengthening of Thailand’s road safety network, particularly in relation to motorcycle safety
- Substantially reduce the rate of motorcycle-related injuries and death

Once again, the first objective is very broad and unclear, while the second one is clearer and focused.
Strategic approaches

To achieve these goals, the accepted strategies were to:

1. Identify a lead agency in government to guide the national road traffic safety effort
2. Assess the problem, policies and institutional settings relating to RTI and the capacity for prevention of RTIs
3. Strengthen the National Master Plan on Road Safety on the aspects of behavioural and legislative strategies and actions
4. Allocate financial and human resources to address the problem
5. Implement specific actions to prevent road traffic crashes, minimize injuries and their consequences, and evaluate the impact of these actions
6. Maintain high-quality, real-time information on road traffic accidents, in order to monitor levels and trends
7. Support the development of national capacity and international cooperation.

It is essential to highlight that the strategic approaches outlined aimed at five areas and these include strengthening national efforts (3 and 7), assessing the problem (2), maintaining good data (6), implementing specific activities (5) and providing funding (4). While these approaches are essential for road safety, they were very broad based. More specific activities recommended to develop these strategies were:

- Advocacy on road safety
- Road safety capacity-building and education
- Increasing awareness of risk factors
- Generating evidence on road safety through monitoring, evaluating and research
- Implementing demonstration projects
- Upgrading road safety legislation and standards
- Strengthening emergency care
- Improving coordination and management and building an enabling environment
- Integrating injury prevention in primary health care.

Governance and road safety management

To address oversight of the implementation process, modalities of planning, implementing and governing the priority programmes, including the one on road safety, the RTG also put in place a mechanism and a governing structure that included the principles of financial and programmatic accountability, as well as inclusiveness,
involvement, ownership and participation by all stakeholders in an effective manner. This included:

- constitution of a steering committee (for oversight and to monitor achievement and progress)
- constitution of a subcommittee (core committee) (further expanded at provincial level)
- plan for review by internal and external agencies
- annual financial audits
- mid-term and final review.

A high-level steering committee was constituted to oversee all five partnership priority programmes, including road safety, to provide continuous oversight, monitor progress and facilitate implementation. This committee was replaced early in 2013 by an executive committee, which will oversee all collaboration between the RTG and WHO, including the five priority programmes.

A subcommittee for road safety has been constituted, composed of the chairperson from ThaiHealth (Dr Udomsilp Srisaengnam), co-chaired by the Ministry of Public Health representative and including high-level focal point(s) of the relevant department(s) of the Ministry of Public Health, high-level focal point(s) of the relevant autonomous agencies, a WHO focal point, high-level focal point(s) of other key government sector professionals from relevant centre(s) of excellence, and relevant civil society representative with competence in specific areas of concern. The subcommittee is meant to meet quarterly or as frequently as required to oversee progress in implementation. The terms of reference include:

- provide oversight and guidance on plan operation and implementation
- monitor the achievements and progress in each plan
- provide guidance to improve the performance and facilitate achievements in each plan
- other responsibilities as assigned by the steering committee.

A road safety subcommittee meeting was held on 5 March 2013, to review progress and track achievements. The subcommittee is a good example of governance and management to provide leadership, oversee implementation and monitor progress. The review of meeting minutes and stakeholders’ perceptions indicated that it has been working well, and issues were discussed according to the agenda. However, the subcommittee has made limited progress with regard to the objectives. It has focused on individual activities and placed little emphasis on strengthening national efforts, identifying funding and focusing programmes.
**Development of the workplan**

It was also proposed that the road safety subcommittee will prepare a plan of work (including implementation to facilitate preparation, review, comparison and approval by the steering committee) for a 5-year programme. Accordingly, a workplan for road safety was developed by the lead organization and was reviewed by external experts. The opinion was expressed that it was timely and appropriate that Thailand had initiated this activity to address the increasing burden of RTIs during the Decade of Road Safety. The project proposal had included important elements such as advocacy, capacity development among road safety stakeholders, increasing social awareness, and improving road safety data. It was felt that the project was ambitious and lacked specificity. It was recommended that there should be justification with regard to timelines, a need to be more specific in the area of motorcycle injuries (with clearly defined objectives and information) and on other targeted factors to be included, and challenges faced in data-collection systems. Specifically, the question was raised of how this plan would support the larger national plan for road safety proposed by the government. The reviewers specifically mentioned that there was a need to interlink strategies, goals and mechanisms to the objective of motorcycle injuries.

The revised workplan document of 2 December 2010 was an improved version compared with the first workplan document, with more focused areas in collaborative roles and activities, inclusion and refinement in process and outcome indicators, and a 5-year budget (of approximately 40 million baht per year, with a total of 186 million baht for the 5-year period).

**Quality assurance review**

A quality assurance review was undertaken from 14 to 21 May 2012, to assess the viability of this new method of collaboration between WHO and the RTG from a managerial perspective, to understand the managerial quality of the five partnership priority programmes and to share lessons and best practices across the five programmes. In general, it indicated that all five programmes had strategic plans or frameworks in place; consensus among stakeholders had not been reached; institutional agreement or common direction was still doubtful (especially among institutions); operational workplans simply showed a list of outputs and activities and there was no clear linkage to budgets or to other elements; a systematic approach to monitoring was not yet in place for any of the programmes; indicators were merely description of activity areas; and reporting systems to capture information on achievement values in relation to the indicators were lacking. With regard to financing, the review highlighted that multiple financial reporting requirements were causing extra work and that there was a need for a consolidated financial report meeting.

With specific reference to road safety, the review highlighted needs for:

- a simple vision document that is jointly developed by all key stakeholders and should provide a comprehensive view of all related programmes, expected outcomes and outputs
• an annual workplan that can be monitored and updated and linked to the strategic document and to individual budget lines
• clear written delegation of authority to develop workplan and budget approvals, along with revisions as and when required
• strengthening data-collection mechanisms and identifying programmatic areas
• development of dissemination mechanisms such as a newsletter, Facebook page, share point space, press tours and others
• a systematic approach to reporting, including indicators
• a strong full-time team to manage the programme
• a four-tiered structure for the programme, with clear terms of reference at each level.

Overall, the review observed that programmatic fragmentation and insufficient institutional consensus (especially among central government actors) was an impediment to success.

Activities for implementation

A detailed project proposal was submitted on 17 May 2012, highlighting various activity components for ThaiHealth to implement the project, with a budgetary outlay of 2 million baht. Some of the major activities proposed were:

• establishment of a national lead agency – continuous activity on advocacy without any funding
• legislation review – continuous activity without any funding
• road safety management system – support requested from WHO, September 2012
• road safety information system – support requested from ThaiHealth, June 2012
• strengthening enforcement through training – support requested from WHO, May to December 2012
• capacity-building – support requested from ThaiHealth, August to November 2012
• a large number of advocacy and training activities, 2012–2013.

Many of these activities are in progress and independent activities have been completed.

Activities completed during 2011–2013

It is important to highlight at this stage that all listed and accompanying partners undertook and implemented road safety activities according to their organization’s
goals. Thus, it was difficult to clearly delineate which specific activities were carried out in this programme, owing to an intermix of personnel, activities and funding. The activities that major partners have implemented in road safety are included below, but not all were part of the programme.

**ThaiHealth**

ThaiHealth is the lead coordinating agency for Thailand under the Thailand–WHO Partnership Priority Programme on Road Safety, as designated by the RTG. Strengthening the five pillars of road safety is a recognized area of work by ThaiHealth in road safety. The 2012 proposal included the need for development of a road safety management system (proposed budget of 1.4 million baht) and strengthening the enforcement system. Towards this end, a high-level meeting on road safety for interministerial officers and provincial officers was conducted by ThaiHealth during September 2012, to raise awareness and to advocate for policy, planning and resource allocation purposes (with a budget of 600,000 baht). ThaiHealth works with all key partners on strengthening road safety through policy and programme strengthening at four levels. Firstly, the road safety development committee, police and transport departments are supported to develop internal policies and collaborative programmes. Secondly, through the WHO collaborating centre in Khon Kaen, it has facilitated implementation of several programmes with programme inputs and funding. The third area of influence is working with civil society organizations (Drink Don’t Drive Foundation, Road Safety Networks, Stop Drink Organization, Consumer Protection Foundation and others), primarily focusing on reducing drinking and driving and promoting helmet use at the provincial levels. Lastly, and most importantly, ThaiHealth supports knowledge generation (by working with academic bodies for research), sharing and management to strengthen road safety.

**The WHO Collaborating Centre for Injury Prevention and Safety Promotion**

The WHO collaborating centre in Khon Kaen is the implementing partner for the Thailand–WHO priority partnership programme financially supported by ThaiHealth and WHO Thailand, with programme linkages to the Ministry of Public Health. The activities, thus, overlap between different agencies apart from the centre’s own trauma care and WHO collaborating centre roles, responsibilities and activities. A number of advocacy activities have been carried out, on developing workplans (30 September 2011), establishing a national institute for road safety (12 December 2011), motorcycle safety (two meetings in 2012), collaborative meetings, a proposal on providing road safety technical support to police, a network meeting for road safety among partners (15 June 2012), and others. All these meetings have aimed at raising the profile of road safety, networking with partners, and discussing plans and programmes.

In the area of capacity-building and training with dissemination of WHO resource materials, the centre has carried out: a 3-day training for 152 doctors and nurses from different provinces (25–27 May 2012); TEACH VIP (violence and injury prevention) –
training for 532 participants from different sectors (31 August to 2 September 2012); a national road safety forum meeting on 25–26 August 2012; training for 145 police officers on enforcement and information systems (23–25 November 2012); Global Road Safety Partnership – Asia road safety seminar on 7–8 March 2012; four regional seminars on road safety in 2012; and a seminar for professionals and media persons, to promote the Decade of Road Safety, on 8–9 November 2012.

Many joint activities have been carried out in collaboration with other agencies in the area of increasing social awareness of road safety. Public campaigns on road safety during festival times and at other times of the year have been carried out in 2012–2013.

With regard to road safety management, planning for a monitoring and evaluation system through ranking methods has been carried out, beginning in January 2012. Data collection, analysis and management were the focused themes of this programme. The National status report on road safety 2011 has been published by the centre.

Another proposal for strengthening law enforcement (objectives of reviewing the current situation of law enforcement and increasing capacity among police) was submitted by the WHO collaborating centre on April 29 2013, for a budget of 600 000 baht for the year 2013; for improving child safety in cars (objectives of increasing knowledge among hospital personnel and women on the importance of child safety in cars) for 400 000 baht; and for strengthening the capacity of public health personnel on surveillance and investigation of RTIs using TEACH VIP methods, with a budget of 1 million baht. Activities are expected to be completed by December 2013.

**The Ministry of Public Health**

The Ministry of Public Health has contributed to road safety in a number of ways, supporting policy and programme inputs, capacity-building and training, advocacy and information systems; acting as a partner in the Thailand–WHO partnership priority programme on road safety; and developing guidelines (under development) and rehabilitation programmes.

The Injury Prevention unit in the Bureau of Noncommunicable Diseases is the prime agency for road safety data management areas. Within the health sector, road safety data are collected from five components, namely an ongoing sentinel injury surveillance in 33 sites; data from emergency medical service systems for those provided ambulance care; hospital data from the Bureau of Policy, Planning and Strategy; and death registration systems, and also from the Ministry of Interior on fatal crashes. In addition, emergency medical services systems also feed in data on national ambulance networks and their performance. The data are analysed and provided as inputs to different working committees and working groups.

The National Institute for Emergency Medicine (NIEM) is an autonomous organization under the Ministry of Public Health, which provides emergency care
services for RTIs, through its network of operational units (advanced life support – 1796 units; intermediate life support – 40 units; basic life support – 1531 units; first responders – 7731 units; operation cars – 14 189; helicopters and planes – 100; and emergency medical service personnel – 122 945, along with 78 provincial despatch centres). NIEM also conducts training for various categories of workers, through short-term and long-term courses; collects data through its operations centre; and participates in collaborative programmes with a number of national and international organizations. By working with the Ministry of Public Health, it directly contributes to emergency care activities in the area of road safety.

The police

Apart from its routine traffic management and enforcement activities, under the programme and with financial support of nearly 45 million baht from ThaiHealth, the department is involved in developing a paper-based fatal road crash investigation system, developed by a consultant and piloted in a few stations (there is a total of nearly 1400 police stations in the country). WHO has provided a few (approximately 10) breathalysers, with supported training of police, and police also participate in campaigns. Data are discussed in provincial meetings, to identify modifiable human, road and vehicle factors. Training for police is carried out by the police academy and other agencies and there is no internal department strategy on road safety.

A number of other agencies (such as transport, justice and others) are involved in road safety work but the activities of these departments are not covered in this report.

Results/findings

The national lead agency

Thailand went through an elaborate process of reviews, approvals and official permissions in setting up the national lead agency and developing the master plan with inputs from all stakeholders. However, review of the implementation of the programme with stakeholders revealed that although the agency has been striving to achieve its goals and objectives, progress and success are still far from satisfactory, for the following reasons:

- the agency does not have the legal authority and powers for implementing programmes, regulations and activities
- coordination between participating ministries and departments is a significant problem for implementation
- no funding is available with the agency for joint implementation of overall road safety activities
- the agency has limited capacity and resources to lead all road safety activities
the agency has not been well accepted by all stakeholders since its establishment (even after 2 years) and has not been able to influence stakeholders for a vision and mission in road safety.

Efforts are in progress to strengthen the agency, and it is clear that it should take the overall responsibilities of advocacy, guidance, coordination, funding, implementation, setting standards and targets, feedback, and monitoring and evaluation of all activities. For this to happen, the agency should have adequate powers, authority, capacity, resources, funding and approval by the national government.

Road safety plans

The present National Master Plan on Road Safety needs more focus, activity definitions, timelines and monitoring mechanisms, along with measurable indicators.

The Thailand–WHO partnership priority Programme on Road Safety is limited by the issues listed next.

• The programme is an activity-based project and needs to move to more specificity, which can lead to the development of integrated programmes.
• The plan is overambitious and difficult to achieve (also highlighted by the quality assurance review).
• Clearly defined and agreed-upon programmes, activities and timelines have not yet been developed.
• Feedback to all stakeholders and their continued involvement has been limited.
• Monitoring progress has been difficult, as there were no clearly defined indicators.
• Evaluation (concurrent and end-line) has not been clearly highlighted or planned.

Context

As RTIs are likely to increase, owing to motorization, urbanization and population changes, attempts need to be made to control the problem. As the burden and impact is hugely felt by the health sector, it has to take a leadership role in prevention, care and control of RTIs. In this context, WHO, the Ministry of Public Health and ThaiHealth, along with other ministries and departments, have come together to address this growing problem in the CCS and, at the same time, to support ongoing national initiatives and efforts.

Relevance

The proposed programme is relevant, timely and appropriate, as a defined programme of this nature can set the stage, pave the way and lead ongoing efforts for further strengthening and collaboration.
Awareness
Discussion with stakeholders revealed that many stakeholders are not fully aware of the Partnership Priority Programme on Road Safety and its details, and hence considered this to be another project. It was observed that WHO, with its contributions at both global and national levels, can provide major inputs and strengthen the programme, along with ThaiHealth and the Ministry of Public Health.

Acceptance
All stakeholders accepted that this is an important health programme, which can definitely save lives and limbs and can have an impact in the country and region.

Policies
One difficulty that the programme has faced is that Thailand lacks a national road safety policy with clearly stated objectives, plan of action and mechanisms for implementation developed by a core team, accepted by all partners and supported by the highest authority.

Governance and management
Although the steering committee and subcommittee have been established and meet frequently, there is a need for more clarity on their role and responsibilities. Although ThaiHealth is the lead agency under this programme, it has to provide its inputs and recommendations to the national core committee and to the steering committee. In the absence of powers, statutes, authority, funding and accountability for the national lead agency, the road safety agenda has not moved forward significantly.

Information systems
A review of data issues in consultation with stakeholders revealed that:

- the injury division in the Bureau of Noncommunicable Diseases was the primary responsible agency for information and data management on RTIs
- the Ministry of Public Health collected data from different sources, such as 33 sentinel sites from injury surveillance programmes, hospital information systems, vital registration system, NIEM and special surveys during festival times. There was wide variation in data collected from hospitals (which was more related to care and management) and those collected from other sources mentioned
- significant underreporting existed, as not all RTIs were captured by police systems
- the 30-day international definition was not strictly followed in Thailand, thus resulting in serious underreporting of road crashes and deaths
- the police also collected data on fatal and nonfatal crashes, which were not integrated with other data sources
• collected data or summary data were not available in the public domain and there was limited feedback to all stakeholders

• the capacity to analyse and present information was limited and was hampered by lack of resources

• data collected from other agencies were not integrated and were of limited help for the programme.

Lastly, and most importantly, the responsibility of managing RTI information rested with the Ministry of Interior and Ministry of Public Health in Thailand. Recently, a memorandum of understanding was being developed by the Ministry of Public Health, along with the Ministries of Interior, Police and Transport, and NIEM, for combined data pooling, analysis and management. Recent efforts by ThaiHealth and the WHO collaborating centre to strengthen fatal crash data through training of police, along with new methods of data collection, was also a welcome development. However, there appeared to be vast differences in the need for and focus of data collection between police and the health sector, which needs to be resolved.

Management

The Thailand–WHO Partnership Priority Programme on Road Safety was managed as an activity with a project-based approach rather than a programmatic approach. Although several areas of activity have been carried out during 2011–2013 (advocacy, capacity-building and training, strengthening enforcement [helmets and drink driving], campaigns, data management and others), each one was operated as an individual project. Amidst a plethora of individual and institutional activities by individual stakeholders, a joint programme still did not seem to exist. This has led to discontinuity of the programme soon after a defined activity was completed, as a result of funding problems.

At the higher level, the programme was overseen by the steering committee (changed in early 2013 and replaced with executive committee), but the role seemed to be limited to activity review and not programme review. The meetings have been held at regular intervals of 6 or 3 months, but a complete analysis of problems, solutions and progress on these solutions seemed to be missing.

Implementation of integrated activities

The activities of the Partnership Priority Programme on Road Safety plan had motorcyclist safety as its major focus, since motorcycles account for 70–80% of road crashes in Thailand. The other major area of focus was towards reducing drinking and driving. Achievement of this goal requires implementation of a set of data-guided activities that cover advocacy, education, enforcement, engineering (vehicle and road) and trauma care, in a systems approach through a policy framework.
Discussion with stakeholders revealed that the focus has been predominantly on campaigns, and even these were not country wide, visible and continuous in nature, but occurred more during festival times. Enforcement was hampered by lack of personnel and equipment (breathalysers and others). The penalty for violators of the helmet rule was too small, while for drinking and driving it was reported to be moderate (up to 3000 bahts, according to the courts). Trauma care guidelines were in the process of development and were likely to be available shortly. The need for a comprehensive motorcycle safety policy should be seriously considered, with integrated and data-driven activities.

**Coordination**

Coordinating all activities through intersectoral approaches from all partners appears to be the biggest challenge in Thailand for road safety. With nearly 15 ministries and departments involved in road safety, each agency prefers to do their work in their own way. Although the National Master Plan on Road Safety and WHO–RTG–MOPH plans specify the requirements for strong coordination, this is clearly the weakest link in the chain of activities. This can be addressed through a strong lead agency that has powers to coordinate, along with capacity-building of professionals in different ministries. This mechanism also paves the way for sharing resources and avoiding duplication and wastage of resources.

**Funding**

The workplan of the Partnership Priority Programme on Road Safety had proposed a budget of nearly 200 million baht for a 5-year period; the budgetary allocation and spending seems to be mixed. In the 2-year period of 2011–2013, the amount allocated and spent is in the range of 15 million baht, and a large part of it has been used for training and campaigns (based on the report by the WHO collaborating centre in Khon Kaen). The programme proposal for operational planning in the area of road safety had allocated an amount of 4.5 million baht (140 000 USD) for 2012–2013. However, this did not include financial resources spent by individual organizations or ministries for road safety. The senior police officer interviewed in the review programme also stated that an amount of 45 million baht was available from ThaiHealth to improve police data-collection systems. The Ministry of Public Health has spent a large amount for strengthening and training emergency medical care services. Thus, it was apparent that there was no dedicated pool of funds coordinated by one department, but each department spent their own budget and therefore it was difficult to estimate the cost effectiveness of the programme.

**Feedback**

A major limitation of the 2-year implementation appears to be limited feedback given to stakeholders of other departments. This has resulted in a disjointed nature of activities and also a lack of continuity in each of the programmes, which requires strengthening.
**Reporting and monitoring mechanisms**

A set of simple, measurable and operational indicators agreed upon by the core committee and all stakeholders, for both the WHO programme and the national programme, was lacking. The conduct of periodic meetings by the subcommittee and steering committee seemed to be the only mechanism. The indicators proposed in the workplan were too general and difficult to track and needed input from other stakeholders.

**Outcomes**

The outcomes under the partnership priority programme were difficult to quantify, owing to the overlapping nature of activities and short duration of implementation of the programme (approximately 1 year after all the preparatory work). Secondly, the lack of measurable indicators for outcomes has been highlighted earlier. The report of the WHO collaborating centre indicates that the situation with regard to helmets has remained similar to the pre-programme period, in the areas of helmet use and overall road statistics. The programme would benefit from timely reporting on indicators that should be an inbuilt component of the programme.

**WHO contribution**

In the WHO Country Office for Thailand, a technical officer provides support for the programme (shared activity with disaster management and control) through coordination, technical support and information sharing, along with help in budgetary mechanisms. The WHO collaborating centre in Khon Kaen is the main implementing agency and works closely with the WHO Country Office, ThaiHealth, Ministry of Public Health and other agencies. In all activities, WHO provides technical expertise to plan and implement activities, along with budgetary support for defined activities. The knowledge and resources available from WHO are shared and disseminated among partners, for effective implementation.

**Conclusions**

**General conclusions**

The strategic plan did not provide a basis for an integrated programme with a shared vision and clear objectives that partners could agree on and work towards implementing. Although eight strategies were identified, collaborative roles and activities were defined (in the areas of advocacy, capacity-building, increasing awareness and improving road safety data and model development for replication); process and outcome indicators were delineated; the expected outcomes at 2 and 5 years were not clearly defined; the mechanism of implementation of the programme was unclear; and a reporting and monitoring system was not included. Review of the mechanisms of implementation was through a set of several projects and not focused towards the primary objective.
of reducing motorcycle deaths and injuries and strengthening national efforts. Some of the key challenges were consensus and data-driven programmes, collaboration, timely implementation, the activity-based nature, clear accountability with roles and responsibilities, and monitoring.

**Potential impact**

The potential impact of the programme during the last 18–20 months was in the convergence of partners towards a common vision and goal, increased networking among stakeholders, efforts for capacity-building, and creating partnerships. However, programme implementation seemed to be fragmented. If the programme is geared for continuity, coordinated well, monitored for progress and provided with the required funding, it has the potential to be a good demonstration programme that can feed into the larger National Master Plan on Road Safety (which needs to be strengthened for its role as an effective implementer).

**Sustainability**

The programme’s sustainability at this stage depends on greater political support, cooperation of different ministries, commitment to implementing activities and implementation of activities based on consensus and the availability of funding.

**Recommendations**

The present report has provided an outline of the current burden and impact of RTIs, based on available data in Thailand, and reviewed progress under the Thailand–WHO Partnership Priority Programme on Road Safety. The following recommendations for strengthening the programme are provided.

**The Thailand–WHO Priority Partnership Programme on Road Safety**

- Strengthen existing partnerships and networks towards a common goal with defined programmes and timelines.
- Strengthen the national lead agency, with defined roles and responsibilities, funding, authority and powers to guide coordinate, implement, monitor and evaluate road safety activities.
- Integrate and implement all activities that can reduce motorcycle deaths and injuries through enforcement, education, advocacy and collection and analysis of data.
- Shift from a project mode of activities to a programme mode of integrated activities.
- Strengthen road safety data systems to guide, implement and monitor activities.
- Support monitoring mechanisms with a set of simple and measurable indicators.
- Develop a feedback system for all implementing partners, through well-established communication channels.
WHO

- Advocate the RTG to formulate and implement a national road safety policy.
- Advocate the RTG and other stakeholders for an increased investment in funding and research.
- Provide strategic directions for strengthening the programme in the remaining part of the CCS period and during 2014–2015, to implement focused programmes.
- Increase the capacity and resources available within the Organization.
- Influence through the Organization’s convening abilities for strengthening the national lead agency.
- Support the development of a monitoring framework, along with a set of simple, measurable and objective programme indicators to measure progress within the programme.
- Support a total evaluation of the programme at the end of the defined timeline, for outcome, impact, cost effectiveness, sustainability and replication of the approach.

References


Summary of the National Master Plan on Road Safety

Department of Disaster Prevention and Mitigation, Secretariat of the Road Safety Operations Centre, development of the National Master Plan on Road Safety, July 2011

(1) Thailand has also implemented a Master Plan for Action on Road Safety 2009–2012, which is a macro policy to address the growing number of road crashes. This master plan is focused on laying the foundation for the creation of a safe system over the next 10 years. Over time, it is believed (could not be confirmed), some of the strategies under the master plan have partly been implemented by relevant agencies. The implementation plan for road safety efforts in Thailand will cover the following eight areas:
encouraging the use of crash helmets by establishing and enforcing a mandatory use of crash helmets among all users of motorcycles or motorized two-wheelers
• reducing the risk behaviour of drinking and driving, through a public awareness campaign and vigorous law enforcement
• reducing high-risk crash sites by addressing and eliminating high-risk road sections within a specified timeframe
• setting and enforcing speed limits, especially for motorcycles, public buses and trucks
• improving vehicle safety features, particularly in motorcycles, pickup trucks, public buses, and commercial trucks
• improving performance and encouraging safe practices among road users
• developing an efficient, comprehensive emergency medical service system including post-crash treatment and rehabilitation
• developing a road safety management system by ensuring that the agencies responsible for action on road safety are sufficiently equipped with the necessary resources, technical expertise and manpower to effectively carry out its duties.

(2) A Master Plan for Development of the Traffic and Transport System 2011–2020 is also in place, developed by the Ministry of Transport.

(3) Participants attending the second National Health Assembly on 18 December 2009 had reviewed the road safety situations and had resolved that appropriate steps must be taken.

(4) The cabinet resolution in response to the National Economic and Social Advisory Council’s (NESAC’s) recommendations on the safety of public buses has acknowledged NESAC’s feedback and recommendations regarding “proposed improvement of public bus services safety standards” and agreed to press ahead with several measures.

(5) Following the interministerial conference in Moscow, the cabinet meeting on 29 June 2010, reaffirmed and officially approved 2011–2020 as the Decade of Action for Road Safety, aiming at mobilizing existing knowledge and resources from across a range of sectors, to implement the Road Traffic Injury Prevention Programme as proposed by the Road Safety Operations Center.

The Road Safety Operations Center, located in the Department of Disaster Prevention and Mitigation has been designated to serve as a lead agency and to prepare a plan of action for the Decade of Action for Road Safety, with the aim of achieving the goal of reducing fatality rates from road traffic accidents to less than 10 deaths per 100,000 population by 2020.
Eight pillars have been established to serve as the guidelines to implement the Decade of Action for Road Safety 2011–2020. These include promotion of the use of crash helmets, reduction of risk behaviour of drinking and driving, reduction of high-risk crash sites, setting and enforcing speed limits, improving vehicle safety, improving performance and encouraging safe practices among road users, development of an emergency medical service system including post-crash treatment and rehabilitation, and development of a management system (these are similar to the earlier master plan mentioned above).

(6) The Ministries of Tourism Development and Sports, Transport, Labour, Education, Interior, Public Health and Industry, and the National Economic and Social Board, provided letters of support and officially endorsed the road safety action plan. On 7 January 2011, the Department of Disaster Prevention and Mitigation was officially designated as the national lead agency, signed by department’s Director-General, Wibun Sanguanpong.

(7) The new master plan has detailed description of the situation analysis, international best practices, lessons learnt in the last four decades of road safety and the relevance and applicability of the same to Thailand.

(8) **Objectives of the development of the plan of action for the Decade of Action for Road Safety**

- To establish the implementation guidelines for the Decade of Action for Road Safety through multisectoral engagement from across a range of sectors, and to strengthen the capacity and capabilities of the Road Safety Operations Center as Thailand’s dedicated agency leading the actions on road safety.

- To prepare the programme directions for road safety management for the next 10 years, which are in line with the mandate of the Moscow Declaration, the resolution of the cabinet and the Master Plan for Action on Road Safety, and respond to current circumstances that will have an impact on the policy factors with regard to road safety issues.

- To develop a clearly defined national strategic map and corresponding interventions that will spell out the standard operating procedures to be followed by relevant agencies over the next 10 years, in order to achieve the goals of the Decade of Action for Road Safety 2020.

- To create good understanding among relevant agencies at both policy-maker and practitioner levels and to ensure concerted and unified efforts to advance the RTI prevention programme.

(9) **Strategic approaches**

The new Master Plan for Action on Road Safety 2009–2012 is made up of six strategic strands:

- making road safety a national agenda that needs to be addressed urgently
• building stability for sustainable road safety solutions
• enactment and enforcement of comprehensive legislation relating to road safety
• developing a strategy for RTI prevention at national level
• developing a strategy for RTI prevention at regional and local levels
• strengthening research and development, and monitoring and evaluation.

(10) The master plan clearly highlights that to realize the goals of the Decade of Action for Road Safety in Thailand, it is important to have:
• an efficient road-safety management system in place
• improvement in legislation and the judicial process
• sustained, sufficient funding sources
• establishment of an independent research arm
• a safety culture that is firmly established as a shared vision of Thai society.

(11) To develop road safety, four core areas and their timelines were defined in the master action plan:
• a core work programme on the development of an efficient database system and monitoring and evaluation mechanism
• a core work programme on the improvement and enactment of comprehensive legislation and strict law-enforcement measures
• a core work programme on development of a safe system approach and safety culture
• a core work programme on development of a supporting system to achieve the implementation goals.

All four core work programmes are designed to be in line with the five-pillar strategic strands. Strategic goals and implementation strategies have been defined for each of the strategies defined above.

Framework for the development of a four-point master plan

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(12) Guidelines for monitoring and evaluation to be put in place are also defined in the master action plan.
Annex 10: Report for the review of the Communicable Disease Control Programme

Objectives and method of the Country Cooperation Strategy review

The review of the WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) had four objectives:

(1) to review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
   • the leverage that the five CCS priority programmes have created for channelling other funds into the programme
   • the quality of the activities performed by the five priority programmes and value for money
   • the relevance and World Health Organization (WHO) support to communicable disease control (the unfinished agenda) and border and migrant health

(2) to identify the lessons learnt from planning and implementation of the five priority programmes

(3) to propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

(4) to assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using semi-structured interviews. Summaries or recordings of the interviews were made; the programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

Review process

(1) Review documents related to the WHO CCS and communicable diseases in Thailand. Useful documents were provided and collected from the WHO Country Office for Thailand and some key informants. These include the WHO CCS for 2004–2007, CCS 2008–2011, CCS 2012–2016, technical reports on HIV/AIDS, tuberculosis (TB), malaria, emerging communicable diseases, etc.
(2) Technical briefing by the WHO Country Office on the development of the 2012–2016 CCS

(3) Identification of key informants

(4) Meeting and interviews with key informants as follows:
- administrators, experts and key managers of the Department of Disease Control, Ministry of Public Health
- A technical expert, United States Agency for International Development (USAID)
- Technical experts, US Centers for Disease Control and Prevention (US CDC), Southeast Asia Regional Office
- Selected technical staff, WHO Thailand

The names and titles of the key informants are listed at the end of this annex.

(5) Analysis and synthesis of the data

(6) Preparation of a report on the findings, analysis and recommendations

**Background**

Communicable disease prevention and control has long been a main component of collaboration between WHO and the Royal Thai Government (RTG). Such collaboration has produced enormous impact in the country, as witnessed by the success of smallpox eradication, yaws elimination, and reduction of various communicable diseases through an epidemiological surveillance system, expanded programme on immunization, vector-borne disease control, sanitation and disinfection, food and water safety, and general health promotion. The collaboration has also contributed to strengthening the health system to be capable of policy development, planning, and implementation of communicable disease control programmes.

In the previous two CCSs, communicable disease control was a key component of the strategic agenda. The 2004–2007 CCS listed communicable disease surveillance and malaria control as two of the six areas of work and disease control was also integrated in others such as health systems and border and migrant health. In the 2008–2011 CCS, enhancing primary prevention, surveillance and control of communicable diseases and epidemics, was one of the seven components of the strategic agenda. The financial contribution from WHO for communicable diseases in the biennium 2010–2011 was over US$2.5 million (from an overall budget of US$12.6 million).

Although communicable disease control is not listed as a priority programme for the current CCS (2012–2016), there is still some concern about the need to continue the collaboration in this area as unfinished agendas – particularly TB control, HIV prevention
and care and malaria control. Communicable disease control was, therefore, included as one topic for assessment in the mid-term review of the CCS.

**Programme description**

Communicable diseases have long been major health problems in Thailand. Although successful prevention programmes have brought down the incidence and mortality from many communicable diseases, diseases in this group continue to pose major challenges to health development in the country.

Communicable disease prevention and control programmes in Thailand have been under the Department of Communicable Disease Control, which was reformed to become the Department of Disease Control in 2001 when noncommunicable and occupational diseases were added to its responsibility. Currently, there are specific offices responsible for priority communicable diseases, which include the Bureau of AIDS and Sexually Transmitted Infection (STI), Bureau of Tuberculosis, Bureau of Vector Borne Diseases, Bureau of Emerging Infectious Diseases, and Bureau of General Communicable Diseases (responsible for childhood immunization, diarrhoeal diseases, zoonosis), and the Rajprachasamasai Institute (for leprosy) and Bamrasnaradura Institute (for treatment services in the capacity of infectious diseases in hospital).

**Planning of communicable disease programmes**

Each disease control office develops an annual and medium-term plan for specific diseases under its responsibility. There was no common plan for all communicable diseases. However, the Planning Division of the Department of Disease Control prepared an integrated plan on “strong districts”, which aims to strengthen disease response at the local level, through community leadership and participation in developing a district plan based on the local disease situation and using its own budget. All technical offices of the department provide guidance and technical supervision directly to the district and support monitoring and evaluation of the local implementation.

**Monitoring and evaluation of disease control programmes**

The monitoring and evaluation process for disease control is generally weak, except for HIV, which has received technical and funding support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. There is a need for technical support to strengthen monitoring and evaluation for disease control programmes. Some key informants suggested that good monitoring and evaluation practice should be learnt from the HIV project, and applied to the work of other priority communicable diseases.

**Context**

Communicable disease control has become routine work in Thailand. Plans and programmes are set on a routine basis, driven by the available budget in the Department
of Disease Control. All disease programme offices in the department work almost independently. They have their own strategic plan and annual programme. Some offices have been successful in procuring funds from international donors (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria). In order to integrate all areas together, the Department of Disease Control is currently strengthening disease control capacity at district level. All programme offices are required to set up technical handbooks and guidelines to support all provinces and districts. The 12 regional offices of the department have been reorganized to support this initiative. In the meantime, the Ministry of Public Health is working on organizational reform, with a main objective to form the National Health Authority. Overall functions of the Ministry of Public Health are grouped into four areas: (1) health services, (2) health promotion, (3) disease prevention and control, and (4) health consumer protection. With this reform, the role of disease control will be to concentrate its work on the following 11 areas:

(1) policy and strategy development
(2) knowledge management and research and development
(3) policies and health technology assessment
(4) standardization of services
(5) surveillance, control and public health emergency response
(6) development of legal mechanisms as a public health tool
(7) development of international health cooperation
(8) supervision, monitoring and evaluation
(9) financial management
(10) development of an efficient information management system
(11) policies and management of the health workforce.

Some areas of work may require support from partner organizations, including WHO.

Thailand is an active member of the Association of Southeast Asian Nations (ASEAN), and communicable diseases (including HIV/AIDS) are included in the issues that are addressed by the ASEAN member states.

There are many key partners working with the Ministry of Public Health on communicable disease control. The main United Nations agencies beside WHO are the United Nations Children’s Fund (UNICEF), for immunization and infectious diseases in children; the United Nations Population Fund (UNFPA) for women’s health (including HIV and STI); and the Joint United Nations Programme on HIV/AIDS (UNAIDS), for the HIV/AIDS programme. Other key health partners include the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Bill and Melinda Gates Foundation. The Ministry of
Health and US CDC have also established the Thailand–US CDC Collaboration Centre (or TUC) to strengthen national capacity in the prevention and control of emerging infections, HIV and TB. USAID, Regional Development Mission Asia is also supporting communicable disease control in Thailand, particularly for drug-resistant malaria along the border areas. In addition, some international nongovernmental organizations provide services for migrants and displaced persons in temporary shelters along the Thai/Myanmar border.

Results/findings

The current situation on communicable disease in Thailand

Based on the views of key informants, some priority communicable diseases requiring greater attention are discussed next.

HIV/AIDS and sexually transmitted infection

Thailand is one of the few countries to make substantial progress in fighting AIDS. Currently, the number of new infections is around 10 000 per year, and there are an estimated 480 000 people living with HIV/AIDS. AIDS is listed in the top five of all leading causes of deaths in Thailand. Although the Thai AIDS response has been highlighted as one of the successful programmes in the world, there is still a high level of infection and an increasing trend of new HIV infections among men who have sex with men and injecting drug users. Support may be needed to strengthen interventions for the most at-risk populations, especially at provincial and community levels.

STIs are on the rise, particularly among adolescents and men who have sex with men. Successful STI control in the past has resulted in a weakness of the STI service system. This complacency is becoming a major concern among STI experts. The control at provincial level is currently very weak. Those services that are available are not user friendly. Weakness in the reporting system is also observed.

Tuberculosis

Thailand is one of the 22 high-TB-burden countries. In 2011, the estimated prevalence and incidence rates of all forms of TB were 161 and 124 per 100 000 population, respectively. The main concerns on TB are the high prevalence among mobile populations and foreign migrant workers, high level of TB–HIV prevalence, the need to strengthen the directly observed treatment – short course (DOTS) programme, and the weakness of rural health systems to handle drug-resistant TB.

Emerging communicable diseases

The emergence of severe acute respiratory syndrome and Avian Influenza h5N1 in 2003 as well as H1N1 influenza pandemic in 2009 initiated a response from RTG. A
preparedness and early response programme has been established, with full participation from health and non-health sectors. The Onehealth approach is well accepted and endorsed. A national strategic plan on emerging communicable diseases has been developed for 2013–2016.

**Dengue haemorrhagic fever**

Dengue haemorrhagic fever has been an endemic disease in Thailand. Each year, outbreaks of dengue were reported from all regions of the country. Disease morbidity is high, with an increasing incidence among adults.

**Malaria**

The incidence of malaria has been decreasing nationwide but problems remain in border areas, both in terms of the number of cases and the magnitude of drug resistance. Currently, the high-prevalence areas are the Thai/Myanmar and Thai/Malaysia borders. The emergence of artemisinin resistance is a matter of great concern and requires cross-border collaboration to control the endemic situation.

**Vaccine-preventable diseases**

A successful immunization programme has brought vaccine-preventable diseases under control in the past 30 years through the high coverage of immunization for vaccines under the national immunization programme, together with an effective health service system. The targets of polio eradication and measles elimination have been on track. However, with the high level of population mobility, particularly from neighbouring countries where immunization coverage is low, it is expected that re-emergence of some vaccine-preventable diseases may occur, as witnessed by various outbreaks of diphtheria in 2012. Formation of the ASEAN community in 2016 will exacerbate the cross-border transmission of vaccine-preventable diseases, as well as all other communicable diseases.

**Pneumonia**

Pneumonia has long been a main cause of deaths of children and the elderly. Pneumonia is the number one cause of death among all infectious diseases in children aged under 5 years. It is of concern that there is no specific programme in the Ministry of Public Health to handle this group of diseases. Possible introduction of pneumococcal vaccine in children has been discussed but without any progress.

**Endemic and neglected communicable diseases**

Diseases in this group include diarrhoeal diseases, leptospirosis, opisthorchiasis and filariasis. Except for diarrhoea, many diseases in this group are localized in some regions. Leptospirosis is common in flooding areas, filariasis in the borders, and opisthorchis in the north-east region. It is the most common cause of cholangiocarcinoma in Thailand.
Mid-term review of the WHO Country Cooperation Strategy 2012-2016  Thailand

Collaboration with WHO

A major collaboration between WHO and the RTG has been on supporting disease control programmes. The collaboration has been perceived as bringing the success in disease control in the country. Communicable diseases are no longer leading causes of mortality in the general population. The success has, to some degree, resulted in a negative effect, in that communicable disease control has become a low priority for collaboration, and hence it is not in the list of priority programmes in the current CCS. Nevertheless, support from WHO on disease control has continued. Technical assistance has been provided in almost all communicable disease areas. Most of the support is in the form of technical advice and participation by experts from the WHO Country Office for Thailand and the Regional Office for South-East Asia, who facilitate upstream policy development and downstream policy implementation, through high-level consultations, quality research and analysis in selected areas such as HIV treatment. WHO also promotes intercountry collaboration, which brings together national health authorities and disease control personnel from various countries in the region, to exchange information on the disease situation and explore intercountry and cross-border collaboration.

The Department of Disease Control, Ministry of Public Health is hosting two WHO collaborating centres: (1) WHO Collaborating Centre for Training and Research on HIV/AIDS Clinical Management and Counselling – at Bamrasnaradura Infectious Disease Hospital, and (2) WHO Collaborating Centre for Research and Training in the Field of Epidemiology – at the Bureau of Epidemiology. A few collaboration activities, though very limited, have been performed in the last 2 years between WHO at Country Office level and the Bureau of Epidemiology, but almost no collaboration has occurred with the Infectious Disease Hospital in recent years.

WHO is also working directly or indirectly with other international agencies to support disease control. These include the US CDC Southeast Asia Regional Office, on emerging communicable diseases, TB, HIV research, animal and human interface programme or OneHealth, etc.; and USAID Mission Asia (on malarial control at border areas, HIV among migrants in refugee camps, emerging pandemic threat, counterfeit drug control, etc.

Conclusions

Based on the assessment, all national key informants expressed the need for more collaboration with WHO in disease control. The needs can be categorized into the following areas:

• policy advocacy or upstream policy dialogues with high-level policy-makers in various areas, such as the attention on drug-resistant TB, the need to revitalize the STI control programme, or advocacy on the need to strengthen the control of neglected communicable diseases
• technical assistance – through (1) direct technical support from in-country WHO experts or advisers from the WHO Regional Office for South-East Asia; (2) sharing of technical information; and (3) supporting participation of national technical health personnel in technical fora organized within and outside Thailand. Technical support for the development of proposals for funding (such as those to be submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria) is also requested

• organization of, or support for, training on some specific disease control interventions

• provision of some funds for disease control activities (although funding is not a big issue, some seed funds for model development or technical activities may be useful)

• strengthening the monitoring and evaluation system for all communicable disease control programmes

• the work of WHO in promoting intercountry collaboration is appreciated and should be continued

• continued advocacy and support on international health initiatives related to communicable disease, led by WHO, such as polio eradication, elimination of measles and elimination of congenital syphilis

• exploration of the approaches to increase the role of WHO collaborating centres within the Department of Disease Control, particularly in the areas of direct technical support to neighbouring countries

• as communicable disease control is an unfinished agenda of the 2008–2011 CCS, collaboration strategies listed in the previous CCS are still valid and should be continued.

Recommendations to improve collaboration between WHO and the Royal Thai Government

Recommendations for the Ministry of Public Health

(1) Explore an approach to establish regular and routine meetings (for example, monthly meetings) between WHO and the Ministry of Public Health, to discuss the progress of collaboration and to exchange on priority approaches to strengthen communicable disease control.

(2) High-level discussions should be organized to reach agreement on what areas of collaboration should be included for the biennium 2014–2015 and beyond, for WHO–Ministry of Public Health collaboration.
(3) Engagement of WHO for all programmes to control priority communicable diseases, particularly implementation at both national and local levels. Engagement of WHO in all national reviews or assessment programmes is a useful approach to strengthen the collaboration.

(4) To promote more technical and information exchange, translation support should be provided to foreign WHO experts participating in all technical fora or events organized by the Ministry of Public Health.

**Recommendations for WHO**

(1) Increase the advocacy role of WHO for communicable disease control. More frequent dialogue with high-level policy makers of the Ministry of Public Health is recommended.

(2) Put more effort to support upstream policy development.

(3) Support the ministerial reform by using the comparative advantage of WHO in some of the 11 disease control roles set by the Ministry of Public Health, such as the national policy and strategy development; knowledge management and research and development; policy and health technology assessment; surveillance, control and public health emergency response; international health cooperation; and supervision, monitoring and evaluation.

(4) Strengthen monitoring and evaluation for communicable disease control programmes, through capacity-building, model development, and learning experience from other countries, as well as participation in some monitoring and evaluation and assessment activities.

(5) Continue to promote and strengthen cross-border and international collaboration in communicable disease control.

(6) Continue to support and strengthen the collaboration strategies listed in the 2008–2011 CCS, as most of them are not yet finished. These include:

- strengthen risk communication skills for health personnel;
- improve managerial skills and coordination in epidemic surveillance and response, particularly at the peripheral level;
- facilitate quality assurance of laboratory investigations;
- support for monitoring DOTS, antiretroviral therapy and malaria treatment at all levels;
- support for timely implementation of International Health Regulations 2005; and
- support for vaccine production.
(7) Support downstream policy implementation by providing technical and financial support to develop disease control demonstration models at local level for priority communicable diseases, such as management of multidrug-resistance in high-prevalence areas, a model to eliminate congenital syphilis, etc.

(8) Support knowledge management in communicable disease control and demonstrate the effective use of health knowledge in planning and strategizing disease control programmes.

(9) Continue to build capacity of disease control personnel, particularly through international training and participation in international technical meetings.

(10) Explore and identify ways to address linguistic barriers, through the use of local consultants, short-term national professional technical officers or hiring a fixed-term translator within the WHO Country Office for Thailand.

(11) Support the preparation for disease control to strengthen the national efforts on the establishment of the ASEAN community, which will begin in 2016.

(12) WHO work in establishing a stockpile for emergency drugs and medicines has been viewed as a useful tool to ensure the availability of vaccine and drugs for the management of outbreaks of re-emerging and neglected diseases. This approach should be continued.

(13) Continue to advocate and support on international health initiatives related to communicable disease, led by WHO, such as polio eradication, elimination of measles, elimination of congenital syphilis, and the OneHealth programme.

(14) As WHO is trying to be more strategic in its approach to promote the collaboration, support to all the recommendations listed above may not be possible. Therefore, a consultative meeting between the Ministry of Public Health and WHO should be organized to identify priority communicable disease control areas that WHO is able to support; and other key partners can also be identified and mobilized.
Objectives and method of the Country Cooperation Strategy review

The review of the WHO Country Cooperation Strategy Thailand 2012–2016 (CCS) had four objectives:

(1) to review the progress, process, outputs and outcomes of the five priority programmes, plus selected topics for unfinished agenda (e.g. communicable disease control and border and migrant health), and specifically to look at:
   • the leverage that the five CCS priority programmes have created for channelling other funds into the programme
   • the quality of the activities performed by the five priority programmes and value for money
   • the relevance and World Health Organization (WHO) support to communicable disease control (the unfinished agenda) and border and migrant health

(2) to identify the lessons learnt from planning and implementation of the five priority programmes

(3) to propose potential changes to the priority programmes, including possibly winding down some existing ones and establishing new ones

(4) to assess the balance between priority programmes and other components of the CCS and propose modifications, if relevant.

Each programme was reviewed by an independent external reviewer (see Annex 2). The method used was to review the documentation related to the programme, identify the major stakeholders and interested parties, and interview key informants using semi-structured interviews. Summaries or recordings of the interviews were made; the programme reviewer analysed the information collected and prepared a draft review report for each programme. These were reviewed and discussed by the evaluation team as a whole, before finalizing the report for each programme area.

Background

Border and migrant health was included in the 2012–2016 CCS under the heading of “major public health challenges and the unfinished agenda” where Thailand is lagging behind other countries and where opportunities for major gains are evident. In particular, it reports that WHO will focus its technical support on “[…] ensuring equitable access to health services among migrants and mobile populations”. In the 2008–2011 CCS, the strategic agenda included the item “Multisectoral approach to address health services
for the poor and at-risk populations, including those in border and conflict areas”. In the 2004–2007 CCS, one of the priority health areas was defined as “border health” and to “limit border health to the Thai/Myanmar border”.

Over the course of three CCSs, the domain has evolved from a narrowly described Thai/Myanmar border health concept to a broader domain that includes a wider group of migrant populations and their families residing, living and working in Thailand.

**Context**

**Migrants in Thailand**

Thailand is the primary host country for low-skilled workers from three neighbouring countries within the Association of Southeast Asian Nations (ASEAN) region – Cambodia, Laos and Myanmar. It is also a sending country for a relatively small number of low-skilled labour migrants leaving for countries across Asia, the Middle East and Africa. Continuing demand for migrant workers in Thailand is driven by a combination of demographic transition and upgrading of the skills of the Thai workforce, which has left certain sectors facing a shortage of unskilled labour. Positive growth rates in the working age group in Cambodia, Laos and Myanmar has helped to ensure a steady flow of migrants willing to fill gaps in labour supply in Thailand.

Thailand has been hosting refugees from neighbouring countries for more than two decades. Some 128 000 refugees live in nine camps in four border provinces of Thailand. In addition, around 300 000 so-called Myanmar displaced persons (MDPs) live outside camps in the four border provinces of Thailand.

The number of emigrating Thais is relatively small, with around 150 000 documented migrant workers per year migrating to other countries in Asia, Middle East and Africa.

**Terminology issues**

The latest CCS describes the magnitude and challenges with respect to health for various migrant groups living and working in Thailand, as well as refugees and asylum seekers (so-called non-Thai displaced persons) living in camp settings (so-called temporary shelters) in the border areas of the country, and related public health matters. The formulation of the “unfinished agenda” is “…migrants and mobile populations”, which can be interpreted widely and can cover a different set of populations (e.g. including also internal migrants and travellers). Interviews with key informants revealed how different migrant groups require different attention and policy approaches. The way in which terms like migrants, mobile populations and border health are interpreted also affects the understanding of WHO’s role in the domain.

For the purpose of the review, and following the spirit of the CCS and WHO programme work, the review did not consider all types of migrants and mobile
populations, e.g. travellers, emigrating Thais, but rather focused on the health concerns of migrant populations, mainly from Cambodia, Laos and Myanmar, living and working in Thailand, and the so called displaced persons living in nine camps across four border provinces along the Thai/Myanmar border, and related public health matters of hosting communities.

Migrant groups residing in Thailand of relevance for the review process

- Migrant workers: 2.5 million, of whom an estimated 1.4 million are without registration throughout Thailand
- Non-migrant workers in an irregular situation: 218 000 throughout Thailand (students, children, other unregistered non-workers)
- MDPs: 300 000 (living outside camp settings in the border area)
- Displaced persons: 129 000 (living in camp settings in the border area) (refugees and asylum seekers)
- Ethnic minorities: 323 000

Sources: Bureau of Registration Administration, Department of Provincial Administration, International Organization for Migration, 2011; TBC 2012.

Programme description

The rationale for a WHO programme

Migrants are a driver of development in Thailand, representing at least 5% of the labour force in the country and contributing 6.2% of the gross domestic product. In addition, migrants support development in their home countries, through remittances sent home. Despite their known contributions to the Thai economy, migrants experience uneven access to health services, especially those in an irregular situation (e.g. unregistered, trafficked), for a variety of reasons, including: lack of entitlements/health insurance, high costs, logistical obstacles, fear of deportation, isolation, discrimination, cultural or linguistic obstacles, administrative obstacles, and lack of awareness of available services. As a consequence, migrants may turn to self-diagnosis, self-medication and substandard care, or delay health care, risking deterioration of health conditions and emergency care, as well as long-term disability and loss of gain.

Public health challenges and health security concerns in Thailand related to the unattended health of a vulnerable migrant population that carries a disproportionate share of the health burden are well documented and recognized. However, policies to better attend migrant health lag behind this recognition and are incoherent; health services are substandard or migrant insensitive; and migrant health data are gathered and shared inconsistently, hampering research, surveillance and monitoring efforts. Refugee and MDP health has been looked after through parallel health services provided
WHO Thailand border and migrant health activities

WHO has been addressing migrant health for over two decades, in close collaboration with the Ministry of Public Health, international organizations and NGOs, to address the health concerns of camp-based populations and surrounding communities along the Myanmar border (The Border Health Programme, 2001–2007, supported by the Department for International Development). Routine reporting and system surveillance were established and outbreak responses gradually improved; coordination among stakeholders increased; and capacity-building efforts ameliorated public health-care services for migrant populations in the border area, as they were jointly carried out with the International Organization for Migration/Ministry of Public Health Migrant Health Programme.

The European Union (EU)-funded WHO programme “Strengthening health security in Thailand by improving health statuses of Myanmar refugees and displaced persons in Thailand” was developed based on experiences and collaboration with partners during the Border Health Programme. Government partners and organizations were consulted during the development phase of the programme. Activities have been carried out in coordination with a wide range of international organizations, NGOs, government partners and academia. The main Ministry of Public Health counterparts are the Permanent Secretary Office: Bureau of Policy and Strategy (BPS), Bureau of Public Health Administration; Department of Disease Control: Bureau of Epidemiology, Bureau of AIDS/TB, Bureau of Vector Borne Disease Control and Office of International Collaboration.

The overall objective of the programme is to contribute to the improved health status of Myanmar refugees and displaced persons living in and nearby refugee camps located in the four border provinces in Thailand, by improved social health protection mechanisms and public health response for refugees and MDPs, which will ultimately lead to strengthened health security in Thailand.

The target population includes around 140,000 refugees, 300,000 MDPs and 150 medical staff supporting the health of the refugees in four border provinces. The final beneficiaries also include an additional 2.4 million Thais living in the four border provinces and 2–3 million non-Thai migrants living in Thailand.

The programme has focused on development of policies and mechanisms to ensure equitable access to basic government health services for refugees and MDPs living in camps and surrounding areas; ensuring public health security of society by strengthening disease surveillance and outbreak response and outbreak-prone disease preparedness in refugee camps and surrounding areas; and ensuring that public health gaps of the target populations are well defined and addressed.
Results/findings

Programme progress

Since the start of the programme in January 2011, considerable progress has been made against defined expected results and indicators. A selected milestone at policy level is the support in the development of the Ministry of Public Health Border Master Health Plan 2012–2016, which was endorsed by Cabinet and launched by the Ministry of Public Health in August 2012. Border health units were established and staffed in the targeted provinces; guidelines for disease surveillance in temporary shelters, and monitoring and evaluation frameworks were developed; and related capacity-building efforts reached health-care providers in all 31 provinces. Migrant health information centres are operational in the four border provinces and at central level (Bureau of Policy and Strategy), thereby establishing the foundation in pilot provinces to provide data on border and migrant health and improve health security. An in-depth analysis of financing mechanisms for migrant health care can assist policy-makers nationally and internationally in strengthening health security and social protection in health for migrants.

National, as well as cross-border, multistakeholder meetings on selected topics throughout the life of the programme facilitated the necessary collaboration among involved communities, countries and sectors, and sharing of experiences, technical information and lessons learnt. Contributions to Royal Thai Government (RTG) regional involvement in the ASEAN migrant health discussions and the Healthy Borders session at the fifth National Health Assembly illustrate advocacy efforts of the programme nationally and internationally.

Informants confirmed the advance in policy and programme objectives, highlighting increased health security, technical know-how on specific domains, e.g. infectious diseases (HIV, tuberculosis [TB] and malaria) and vaccination, gap analyses, and policy development, but it is still too early to speak about the impact of the programme activities. Also, the sustainability of the established border health units and their expansion to other border areas remains unclear.

The programme has received yearly in-house monitoring of accomplishments and progress against detailed indicators defined for the above-mentioned expected results. One external evaluation was carried out by the donor in 2011, which did not lead to any changes to the programme. In addition, the hope is that the programme can benefit from monitoring and evaluation from the Ministry of Public Health, Inspector General Office, using the identified indicators of the second Master Plan for Border Health.

Programme funding and leverage

The funding of the programme amounts to 2.4 million euros (approx. US$ 3.3 million) for a period of 4 years, of which 80% is funded by the EU and the remaining 20% is
from WHO core funding. This amount translates into approximately 10% of the total funding for the WHO Country Office for Thailand. Staffing of the programme (one international professional, one national professional and one member of administrative support staff) similarly translates into 10% of the total staff of the Country Office. Other WHO Thailand areas of work, in particular HIV, TB, malaria and vaccinations, have been supported by the international migration health programme coordinator and may have integrated migrant health in these other areas of WHO work. At the same time, the multitasking has possibly distracted attention away from other relevant areas in need of further development. In addition to WHO staff and consultants’ salary support, available funding has allowed ad hoc support of Ministry of Public Health needs for expertise, convening of partners and stakeholders, and the establishment of a border health unit structure.

EU funding was obtained following an open call for proposals under EuropeAid, Aid to Uprooted People Programme in Thailand, in 2010. It is important to underline that the call for proposals focused on “uprooted people”, which determined the focus on the displaced and camp-based population as the target group. Hence, the programme was designed to primarily target the health of refugees and MDPs in the four border provinces, as well as to benefit the health of 2–3 million non-Thais living in the country.

The programme has been using national health security and the border health work as a leverage point for addressing the broader political issues surrounding the legal status of various migrant populations, by highlighting the close links between the overall public health situation in Thailand and the health status of non-Thai populations. Indeed, WHO programme activities have been promoting the health of migrants throughout the country, as is reflected in (gap) analyses, consultants’ reports, meetings/multistakeholder events and other deliverables. For instance, the in-depth analyses on health finance mechanisms, and a survey of Thai public opinions on refugees and displaced persons, propose improved approaches of relevance to the migrant health domain at large and can also provide useful lessons to share for international contexts. WHO has also supported avenues for additional funding of benefit to migrant populations, such as development of the regional proposal of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

**Governance: Border Health Master Plans, migrant health strategy**

On the policy front, a major development was the launching of the second Border Health Development Master Plan by the Minister of Public Health in August 2012. The Master Plan by the Bureau of Policy and Strategy offers a collaborative framework for relevant offices within the Ministry of Public Health, other line ministries, local administrative organizations, international organizations and NGOs, to develop the public health activities in border areas. It corresponds with the 11th national Economic and Social Development Plan, the National Security Plan, and the 11th National Health Development Plan and policy of the Ministry of Public Health. The plan seeks to address
gaps of border health, specifically in the areas of developing a quality health service system, increasing access to primary care services, and promoting participation from all relevant stakeholders. The plan covers Thai nationals living in border areas, registered and non-registered migrants, displaced persons living in temporary shelters, and ethnic minorities in border areas. It includes indicators under its defined strategies, which will facilitate the monitoring that will eventually be needed.

Since 2005, a Migrant Health Strategy has been drafted by a working group of public health officers and relevant agencies from policy and implementation levels, including both government and nongovernment organizations, under the auspices of the Bureau of Health Administration, Office of the Permanent Secretary. This plan covers a wide group of migrant populations, both registered and non-registered. It does not include displaced persons residing in temporary shelters. Its goals are similar to the Master Plans, aiming at accessible and quality health services for migrants, underlining collaboration among sectors and communities and improved monitoring of migrant health.

These two major policy documents together cover a considerable domain, including border health matters, as well as country-wide migrant health concerns.

WHO has been providing ongoing inputs to the development of both documents and, in its work, bridging the domains of border and migrant health. The Master Plan document spells out the role of WHO under the plan, including technical support; coordination and facilitation among stakeholders; development of information systems and surveillance systems; capacity-building to health officials; addressing public health threats; and collaboration with experts and academia to generate evidence for policymaking. The described roles correspond well to the ongoing WHO work.

A National Master Plan for HIV/AIDS Prevention, Care and Support for Migrants and Mobile Populations (2007–2011), which was developed and launched by the Department of Disease Control, aims to reduce new HIV infections among migrant and mobile populations and to increase the quality of life of HIV-positive migrants. It targets a broad range of migrants, including documented and undocumented migrants from neighbouring countries, workers, displaced person living in camps, and ethnic minorities.

**Migration trends that may impact strategies**

**Developments in the non-health sector**

The multisectoral aspect of migration health has been well documented. Addressing the health of migrants requires the action of several arms of governments, including health, migration, foreign affairs, interior and labour, to name a few. The ASEAN Economic Community (AEC) was mentioned by many informants, as well as the CCS document, as being likely to have a significant impact on migration flows in the region and Thailand in the near future. The country may well see continued inflow of migrants and also
see more people (skilled) leave, when migration within the region is facilitated. The health of future Thai migrants leaving the country, and their need for social protection in health for themselves and their family members, many of whom will be left behind, is unaddressed. In addition, demographic trends indicate that, for years to come, migrants will be required to strengthen the Thai workforce and Thai economy. Now is the time to ensure the health of migrants, and the public health impact of the wider AEC concept needs to be properly addressed.

**Disaster preparedness and response**

Experience shows that migrants living in Thailand have been seriously affected in emergency situations, e.g. flooding, tsunami. However, national preparedness plans (e.g. National Disaster Management Act) did not account for the considerable number of migrants living in the country and their possible problems in finding access to health services when in need. The CCS includes disaster preparedness and response under its five Partnership Priority Programmes of work. As part of current efforts, more emphasis is being placed under this priority programme on tourists, internally Thai displaced persons and affected migrants in Thailand. Some key informants underlined the cross-cutting nature of the migrant health topic in this respect.

**WHO contribution and added value**

**General**

Stakeholders interviewed unanimously described WHO as the credible and long-standing trusted and technical health agency, which can provide evidence-based advice and a neutral space to bring together the various arms of governments and different communities/countries, to ensure health messages are inserted in multisectoral debates at national, regional and global level. The work of WHO in Thailand, at border level as well as at central level, was considered of great value by many, as it has provided the examples needed for use elsewhere. It is recognized as not covering the entire spectrum of the migrant health agenda nationwide but as having the potential for wider impact.

**Sharing country experiences and multicountry coordination**

The RTG Ministry of Public Health has been vocal in relevant debates at regional as well as global level, such as the Global Forum for Migration and Development, World Health Assemblies, and global health and foreign policy debates. WHO facilitates and creates the opportunities for countries, such as Thailand, to present their experiences and learn from others and, moreover, to coordinate activities to enhance the health of migrants among countries of migrant origin, transit and destination. Experiences that are valuable to share are not limited to technical and disease-related topics such as TB or malaria but can relate to financing mechanisms, the image of migrants, and other management-related angles. Meetings convened by WHO over the course of the programme have shown how the Organization was able to offer a platform of open
dialogue between the ministries of health of different governments, which would have been difficult for the Thai government to achieve on its own.

**Sharing experiences and coordination within WHO**

While the technical team in WHO Thailand is small, it is understood that it has the ability to use the knowledge and expertise of other parts of the Organization. In addition, WHO Thailand can promote the topic and share experiences with the other countries and regions of WHO. Addressing migration requires close collaboration and coordination among countries and regions, and this applies to the Organization itself as well.

**Collaboration with other sectors at organizational level.**

Collaboration with other agencies is widely recognized but, according to some informants, there is room for a broader scope. For instance, there is little collaboration with the International Labour Organization, while the vast majority of migration flows are driven by the world of work. The ability of WHO to connect partners with relevant persons in the government, especially at provincial level, and provide quality advocacy and technical advice in the health domain, is pertinent. Where WHO as a health agency cannot find easy access to certain sectors, it can use the strength of its partner agencies, which can facilitate that access thanks to their complementary mandates.

**Perceived gaps**

**Positive image-building of migrants**

The economic contribution of migrants to Thailand is well known. However, the image of migrants remains poor, hampers integration in society and fuels marginalization. Positive image-building about life in a diverse society is required among the general population, as well as among health-care providers and policy-makers. Some reported that the negative image of migrants among the workforce may well undermine capacity-building efforts. WHO activities have, in fact, been addressing aspects of migrants’ image; for instance, a survey of Thai public opinion on Myanmar refugees and displaced persons provided relevant information for policy-making. In addition, events and messages organized by WHO promoted the positive image of migrant groups in the country. The fact that this topic was raised as a gap may well be a reflection of a lack of information sharing and consequent lack of knowledge by stakeholders of the scope of WHO’s work.

**Addressing health needs beyond infectious diseases**

Informants praised the work of WHO and its knowledge in several relevant technical areas, such as infectious disease control, health information systems, and epidemiology. Noncommunicable diseases were considered relevant but of less immediate concern by many. However, an area that many key informants reported could benefit the work, was capacity-building on mental health and substance abuse angles. Being a migrant in
a marginalized situation creates mental health concerns. Substance abuse has been a related problem that fuels risk behaviours and family violence. Other areas that seem to have been ignored are reproductive health and occupational health, considering the vast majority of migrants are workers who often work under degrading, dangerous and dirty conditions. Capacity-building of the health workforce at all levels on the full scope of health issues associated with migration and population mobility is considered to be still much needed.

It is noteworthy that within the Ministry of Public Health, and among partners, awareness of WHO’s contributions was highest with respect to infectious disease control. Some informants were not aware of the scope of the WHO programme but were aware of the particular contributions to infectious disease control provided by the WHO programme team members.

**Social health determinants and human rights**

Advocacy messages would benefit from stronger linkages with social determinants of health. Human rights, while addressed, could be underlined more. Social health determinants receive great attention from WHO nowadays, but this does not feature highly enough in the migrant health agenda in WHO Thailand.

**Conclusions**

**The strategy in the CCS**

All key informants considered the inclusion of migrant health and mobile populations into the CCS as positive. Some informants found it is not addressed sufficiently in the CCS, as it is only an “unfinished agenda”; others considered it a cross-cutting topic. WHO has given considerable priority to the topic, which may have been driven to some extent by the funding. However, there is a risk that, given its relatively low profile in the CCS 2012–2016, it is not given the priority that senior officials in the Ministry of Public Health and other organizations believe that it warrants.

**Migrant and border health policies**

The development of the second Border Health Development Master Plan and draft Migrant Health Strategy and related consultative processes have been impressive and a great accomplishment in themselves. Their respective future implementation would address the health of a broad range of still vulnerable populations and protect the public health of Thailand. The desired move at policy level, from solely addressing border health in a few provinces to a country-wide migrant health concept, illustrates the evolving appreciation of the scope of migration health in today’s diverse Thai society, and hopefully a changing attitude towards migrants and a recognition of their positive contribution towards the country’s development.
Terminology

Inconsistent use of terminology to describe different migrant groups has led to some confusion among stakeholders about targeted populations. Key informants shared the opinion that, for the sake of public health, the topic should be inclusive of the large interpretation of the concept of “migrants” and throughout the country, including border areas, registered or unregistered, documented or undocumented. It remains unclear whether tourists, as a “mobile population”, or internally displaced Thais should be considered as falling under the concept of “migrants and mobile population”. Meanwhile, major economic and development drivers of migration may well change the make-up of the migrant population in Thailand in the near future.

WHO programme

WHO’s work at provincial level, consistent with donor objectives, was appreciated by government and partner informants. Programme activities and outputs have been used wisely to advocate for the broader cause of migrant health. Recognizing the close linkages between border health and migrant health, the work of WHO has in reality been referred to as “border and migrant health” and indeed outputs and outcomes promote the health of all migrants in the country and are in line with the 2008 World Health Assembly resolution on the Health of migrants (1) and follow the spirit of Thailand’s Border Health Development Master Plan and draft Migrant Health Strategy.

A multisectoral approach to health security and the role of WHO

Adequate health security for various migrant groups, including unregistered migrants, refugees and displaced persons in Thailand, will require solutions on the political status of these people, which are beyond the scope of the WHO as a health agency and the scope of the Ministry of Public Health. WHO, in close collaboration with its partners, is in a unique position as the credible technical agency to bring together the various arms of governments, different communities and countries, to ensure health concerns are understood and integrated in multisectoral debates that drive migration and determine migrants’ status in countries. Health should not become an afterthought but be at the forefront of the regional economic and development debates. Only WHO can take on this role adequately.

Information sharing

Migrant health, by default, connects countries and regions, which implies intercountry and interregional collaboration within WHO. Part of this issue relates to information and experience sharing, which is needed within WHO and can be improved among partners. Information sharing and raising awareness of ongoing activities has also been challenging among the various Ministry of Public Health departments.
Recommendations

Focus on strengths and mandate

WHO, in its country programme, should continue to give priority to the topic of border and migrant health. In the next 2 years, and in light of the ongoing EU-funded programme, it should consolidate established programme structures and accomplishments and focus on its core strengths; establish and support migrant health dialogues and cooperation across sectors and among regions and countries of migrant origin, transit and destination; and raise awareness and promote the health of migrants at multisectoral and multicountry dialogues in migration, and economic and development domains.

Accounting and preparing for additional migrant groups

Reflection on the expected migration trends in the near future, and the drivers behind such trends, can benefit continued policy and strategy development. The Border Health Development Master Plan, the Migrant Health Strategy and possible future strategies can be an opportunity to prepare for future trends that are inclusive of the full spectrum of migrant populations of relevance to the public health situation in Thailand.

Addressing the full scope of border and migrant health challenges

The capacity of the health and relevant non-health workforce needs strengthening, to appreciate and address health and social issues associated with migration, beyond infectious disease control, and to underscore the social determinants of migrant health and human rights as cross-cutting factors.

Implementation and monitoring of Ministry of Public Health policies

Finalization and endorsement of the Migrant Health Strategy has high priority. Equally relevant is monitoring of the implementation of both the Migrant Health Strategy and the Border Health Development Master Plan, incorporating a public health approach to the health of migrants and providing equal access to migrant-friendly health services for all border populations and migrants, regardless of their status.

Multisectoral policy coherence

Enhancing migrant health requires the promotion of coherence among policies and regulations within the health sector and among other sectors that affect migrants’ ability to access adequate health services.

Focal person in the Ministry of Public Health

Sustainment of a strong coordination point within the Ministry of Public Health can enhance information sharing and increase efficient use of existing knowledge and expertise, benefiting ministries and agencies working in this area, including WHO.
Reference

The World Health Organization (WHO) Country Cooperation Strategy (CCS) is WHO’s key instrument to guide its collaboration in and with a country, in support of its national health agenda. The WHO Country Cooperation Strategy Thailand 2012–2016 was developed through an extensive and broad consultation process. This was the fourth WHO CCS for Thailand but a very different, innovative approach was proposed for working in five priority areas. The CCS called for WHO to undertake a mid-term review of the CCS, which was agreed by the Ministry of Public Health. This document presents the findings and recommendations of this mid-term review.