Country Office Evaluation

- Thailand -

(Volume 2: Report Annexes)

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World Health Organization

WHO Evaluation Office

Table of contents

Annex 1: Terms of Reference

I. Introduction

1. Country Office Evaluations (COE) are part of the Organization-wide evaluation workplan approved by the Executive Board in January 2016. The workplan clarifies that COEs "*will focus on the outcomes/results achieved by the country office, as well as contributions through global and regional inputs in the country. In addition these evaluations aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context"*. They encompass the entirety of WHO activities during a specific period. The COEs provide lessons that can be used in the design of new strategies and programmes in-country.
2. The Thailand COE is the first country office evaluation undertaken by WHO Evaluation Office. The evaluation will cover period of the Country Cooperation Strategy (CCS) 2012-2016.

II. Country context

3. Thailand is an upper-middle-income country since 2010[1] whose human development index increased from 0.69[2] (medium human development group) in 2012 to 0.72[3] (high human development group) in 2014. However, its annual Gross Domestic Product growth rate of 7.5 percent in 2012 decreased to 2.8 percent in 2015.[4] Poverty is mostly a rural phenomenon with varying incidence across the regions. The Northeast is the poorest region and is home to almost half the country's poor. Similarly significant progress towards MDG achievement hides persistent disparities among regions and social groups.[5] In addition, while there has been significant progress on the major communicable diseases, morbidity, mortality and disability due to noncommunicable diseases have continued to rise.
4. The 11th National Economic and Social Development plan (NESDP) 2012-2016 emphasizes equity issues which are translated in the vision of the 11th National Health Development Plan covering the same period. This plan includes five strategies as follows:
    1) Strengthen partners for health promotion and self-reliance in health with Thai wisdom
    2) Further develop systems for monitoring, warning and management of disasters, accidents and health threats
    3) Focus on health promotion, disease prevention and consumer protection in health for Thais to be physically, mentally, socially and spiritually healthy
    4) Strengthen health-care systems with quality and standards at all levels in response to health needs of all age groups and improve seamless referral systems
    5) Create national mechanisms for enhancing the efficiency of health-care system governance and resources management systems
5. As reported in the CCS 2012-2016, a unique feature of the health sector in Thailand is that in addition to the Ministry of Public Health there are other key public health agencies operating side by side with the Ministry, such as the Health Systems Research Institute, the Thai Health

[1] http://data.worldbank.org/country/thailand?view=chart (downloaded 7 December 2016).
[2] http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf (downloaded 7 December 2016).
[3] http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf (downloaded 7 December 2016).
[4] http://data.worldbank.org/country/thailand?view=chart (downloaded 7 December 2016).
[5] WHO, 2016," Needs assessment for the selection of priorities for the Thailand-WHO Country Cooperation Strategy".

Promotion Foundation and the National Health Commission. In addition, there are 34 WHO collaborating centres. The civil society is also a powerful actor in health development.

6. In 2012, the Official Development Assistance (ODA) for health commitment represented 7% of overall ODA commitments.[6] According to the OECD,[7] in 2014, ODA mainly came from the United States, followed by France and Japan to a much lesser extent as well as from WHO, the Asian Development Bank and UNAIDS.

7. While a recipient of ODA, Thailand is also providing ODA to neighbouring countries and making major contributions to global health development. Thailand is financially supporting WHO activities in country. Partnership in health is therefore a key strategy for health development in the country.

8. The United Nations have developed a partnership framework (UNPAF) for 2012-2016 aligned with the development strategies identified in the 11th NESDP, underlining the importance of a two-way partnership of knowledge and experience sharing.

III. WHO activities in Thailand

9. WHO is present in Thailand since 1949. The health sector landscape considerably changed over the recent past: many new actors (both at national and international level) have emerged and partnerships multiplied.

10. Table 1 below identifies briefly the main areas of activities undertaken in the WHO Country Office (WCO) and corresponding levels of investment.

Table 1: CCS and non-CCS implementation (HR & activity combined in US$)
3 biennia as of 8 June 2016

Programs		2012-13	2014-15	2016-17	Total	%
CCS priorities						
1	Community Health	1123171			1123171	5.94%
2	Noncommunicable Diseases	190439	780524	169435	1140398	6.03%
3	Disaster Management	2644885	78782	150586	2874253	15.21%
4	International Trade and Health	546468	319882	93991	960341	5.08%
5	Road Safety	112911	493031	245120	851062	4.50%
Other CCS activities						
	Ageing		67677	13022	80699	0.43%
	Border and Migrant Health	501724	1403488	160558	2065770	10.93%
	Antimicrobial Resistance			49798	49798	0.26%
Other activities						
	International Health Regulations	491208	138720	95773	725701	3.84%
	Tuberculosis Control	563541	275806	90937	930284	4.92%
Non CCS activities		627272	1430863	360042	2418177	12.79%
WHO Country Office		2671862	2500473	509940	5682275	30.06%

Source: Final evaluation of WHO CCS Thailand 2012-2016

11. The CCS 2012-2016 was WHO's key instrument to guide its collaboration with the Royal Thai Government, in support of the national health agenda as formulated in the 11th National Health

[6] See WHO, 2014, "From whom to whom? ODA for health fourth edition 2002-2012".
[7] http://stats.oecd.org/Index.aspx?QueryId=58193 (downloaded 8 December 2016).

Development Plan 2012-2016. It provides the strategic direction for WHO's contribution in-country. The WHO activities are all run from Bangkok.

12. The strategic agenda of WHO as described in the CCS identifies four clusters of activities: 1) five priority areas; 2) normative functions; 3) major public health challenges and unfinished agendas; and 4) support for Thailand's role in health beyond its borders.

13. Over the years, a large network of WHO collaborating centres has evolved and is being constantly updated. As of 8 December 2016 there were 34[8] of them in the country.

14. The WCO conducted a mid-term review[9] of the CCS in 2014 and its final evaluation mid-2016.[10] It mainly concluded that the CCS was well aligned with the country's health priorities. It has oriented most of WHO's resources towards the priority programmes. Most of the activities have been implemented and have contributed to the stated objectives. The method of working through lead agencies and multisectoral committees has been a partial success and holds promise for the future. Its main recommendations can be summarized as follows:
    a. have a clear development process for the next CCS
    b. have clear criteria for lead agency selection
    c. continue to foster multisectoral work but perhaps involve the MOPH more
    d. recognise that multisectoral work requires specific technical skills
    e. explore lighter management processes
    f. move the oversight committee towards more sustainable funding over time
    g. slow down the rate of turnover of key personnel
    h. continue pushing multisectoral working methods in spite of obstacles.

15. In 2016, the WCO also conducted a needs assessment for the selection of priorities for the next CCS as well as a functional review of its office. All these elements informed the CCS 2017-2021, about to be finalized with the Royal Thai Government.

IV. Objectives and scope of the COE

16. The main purpose of the COE is to identify and document best practices and innovations of WHO in Thailand on the basis of its achievements. These include not only results of the WCO but also contributions from the regional and global levels in-country.

17. As all evaluations, this COE meets accountability and learning objectives. It will be publicly available and reported on through the annual Evaluation Report. This evaluation will build on the results of previous evaluative work to:

    a. Demonstrate achievements against the objectives formulated in the CCS (and other relevant strategic instruments) and corresponding expected results developed in the WCO biennial workplans, while pointing out the challenges and opportunities for improvement.

    b. Support the WCO and partners to operationalize the various priorities of the next CCS (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learnt.

    c. Identify best practices emerging from the unique relationship between the Royal Thai Government and WHO as exemplified during the current CCS. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

[8] http://apps.who.int/whocc/List.aspx?cc_code=THA (downloaded 8 December 2016).
[9] http://apps.who.int/iris/handle/10665/161132 (downloaded 8 December 2016).
[10] WHO, 2016, Final Evaluation of WHO Country Cooperation Strategy Thailand 2012-2016.

18. The evaluation will cover all activities undertaken by WHO (WCO, regional office and headquarters) in Thailand as framed in the CCS 2012-2016 and other strategic documents covering activities not part of the CCS that took place over that period of time. In addition it will also include the development process of the new CCS 2017-2021 which will be finalized by the time the evaluation starts.

V. Stakeholders and users of the evaluation

19. Table 2 shows the role and interest of the main evaluation stakeholders and expected users of the evaluation.

Table 2: preliminary stakeholders' analysis

Internal stakeholders	**Role and interest in the evaluation**
WCO Thailand	As lead for the development and implementation of the CCS, the CO is the main stakeholder of the evaluation because it has an interest in enhancing accountability of WHO in-country as well learning from evaluation results for future programming
WHO Regional Office for South East Asia	As a contributor to the development of the CCS, the Regional Office has a direct stake in the evaluation in ensuring that WHO's contribution in-country is relevant, coherent, effective and efficient. The evaluation findings and best practices in Thailand will be directly useful to inform other WCOs in the Region as well as regional approaches in health.
Headquarters management	The results of the evaluation should be of interest as headquarters management is in charge of coordination of the CCSs and strategic analysis of its content and implementation and is responsible for promoting application of best practices in support of regional and country technical cooperation.
Executive Board	The Executive Board has a direct interest in being informed about the added value of WHO's contributions in countries and will be kept abreast of best practices as well as challenges through the annual evaluation report.
External stakeholders	
All individuals in Thailand	WHO's action in Thailand has to ensure that it benefits all population groups, prioritize the most vulnerable and does not leave anyone behind The evaluation will look at the way WHO addresses equity and ensures that all population groups are considered in the various policies and programmes.
Royal Thai Government	As a donor and recipient of WHO's action, it has an interest in ensuring that the partnership with WHO and the future programming under the new CCS is the most relevant, effective and efficient. Considering its engagement in international health development, it also has an interest in seeing its best practices independently assessed and disseminated. In addition to the Ministry of Public Health, there are a large number of public health partners in-country who all have an interest in the evaluation.
UN Country Team	WHO contributes to several outcomes of the UNPAF alongside other UN agencies. There is therefore an interest for the UNCT (and UNAIDS in particular) to be informed about WHO's achievements and be aware of the Royal Thai Government's best practices in the health sector.
Donors	In addition to Thailand, other donors such as the United States, Australia

	Canada and philanthropic foundations, have an interest in knowing whether their contributions have been spent effectively and efficiently and if WHO's work contributes to their own strategies and programmes.

VI. Evaluation questions

20. All COEs address the 3 main EQs identified below. The sub-questions are then tailored according to the country's specificities and detailed in an evaluation matrix to be developed during the inception phase by the evaluation team. Sub-questions have been tailored taking into account the timing of this COE and the available evaluative information. Good practices and lessons learned will be identified across the findings.

EQ1 - Were the strategic choices made in the CCS (and other relevant strategic instruments) **the right ones to address Thailand's health needs and coherent with government and partners' priorities?** (relevance)

21. This question assesses the strategic choices made by WHO at the CCS design stage and its flexibility to adapt to changes in context. **This question will assess both the CCS 2012-2016 and the new CCS 2017-2021 design** which will be finalized by the time the evaluation starts. **When addressing each evaluation sub-question the evaluation team will build on past evaluative information and seek to identify best practices in the design process of the new CCS.** The evaluation sub-questions focus on the following elements:

    1.1 Are the CCSs based on a comprehensive health diagnostic of the entire population and on Thailand's health needs?
    1.2 Are the CCSs coherent with the national health development plans, any other relevant national health strategies and the MDG and SDG targets relevant to Thailand?
    1.3 Are the CCSs coherent with the UNPAF? And are the key partners clear about WHO's role in Thailand?
    1.4 Are the CCSs coherent with the General Programme of Work and aligned with WHO's international commitments?
    1.5 Has WHO learned from experience and changed its approach in view of evolving contexts (needs, priorities, etc.) between both CCSs but also during the course of the CCS 2012-2016?
    1.6 Are the CCSs strategically positioned when it comes to:
        i. Clear identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?
        ii. Capacity of WHO to position health priorities (based on needs analysis) in the national agenda and in those of the numerous national partners in the health sector?
        iii. Specificities of the partnership between WHO and the Royal Thai Government especially in view of the numerous actors involved in the national health sector? And has this positioning evolved between the two CCSs? If so how?
        iv. Reflecting the contribution of WHO in terms of intellectual and social capital.

EQ2 - What is the contribution/added value of WHO towards addressing the country's health needs and priorities? (effectiveness/elements of impact/progress towards sustainability)

22. To address this question the evaluation team will build on the analysis of results per programme area already presented in the CCS 2012-2016 evaluation conducted earlier this year and will focus on the best practices and innovations observed for the following:

2.1 To what extent were the country biennial work plans (operational during the evaluation period) articulated with the focus areas as defined in the CCS (and other relevant strategic instruments) document (or as amended during course of implementation)?
2.2 What were the main results achieved for each outcome, output and deliverable for WCOs as defined in the country biennial work plans, especially in terms of intellectual and social capital ?
2.3 What has been the added value of regional and headquarters contributions to the achievement of results in-country?
2.4 What has been the contribution of WHO results to long-term changes in health status in-country?
2.5 Is there a national ownership of the results and capacities developed?

EQ3 – How did WHO achieve the results? (efficiency)

23. In this area the evaluation sub-questions will mainly cover the contribution of the core functions, the partnerships and allocation of resources (financial and staffing) to deliver the expected results and, for each, will seek to identify best practices and innovations.

3.1 What were the key core functions most used to achieve the results?
3.2 How did the strategic partnerships contribute to the results achieved?
3.3 How did the funding levels and their timeliness affect the results achieved?
3.4 Was the staffing adequate in view of the objectives to be achieved?
3.5 What were the monitoring mechanisms to inform CCS implementation and progress towards targets?
3.6 To what extent has the CCS been used to inform WHO country work plans, budget allocations and staffing?

VII. Methodology

24. Guided by the *WHO Evaluation Practice Handbook*, the evaluation will be based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning.

25. During the inception phase the evaluation team will design the methodology which will entail the following:

- Adapt the **theory of change** developed for the evaluation of WHO's presence in countries. The theory of change to frame the COE Thailand will: i) describe the relationship between the CCS strategic priorities, the focus areas and the activities and budgets as envisaged in the biennial work plans; ii) clarify the linkages with the General Programme of Work and programme budgets, and iii) identify the main assumptions underlying it.
- Develop and apply **an evaluation matrix**[11] geared towards addressing the key evaluation questions taking into account the data availability challenges, the budget and timing constraints.
- Adhere to WHO cross-cutting strategies on **gender, equity and human rights** and include to the extent possible disaggregated data and information.

[11] An **Evaluation Matrix** is an organizing tool to help plan for the conduct of an evaluation. It is prepared by the evaluation team during the inception phase of the evaluation, and is then used throughout the data collection, analysis and report writing phases. The Evaluation Matrix forms the main analytical framework for the evaluation. It reflects the key evaluation questions and sub-questions to be answered and helps the team consider the most appropriate and feasible method to collect data for answering each question. It guides analysis and ensures that all data collected is analysed, triangulated and used to answer the evaluation questions and make conclusions and recommendations.

- Follow the principles set forth in the *WHO* ***Evaluation Practice Handbook*** *and* the United Nations Evaluation Group (UNEG) **norms and standards for evaluations** and **ethical guidelines**.

26. The methodology should demonstrate impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach to ensure triangulation of information through a variety of means.

27. The COE will rely mostly on the following **data collection methods**:

    a. Documents review will include analysis of key strategic documents, such as the general programmes of work, the programme budgets, the WCO workplan and budget, the CCS (and other relevant strategic instruments), the UNDAF, relevant national policies, strategies and other relevant documentation.

    b. Stakeholder interviews. Interviews will be conducted with external and internal stakeholders at global, regional and country levels of the Organization. External stakeholders for this evaluation are: ministry of health officials and officials of other relevant governmental institutions; healthcare professional associations and other relevant professional bodies; relevant research institutes, agencies and academia; health care provider institutions; NGOs and civil society; UN Agencies and other relevant multilateral organizations; donor agencies; and other relevant partners.

    c. Mission in-country. Following the document reviews and some stakeholder interviews, the country visit will be the opportunity for the evaluation team to develop an in-depth understanding of the perspectives of the various stakeholders around the evaluation questions and collect additional secondary data, in particular from external stakeholders. Depending on the need, the mission might include field visits.

28. **Stakeholder consultation**. In addition to acting as key informants during the evaluation process, both internal and external stakeholders will be consulted at the drafting stages of the terms of reference, inception note and evaluation report and will have the opportunity to provide comments.

29. **Limitation**. No major primary quantitative data collection is envisaged to inform this evaluation. The evaluation team will mainly use data (after having assessed their reliability) collected by WHO and partners during the timeframe evaluated.

VIII. Phases and deliverables

30. The evaluation is structured around five phases summarized in Table 3 below.

Table 3: Summary tentative timeline – key evaluation milestones

Main phases	Timeline	Tasks and deliverables
1. Preparation	December 2016 January 2017	Draft and final TOR Evaluation team contracted
2. Inception	Jan –Feb 2017	Desk review of existing literature, HQ and RO Briefings Draft and final inception note
3. Data collection and analysis	Feb- March 2017	Key interviews with HQ and RO WHO staff Country visit Aide memoire of key findings (PPT)
4. Reporting	March 2017	Draft and final evaluation report
5. Management	April 2017	Management response to the evaluation

response and dissemination		recommendations Dissemination of evaluation results

31. **Preparation**. These TOR are prepared following the *WHO Evaluation Practice Handbook*. The final version of the TOR takes into consideration results of consultations with key internal and external stakeholders.

    ⇨ **Final TOR**

32. **The inception phase** will start with a first review of key documents and briefings with HR, RO and WCO. During the inception phase, the evaluation team will assess the various logical/results frameworks and their underlying Theory of Change. The inception note will close this phase. Its draft will be shared with key internal stakeholders (HQ, RO and CO levels) for their feedback.

    ⇨ **Inception note.** It will be prepared following the Evaluation Office template and will focus on methodological and planning elements. It will present, taking into account the various logical/results frameworks and evaluation questions, a detailed evaluation framework and the evaluation matrix. Data collection tools and approaches will be clearly identified in the evaluation matrix.

33. **Data collection and analysis**. This phase will include additional document review, key stakeholder interviews at HQ and RO levels and a country visit. The mission will start a briefing to the WCO and key partners and end with a debriefing with the same group.

    ⇨ **Aide memoire** of key findings to be prepared at the end of the country visit to be used to support the debriefing with the stakeholders.

34. **Reporting.** This phase is dedicated to the in-depth analysis of the results of the data and documents analysis and of the data collected through the field work. The results of this analysis will be presented in the evaluation report. The draft evaluation report will be shared with key internal and external stakeholders for comments.

    ⇨ **Evaluation Report** will be prepared in accordance with the *WHO Evaluation Practice Handbook*; it will provide an assessment of the results according to the evaluation questions identified above. It will include conclusions based on the evidence generated in the findings and draw actionable recommendations.

35. *To be noted: Submission of revised versions of any of the deliverables by the evaluation team will be accompanied by a feedback on each comment provided. This feedback will succinctly summarize if and how comments were addressed and, if they were not, it will justify why.*

36. **Management response and dissemination of results**. The management response will be prepared by the WCO and posted on the internet once finalized alongside the evaluation report. Dissemination of evaluation results and contribution to organizational learning will be ensured at all levels of the Organization as appropriate.

IX. Evaluation team

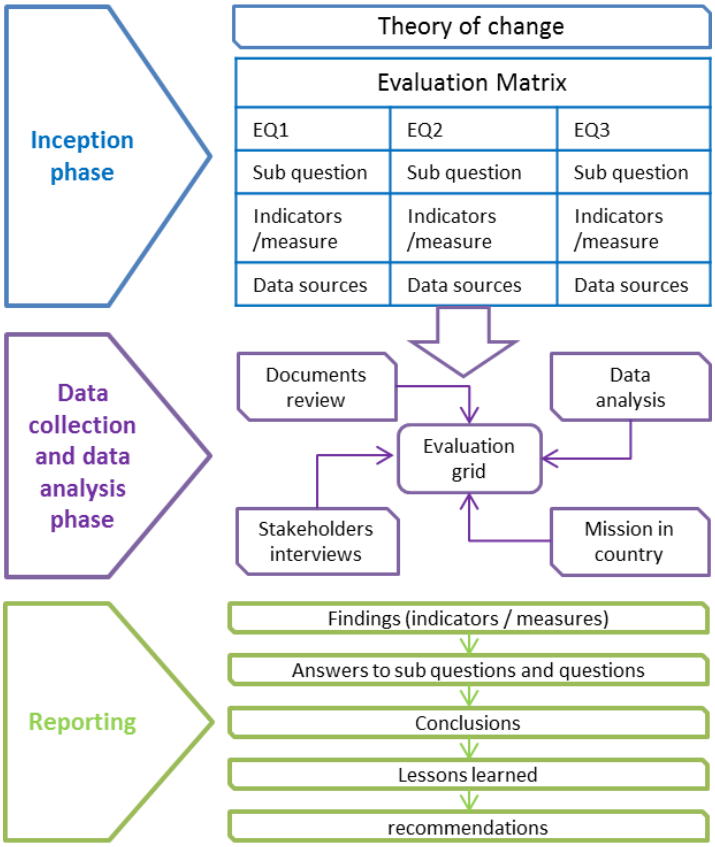
37. The evaluation team will include two senior consultants and the Chief Evaluation Officer and will be led by the DG Representative for Evaluation and Organizational Learning. Together they bring the relevant expertise in terms of expertise in evaluation, health and WHO's governance mechanisms.

Annex 2: Evaluation methodology and evaluation matrix

This annex summarizes the approach adopted in this COE and the main methods and tools employed. It draws on the inception note.

Guided by the *WHO Evaluation Practice Handbook*, the overall methodological approach adopted by the evaluation team is summarized in Figure 1. This shows the sequencing and interrelationship of activities under each of the three main phases of the evaluation process. Concretely, the evaluation was conducted between January and May 2017 by a core team of four members.

Figure 1: Methodological approach



Inception phase

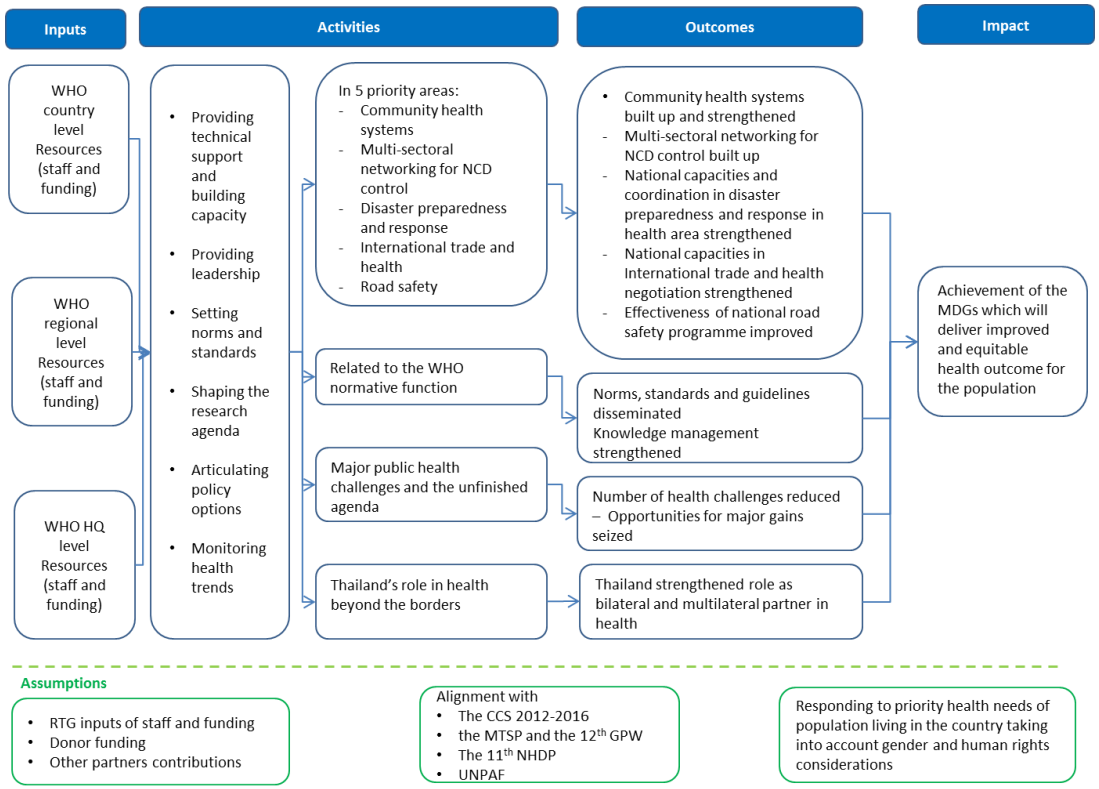
a. Theory of change underlying WHO's contribution in Thailand

In the absence of an explicit logic model or theory of change (TOC) to frame the contributions of WHO in Thailand over the evaluation period, the evaluation team reconstructed a TOC that clarifies WHO's contribution to the national health objectives and goals in terms of health outcomes and potentially the health impact of its collaborative programmes with the Government of Thailand, as defined in the CCS and the biennial work plans.

The TOC aims to encompass contributions from all levels of the Organization and all strategic contribution areas of WHO in the country. The TOC is aligned with that validated by WHO in the

context of the evaluation of WHO's presence in countries[12] and was validated by the WR and WCO team during the field mission.

Figure 1: Theory of Change (TOC) – WHO contribution in Thailand 2012-2016[13]



b. Evaluation matrix

Using the TOC, the evaluation team developed an evaluation matrix which defines specific indicators/measures for assessing each sub-question and indicates what data collection method and data sources will be used to inform each of these. The evaluation matrix is available at the end of this Annex.

c. Inception note

The inception note was prepared following the Evaluation Office template and focused on methodological and planning elements of the evaluation. It presented, taking into account the various logical/results frameworks and the evaluation questions, a detailed evaluation framework and the evaluation matrix. Data collection tools and approaches were clearly identified in the evaluation matrix. It was shared with the WCO prior to the mission for their comments.

Data collection phase

The evaluation team used a pragmatic mixed-methods approach in addressing the evaluation questions. The evaluation matrix details for each sub-question the main data collection methods. To this end, different instruments have been employed and evidence from different sources triangulated.

[12] See WHO, 2015, Evaluation of WHO's presence in Countries.
[13] The main framing document of the theory of change is the CCS 2012-2016.

a. Documents review

The evaluation matrix identified key documents that were reviewed prior to the mission. Relevant information has been extracted to address the corresponding sub-questions. A preliminary review of documents available had shown limitations in terms of data availability as some of the sub-questions do not easily lend themselves to quantitative assessment. This reinforced the case for combining careful review of different data sources.

b. Stakeholder interviews

These have been the main form of primary data collection. The evaluation team conducted a large number of interviews (list available in Annex 5) with WHO colleagues at the three levels of the Organization as well as with all main partners in-country. Care was taken to ensure that the interviewees felt comfortable to express their opinions. The evaluation used a combination of individual and group interviews across the different activities. In practice, individual interviews were usually the most useful in providing detailed information and opinions. Group interviews, on the other hand, provided helpful insights into retrospectively understanding the processes of decision-making (which have often not been systematically recorded) as well as the implementation processes (where participants identified what elements fed into decisions, and how the implementation process took place over time). By default all interviews have been treated as confidential by the evaluation team.

c. Country mission

Planned after the document review, it took place in February 2017 and was the opportunity for the evaluation to complement the information gathered through stakeholder interviews. The mission started with a briefing with the WCO. An in-country feedback session was organized at the end of the mission with the WCO.

d. Data analysis

The evaluation team triangulated all information collected and compiled information in an evaluation grid structured by evaluation question (EQ), sub-question and indicator. Evaluation findings were then drawn only after a thorough cross-checking and triangulation of all information related to each EQ. This ensured that answers to EQs were based on solid and cross-checked evidence. The evaluation team identified a certain number of challenges to address some of the evaluation questions, which are described below.

Reporting

On the basis of the cross-checked evaluation findings, the team formulated answers to the evaluation questions. These answers informed the drafting of the conclusions. These included, to the extent possible, lessons learned and best practices identified in the course of the evaluation to further strengthen the current CCS.

Finally, the evaluation team provided practical, operational recommendations for future adjustments and actions. Each recommendation is based on the answers to evaluation questions and overall conclusions, which in turn will be linked to evaluation findings per evaluation question and ultimately to the data collected.

Gender, equity and human rights

The evaluation ensured that gender, equity and human rights issues were addressed to the extent possible and through several means. A number of sub-questions within the evaluation matrix are gender sensitive with appropriate related indicators. The document review paid specific attention to how these issues were addressed at planning, implementation, monitoring and evaluation stages of WHO contributions. Finally, these dimensions have been reflected in the interviews.

Limitations of the evaluation

The evaluation encountered a few other relevant issues already identified to some extent in the mid-term review and in the CCS final evaluation:

- Though there are broad linkages between the CCS and other WHO corporate planning and reporting tools, these are not clear enough to identify outputs and outcomes specific to the CCS within the WCO work plans.
- In the absence of a clear theory of change or of a logical or result framework, the corporate outcomes and outputs defined in the programme budget are not systematically translated at country level with corresponding benchmarks and quantified targets.
- Considering that WHO's expected contribution to national programmes prioritized in the CCS is not systematically identified at the planning stage, it was challenging to establish the extent to which activities undertaken contribute to the achievement of objectives defined in national programmes, plans or strategies.
- No major primary quantitative data collection was undertaken to inform this evaluation. The evaluation team mainly used existing data collected by WHO and partners during the timeframe evaluated.

Considering the limitations identified above, the evaluation team could only assess progress for each of the main outcome groups identified in the TOC but was not able to measure them against planned targets as they were not identified in a measurable manner.

Evaluation matrix

Evaluation sub-questions	Indicator/measure	Main source of information
EQ1 - Were the strategic choices made in the CCS (and other relevant strategic instruments) **the right ones to address Thailand's health needs and coherent with government and partners' priorities?** (relevance)		
1.1 Are the CCSs based on a comprehensive health diagnostic of the entire population and on Thailand's health needs?	- Availability in both CCSs of a comprehensive health diagnostic inclusive of gender-related issues and covering all populations (minorities, migrants) living in Thailand - Changes in health issues/challenges between the two CCSs	**Documents review** - WHO MTR[14] - WHO Global Health Observatory data - UNICEF MICS 2012 - WB indicators for Thailand - Needs assessment for the selection of priorities for the CCS 2017-2021
1.2 Are the CCSs coherent with the national health development plans, any other relevant national health strategies and the MDG and SDG targets relevant to Thailand?	Level of alignment of health priorities identified in both CCSs with: - Priorities of the health development plans - MDG targets in Thailand - SDG targets in Thailand	**Documents review** - WHO MTR - 11th National Health Development plan (2012-2016) - MDG indicators (latest national report is 2009) - SDG indicators - Needs assessment for the selection of priorities for the CCS 2017-2021
1.3 Are the CCSs coherent with the UNPAF? Are the key partners clear about WHO's role in Thailand?	- Level of alignment of both CCSs with the UNPAFs	**Document review** - UNPAF 2012-2016 **KII** : UNDP - WCO
	- Level of clarity among partners about the role of WHO in Thailand	**Documents review** - MTR and final evaluation **KII** - WCO - Government - MOPH - Natational health institutions? (CCS pages 23-25) - WB? - UNDP, UNICEF, UNFPA, UNWOMEN - Main donors to WHO? - Civil society?

[14] MTR = Mid-term review of the WHO CCS Thailand 2012-2016 , WHO 2014.

Evaluation sub-questions	Indicator/measure	Main source of information
1.4 Are the CCSs coherent with the General Programme of Work and aligned with WHO's international commitments?	Level of coherence between the CCSs and: - MTSP - GPW	**Documents review** - MTR and final evaluation - MTSP - 11th and 12th GPWs
And do they support good governance, gender equality and the empowerment of women?	Availability of explicit reference in both CCS docs to: - good governance - gender equality and empowerment of women	**Document review** - CCSs **KII.** - WCO
1.5 Has WHO learned from experience and changed its approach in view of evolving contexts (needs, priorities, etc.) between both CCSs but also during the course of the CCS 2012-2016?	- Changes of orientation in the implementation of the CCS 2012-2016 and rationale for these changes - Differences between both CCSs based on: o Changes in health needs o Changes in RTG priorities o Changes in WHO regional/global priorities?	**Document review** - CCSs - MTR - Final evaluation **KII.** - WCO - RO
1.6 Are the CCSs strategically positioned when it comes to:	- Indication of best practice in terms of strategic positioning	**Documents review** - Both CCSs - Any relevant WCO documents - MTR and final evaluation **KII.** - WCO - Government - MOPH - National health institutions? (CCS pages 23-25) - WB? - UNDP, UNICEF, UNFPA, UNWOMEN - Main donors to WHO? - Civil society?
1.6.1 Clear identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?	- Explicit elements of WHO's comparative advantage identified in both CCSs - Explicit strategy to value the comparative advantages identified	
1.6.2 Capacity of WHO to position health priorities (based on needs analysis) in the national agenda and in those of the numerous national partners in the health sector?	- Clear linkages between CCS priorities and most important health needs in the country as identified in the health diagnostic (see 1.1) - Indication of role played by WHO in the development of the national health agenda - Indication of role played by WHO in development of main national partners in the health sector	
1.6.3 Specificities of the partnership between WHO and the Royal Thai Government especially in view of the numerous actors involved in the national health sector? And has this positioning evolved between the two CCSs? If so how?	- Indication of partnership elements in both CCSs - indication of evolution between both CCSs - Reasons for change in partners - Reasons for evolution within continuing partners	

Evaluation sub-questions	Indicator/measure	Main source of information
1.6.4 Reflecting the contribution of WHO in terms of intellectual and social capital	- indication of WHO's role in intellectual and social capital	
EQ2 - What is the contribution/added value of WHO towards addressing the country's health needs and priorities? (effectiveness/elements of impact/progress towards sustainability)		
2.1 To what extent were the country biennial work plans (operational during the evaluation period) articulated with the focus areas as defined in the CCS (and other relevant strategic instruments) document (or as amended during course of implementation)?	- availability of explicit linkages between the work plans and the focus areas described in the CCS 2012-2016 - Weight (and trend) of activities in work plans not included in the CCS and rationale for their inclusion in the work plans	**Documents review**: - Biennial work plans - Others? **KII:** - WCO management and various programme managers/lead?
2.2 What were the main results achieved for each outcome, output and deliverable for WCOs as defined in the country biennial work plans, especially in terms of intellectual and social capital ?	- Level of achievement for each CCS priorities and other key activities within and outside the CCS - Identification of best practices especially in terms of intellectual and social capital	**Documents review**: - Previous evaluations - Other relevant documents **KII:** - WCO management and various programme managers / lead ? - Main partners for programmes with key achievements identified in the MTR and final eval
2.3 What has been the added value of regional and headquarters contributions to the achievement of results in-country?	- Indication of HQ and/or RO contributions to CCS development (both) - Indication of HQ and/or RO contributions to specific activities in Thailand - Indication of participation of Thai partners in regional or global initiatives/capacity development opportunities directly linked to CCS priorities - Identified best practices	**KII** - WCO - RO? - HQ? - Partners?
2.4 What has been the contribution of WHO results to long-term changes in health status in-country?	- Indication of long-term WHO engagement in selected areas of work - Perception of stakeholders on WHO's role with regard to changes in these areas - Identified best practices	**Document review** - CCS 2008-2012 ? **KII** - WCO - Government - MOPH - National health institutions? (CCS pages 23-25) - WB?

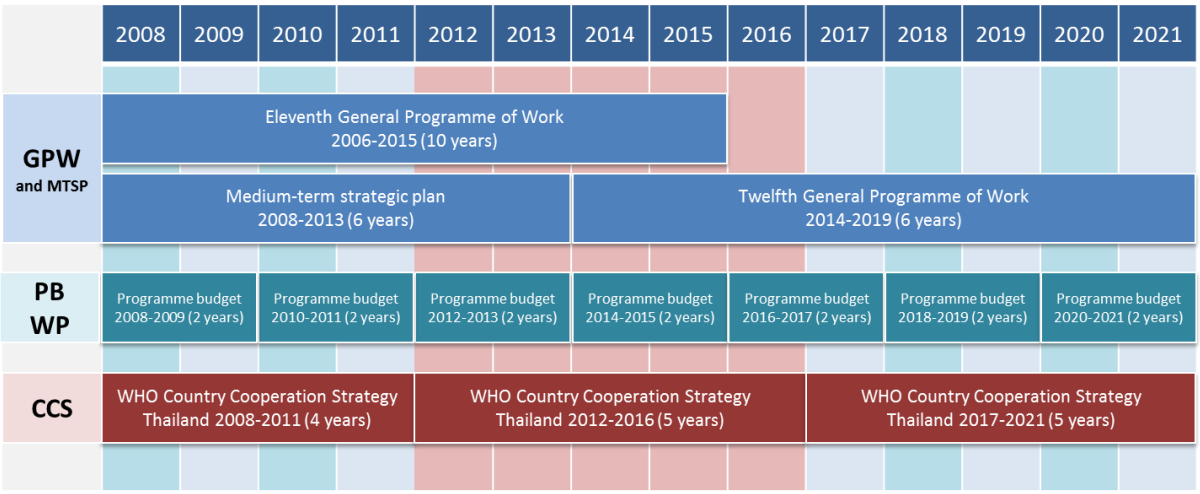
Evaluation sub-questions	Indicator/measure	Main source of information
		- UNDP, UNICEF, UNFPA, UNWOMEN - Main donors to WHO? - Civil society?
2.5 Is there a national ownership of the results and capacities developed?	- Indication of key areas of national capacities developed - Indication of changed practices among partners following WHO support and capacity development activities - Indication of continued activities by national partners following end of WHO support - Identified best practices	**Document reviews** - MTR and final evaluation **KII** - WCO - Government - MOPH - National health institutions? (CCS pages 23-25) - WB? - UNDP, UNICEF, UNFPA, UNWOMEN - Main donors to WHO? - Civil society?
EQ3 – How did WHO achieve the results? (efficiency)		
3.1 What were the key core functions most used to achieve the results?	- Reference to core functions supporting achievement of results in MTR and final evaluation - Linkages between activities in programme budgets and core functions - Perception of stakeholders about WHO functions most used - Identified best practices	**Document reviews** - MTR and final evaluation - Programme budgets **KII** - WCO - Government - MOPH - National health institutions? (CCS pages 23-25) - WB? - UNDP, UNICEF, UNFPA, UNWOMEN - Main donors to WHO? - Civil society?
3.2 How did the strategic partnerships contribute to the results achieved?	- Reference to the strategic partnerships identified in the CCs, in the MTR and final evaluation - Indication of their contributions to the results - Perception of strategic partners about the contribution of the partnerships to the achievements	**Document reviews** - MTR and final evaluation **KII** - WCO - Government - MOPH - National health institutions? (CCS pages 23-25) - WB? - UNDP, UNICEF, UNFPA, UNWOMEN - Main donors to WHO? - Civil society?

Evaluation sub-questions	Indicator/measure	Main source of information
3.3 How did the funding levels and their timeliness affect the results achieved?	- Level of funding compared with budget planned for CCS and other activities - Timing of funding over the CCS period - Main funding mechanisms used	**Document review** - Funding data **KII** - WCO - RO? - HQ? - Main donors to WHO?
3.4 Was the staffing adequate in view of the objectives to be achieved?	- Level and number of staff available for CCS implementation and other activities - Perception of stakeholders of staffing situation	**Document review** - Staffing data **KII** - WCO - RO? - HQ? - Main national partners
3.5 What were the monitoring mechanisms to inform CCS implementation and progress towards targets?	- Availability of monitoring mechanisms - Availability of monitoring reports on progress towards targets - Identified best practices	**Document review** - Monitoring reports **KII** - WCO - RO? - HQ? - Main national partners
3.6 To what extent has the CCS been used to inform WHO country work plans, budget allocations and staffing?	- Availability of explicit linkages between CCS and work plans, budget allocations and staffing - Weight of the CCS versus other activities undertaken by WCO	**Document review** - Work plans, budgets **KII** - WCO - RO? - HQ?

Annex 3: WHO's main planning instruments and associated challenges

This Annex presents briefly the main planning instruments WHO has developed to frame its action at the various levels of the Organization and main implications for country office evaluations.

Figure 1: timeframes of key planning instruments at the different levels of the Organization



The WHO high-level strategic planning document is the **General Programme of Work (GPW)**. It sets priorities and provides an overall direction for a perennial period. The current 12th GPW encompasses six years (2014–2019) and defines 6 categories as high-level domains for technical cooperation and normative work (e.g. communicable diseases, health systems). These categories are divided into individual programme areas (e.g. malaria, nutrition) and provide a programmatic and budget structure for the work of WHO. Through a results chain, the GPW furthermore explains how WHO's work will be organized over the specific timeframe and how the work of the Organization will contribute to the achievement of a set of intended outcomes and impacts.[15] Hence, the GPW is the high-level strategic vision for the work of the entire Organization.

Another high-level strategic planning document was the **medium-term strategic plan (MTSP),** a one-off format for the time period 2008-2013. It was introduced to update the agenda of the (Eleventh) GPW at the time, which was laid out for a long period of ten years. The MTSP identified specific health impacts for 13 strategic objectives, including indicators and targets to be achieved over its six-year period.[16] This approach was then similarly adopted in the subsequent 12th GPW.

At country level, the main strategic planning document to guide WHO's work is the **Country Cooperation Strategy (CCS)**. It is a medium-term strategic vision for its technical cooperation in and with a given Member State, responding to the country's specific needs and the national targets under the Sustainable Development Goals[17] (WHO 2016: 3-5). The CCS therefore identifies a set of

[15] WHO (2014). Twelfth General Programme of Work 2014-2019. Not merely the absence of disease. World Health Organization, Geneva. http://apps.who.int/iris/bitstream/10665/112792/1/GPW_2014-2019_eng.pdf
[16] WHO (2012). WHO Reform: Meeting of Member States on programmes and priority setting, World Health Organization, Geneva. http://www.who.int/dg/reform/consultation/WHO_Reform_1_en.pdf?ua=1
[17] WHO (2016). WHO Country Cooperation Strategy. Guide 2016. World Health Organization, Geneva. http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2016/en/

priorities, each of which is further broken down into individual focus areas. These focus areas are linked to the MTSP strategic objectives or GPW outcomes (depending on when they were designed) and thereby establish a link between the strategic planning at country and corporate level. The time frame of the CCS is flexible to be aligned with national and United Nations planning cycles and to accommodate changing circumstances (e.g. emergencies, humanitarian crises or post-conflict situations).

The strategic priorities and desired results in the GPW find their operational expression for a particular biennium in WHO's **Programme budget (PB)**, which puts in concrete terms how intended outcomes and impacts shall be achieved. The PB is structured by programme area, each one with a set of outputs defining what the Secretariat will be accountable for delivering during the respective biennium.[18]

The PB then serves as the biennial guidance document for the development of **workplans**. Each workplan consists of a set of products and services, with associated activities and related costs but these are not related to the CCS in any explicit way. In WHO's internal planning system, all products, services and associated activities are considered as tasks.[19] Each task is explicitly linked to one output in the programme budget at corporate level, which means the task supports its expected achievement. The workplans ultimately break down the desired results of WHO's strategic planning into sets of corresponding tasks. Workplans are developed and implemented by budget centres, which are generally organizational units.

Some challenges

The elaborations above show that planning at WHO is based on various documents, which are connected through cross-references at different organizational levels. WHO's planning framework intends an explicit interaction between the strategic plans at country (CCS) and corporate level (GPW/PB). Concretely, CCS priorities and focus areas provide country-level input into the PB bottom-up planning process and thus into the identification of corporate priorities and budget allocations. On the other hand, the PB priorities in turn inform new CCS agendas if they are outdated and about to be renewed.[20] However, **the concrete processes of the mutual interaction between the CCS and the PB are not clear**. As shown above, all workplans and their respective tasks must relate to outputs in the PB, regardless of the organizational level at which they are being developed and implemented. This implies that the PB is directly influencing activities at country level (insofar as they must at least be linked to it). It is however not clear how or to what extent the worldwide heterogeneous CCS agendas inform the biennial PB planning process.

As shown in Figure 1, **all planning documents have a different timeframe**. This can cause programmatic divergences between the different levels insofar as perennial planning documents, once drafted and adopted, cannot take into account upcoming strategic shifts being introduced on another level. Figure 1 visualizes the various planning cycles and timeframes while using the country-level example of the CCS Thailand.

There is presently a **missing link between workplans drafted at country level and the strategic priorities established in the CCS**. WHO's organization-wide planning system is designed in such a

[18] WHO (2014). Twelfth General Programme of Work 2014-2019. Not merely the absence of disease. World Health Organization, Geneva. http://apps.who.int/iris/bitstream/10665/112792/1/GPW_2014-2019_eng.pdf

[19] WHO (2015). Programme Management. Glossary of Terms. Unpublished internal document. World Health Organization, Geneva

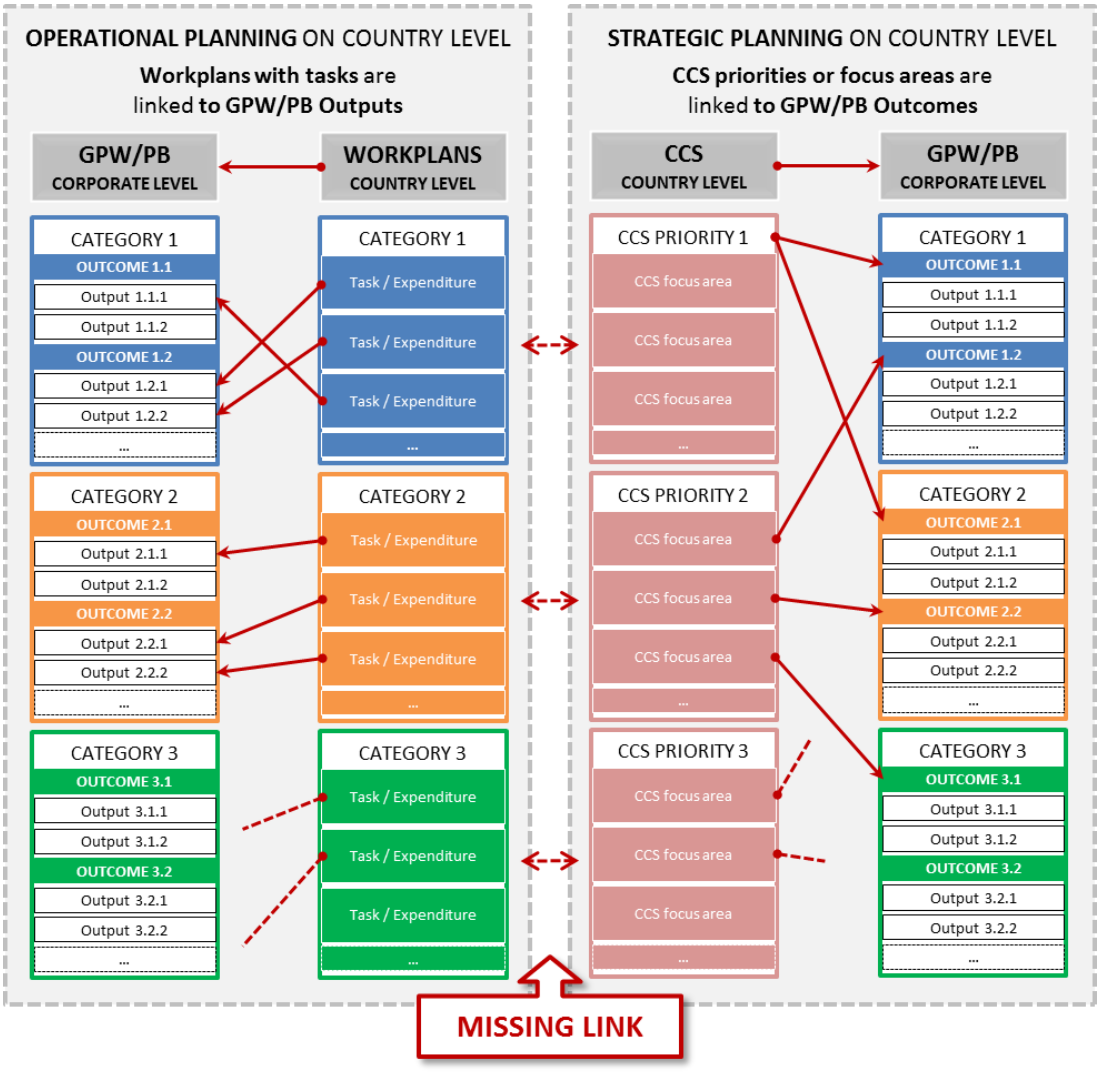
[20] WHO (2016). WHO Country Cooperation Strategy. Guide 2016. World Health Organization, Geneva. http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2016/en/

way that all workplans and their respective tasks relate to outputs in the PB (see left side in Figure 2). The programmatic structure in this process are the categories that represent the high-level domains for WHO's work (e.g. communicable diseases). These categories may be, but are often not, congruent with CCS priorities. Instead, each CCS is supposed to explicitly specify how its various focus areas are connected to one or more outcomes in the GPW, thus providing another link between the country and corporate level (see right side in Figure 2). However, this does not allow drawing conclusions regarding the link between workplans and the agenda of a specific CCS.

Hence, there is no documented traceability how individual tasks in the workplans at country level are supposed to support CCS priorities or their focus areas. This also means that there is no systematic way to assign financial figures to CCS priorities.

Finally, there is **no systematic monitoring and reporting against results** at country level. Indeed, the tasks included in the workplans are not framed together against a specific objective or expected outcome expressing the expected contribution of WHO in-country over a period of time in a specific area of engagement. Nor are there any indicators associated with these except for expenditures and self-reporting under the form of a narrative.

Figure 2: Relation between strategic and operational planning on country level



Annex 4: Evaluation observations for each priority and main activities of CCS 2012-2016 and CCS 2017-2021

This annex covers the five CCS priorities plus communicable diseases which are the areas where it was possible to collect information in the most systematic manner. The added value of this annex is to summarize systematically the priority and activity-specific observations to address some of the EQs in the main report. For each of these, two tables have been developed:

- The first table clarifies their inclusion in the following three CCSs: 2008-2011, 2012-2016 and 2017-2021, to show trends over time in various areas of engagement.
- The second table summarizes the main observations mapped against sub-evaluation questions defined in the evaluation matrix in Annex 2 (column 1). Column 2 summarizes the main findings from the CCS mid-term review (CCS MTR) and CCS final evaluation (CCS FE). Source of text included is always clarified. The third column summarizes key information collected by the evaluation through other documents reviewed, the WCO self-assessment and elements from the interviews specific to the particular topic.

Community health system

CCS 2008-2011	CCS 2012-2016		CCS 2017-2021
Included	Priority until 2013.		Not included
	Objective:	- Empower and strengthen the subdistrict health system so that the community health system will be more effective and responsive to the health needs of the population.	
	Main focus area:	Building up and strengthening the community health system	
	Approach:	- Develop and advocate for national policies on strengthening community health systems; - Support the decentralization policy; - Strengthen primary care; - Support social movements to gain support and public recognition for community health systems; and - Support development of new tools and social innovations.	
	Lead agencies:	National Health Security Office (NHSO) Health Systems Research Institute (HSRI)	

Source: CCS 2012-2016

Summary of key observations per sub-evaluation question

EQ sub-questions	Key CCS mid-term review (CCS MTR) and CCS final evaluation (CCS FE) observations	Key COE observations (documents & interviews)
1.2 Coherence with national health plans (NHDP), strategies, etc.	Primary health care at the core of Thai health policies since 1978 (CCS MTR)	- Coherence with Strategy 4 of the NHDP aiming at strengthening health care systems, ensuring thorough and equitable access
1.4 Coherence with GPW		- Strengthening health systems is prioritized across most strategic objectives of the MTSP and the priorities of the 12th GPW.
1.6.3 Partnerships	- The MOPH changed the membership of the CCS steering committee in 2013 excluding the HSRI which consequently notified WHO that it would like to	

	terminate its contract signed with WHO effective July 2013. (CCS MTR)	
2.2 Main results achieved	- The CCS MTR identified 4 strategic areas of work with very variable results in each of them.	- Various activities undertaken but no results reported
2.5 National ownership of results	- Planning stage: Participative consultation and planning process unanimously ranked the community health programme area at the top (CCS MTR)	
3.1 core functions	Among others	
- Technical support	- Initially WHO provided regular technical assistance (extensive peer review process, participation in steering committee meetings). But following staffing change in the office that the technical assistance reduced (CCS MTR).	
- Leadership	- WHO convening power helped to integrate the visions and strategies of existing autonomous health agencies and build up a partnership. (CCS MTR)	
3.2 Partnerships	- Huge implementation challenges in pooling funds and integrating efforts from all parties to implement the programme (CCS MTR)	
3.4 Staffing	- Initially WHO had a national professional officer participating regularly in the programme management team meetings but afterwards it did not play a significant role following staffing change in the office (CCS MTR) - National programme manager might not have all the required knowledge and skills. (CCS MTR)	
3.5 Monitoring	- Over time WHO contribution seemingly changed towards financial accountability and fund management and away from technical advice. (CCS MTR)	

Multisectoral networking for NCD control

CCS 2008-2011	CCS 2012-2016		CCS 2017-2021
Included	Priority		Priority
	Objective:	- Promote collaboration, partnership and integration among various sectors to tackle NCDs, including health-related and non-health related sectors in Thailand. - Strengthen national policies, plans and interventions for prevention and control of five main NCDs: cardiovascular diseases, diabetes, cancers, chronic respiratory diseases and hypertension.	**Impact:** Thailand on track to achieve the nine national and global NCD targets
	Main focus area:	Building up networks for implementing integrated NCD control.	- Tobacco control - Early detection, prevention and control of cardiovascular disease (hypertension and diabetes) - Reduce childhood obesity
	Approach:	- Promote collaboration and partnership among agencies;	**CCS deliverables** - NCD coordination

	- Networking integration and cooperation through established mechanisms to strengthen policy, social communication and capacity building; and - Establish the linkage and collaboration with regional and global levels of NCD networks.	mechanisms strengthened and streamlined - New knowledge generated, disseminated and used for policy development and programme improvement - NCD surveillance system harmonized and rationalized
Lead agencies:	Thai Health Promotion Foundation	Thai Health Promotion Foundation

Source: CCS 2012-2016 and CCS 2017-2021

Summary of key observations per sub-evaluation question

EQ sub-question	Key CCS MTR and final evaluation observations	Key COE observations (documents & interviews)
1.1 Priority based on population health needs		- Behavioural factors in the Thai population facilitate the increase in NCDs and injuries[21] - In 2014 NCD accounted for 71% of total deaths in Thailand[22]
1.2 Coherence with national health plans (NHDP), strategies, etc.	- The RTG recognizes the importance of both health and non-health sectors to meet the challenges of NCD prevention and control as translated in the Thai Healthy Lifestyle strategic plan 2011-2020 (CCS MTR)	- Coherent with NHDP strategy 2
1.3 Coherence with UNPAF		- For the period 2017-2021 NCD indicators to be integrated in the new UNPAF result matrix.
1.4 Coherence with GPW	- In 2012, NCD was placed more firmly in the global agenda by the UN 66th General Assembly asking WHO and Member States to prevent and control NCDs. (CCS FE)	- Aligned with the 11th GPW (SO 3, 6 and 7) - Aligned with MTSP strategic objective 3 to prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment - Aligned with the 12th GPW leadership priority addressing the challenge of noncommunicable diseases and mental health, violence and injuries and disabilities.
1.5 WHO adaptation capacity to evolving context		- While the CCS 2012-2016 was focused on partnerships and networking to set the foundations, the CCS 2017-2021 is clearly focused on 3 diseases and has identified clear deliverables.
1.6.1 WHO comparative advantage	- WHO presence and visibility highlighted to stakeholders, including high-level management, the importance of the programme at the global level. (CCS MTR)	- Following the experience of the past 2 CCSs, the proposal for NCD for the CCS 2017-2021, considers that WHO will add value, among others, in the following areas: advocacy convening power as a neutral broker, promotion of Thai expertise abroad through RO and HQ, etc.
1.6.3 Partnerships		- Positive partnership and complementarity observed with CDC on NCD - Focus on supporting NCDNET (network): amalgamation of multiple partners to achieve the goals of the Thai healthy life style policy - An important determinant of the success of NCD control is coordination and collaboration

[21] MOPH, 2007, 'Survey report of behavioural factors of non-communicable disease and injuries in Thailand'.
[22] http://www.who.int/nmh/countries/tha_en.pdf (consulted 30 March 2017).

		between the public health agencies which remains a key challenge for the RTG.
2.2 Main results achieved	- Successful collaboration efforts in forming Salt Net which aimed to reduce salt consumption. Otherwise, majority of the work had been concentrated on organizing meetings and forums which have merits in building working relationships with the network members. (CCS MTR) - Initiated a forum for academics, a policy advocacy training course was developed and delivered several times. Capacities of junior policy researchers have been strengthened and good documents on the NCD situation in Thailand were produced. (CCS FE) - However, the major expectation was to have this NCDs network as a mechanism to implement the Thai Healthy Lifestyle strategic plan. It is clear that the network did not fulfil this purpose (CCS FE)	- Thai NCD alliance, a network of agencies working on NCD, was established in April 2016. - Four risk factors and diseases were included in the integrated national NCD plan to align it with the global NCD plan. - MOPH developed the first national NCD guidelines.
2.3 Regional and HQ contributions		- Technical support provided by HQ and SEARO particularly in the areas of nutrition, salt reduction, tobacco control - Use of advocacy materials developed by HQ and SEARO
2.4 Contribution to long term changes		- The Thai Cabinet approved: o a new Tobacco Product Control Act which, among others, aims at limiting where tobacco products can be sold and consumed o the control of marketing of infant and young children food act.
2.5 National ownership of results	- The lack of continued commitment from high-level management in the MOPH affected deeply the advancement of the Thai Healthy Lifestyle strategic plan. This impacted the national resources available and involvement of national partners to achieve the objectives (CCS MTR)	- For the new CCS, NCD planning is done jointly between national partners and WHO with wider and stronger engagement of stakeholders than before.
3.1 core functions	*Among others*	*Among others*
- Technical support	- WHO active involvement in drafting the strategic plan and providing guidance and technical inputs to the secretariat team of this programme (CCS MTR)	- Translation of HQ guidance in national language
- Leadership	- WHO presence and visibility highlighted to stakeholders, including high-level management, the importance of the programme at the global level. (CCS MTR)	- WHO convened first meeting on government partnership to tackle NCD in Thailand to align activities of NCD bureau at MOPH and NCD net. - WHO Director-General explicit support to MOPH on Thai Healthy Lifestyle strategic plan
- Norms & standards		- Four risk factors and diseases were included in the integrated national NCD plan to align it with the global NCD plan. - Development of national physical activity guidelines taking into account best practices and WHO recommendations
- Research	- Produced good NCD research and documents and generated knowledge	- Generation of evidence on tobacco use among the youth

	on the topic (CCS FE)	
- Policy options		- Creation of a public health agency dealing with tobacco control. - Promulgation of tobacco laws and regulations and introduction of sin tax as a control measure
- Monitoring health trends		- Supported data collection analysis and reporting for the global youth tobacco survey and the global school health survey
3.2 Partnerships	- The NCD network did not function as a mechanism to strengthen the implementation of the Thai Healthy Lifestyle strategic plan. (CCS FE)	- NCD programme management moved to MOPH with the new CCS - For the new CCS, planning for NCD is done jointly between national partners and WHO with wider and stronger engagement of stakeholders than before.
3.4 Staffing	- Challenges in establishing a common understanding of the roles, time commitments, qualification and capacity of staff of the network secretariat (CCS MTR) - WHO recruited a recognized retired Thai senior official as programme manager for the first 2 years of implementation which helped connect WHO and the partners as long as he was there. (CCS FE)	- This priority is supported by both an international and a national staff position since 2016.

Disaster preparedness and response

CCS 2008-2011	CCS 2012-2016		CCS 2017-2021
Not included	Priority		Not included
	Objective:	- Establish coordination and collaboration mechanisms in the Disaster Health Emergency Management System among various national and international agencies; - Further support the development of the Disaster Health Emergency Management System to be effectively and efficiently integrated and linked with relevant agencies at all levels in institutional, legislative frameworks, policies, SOPs, contingency plans and capacity building; - Engage various sectors systematically to establish mechanisms for disaster prevention, preparedness, response, recovery and rehabilitation.	
	Main focus area:	- Strengthening national capacity and coordination in disaster management, particularly in the health area.	
	Approach:	- Establish a well-functioning agency network for maximum coordination, cooperation and collaboration in disaster health emergency management; - Strengthen human resource capacity and resource planning; - Establish a management structure and disaster response plan.	
	Lead agencies:	NIEM, WHO	

Source: CCS 2012-2016

Summary of key observations per sub-evaluation question

EQ sub-question	Key CCS MTR and final evaluation observations	Key COE observations (documents & interviews)
1.2 Coherence with national health plans (NHDP), strategies, etc.	- After the 2004 Tsunami, the RTG recognized the need to strengthen disaster risk management. Also, following the 2011 worst floods in half a century, the Prime Minister declared disasters and emergencies priority areas. There is overall a strong commitment and mandate from the RTG, MOPH and WHO to develop a more effective disaster preparedness and management system within the health sector. (CCS MTR)	- Coherence with the 11th NHDP strategy for further development of systems for monitoring, warning and management of disasters, accidents and health threats
1.3 Coherence with UNPAF		- This priority is coherent with the UNPAF expected outcome on mainstreaming of climate change adaptation by the key line ministries into their sectoral and provincial plans, policies and budgets (this outcome includes both WHO and NIEM as key partners).
1.4 Coherence with GPW	- In 2011, the WHA passed resolution WHA64.10 to strengthen all-hazards health emergency and disaster risk management programmes as part of national and subnational health systems. (CCS MTR)	
2.2 Main results achieved	- Development of a framework for health sector management for Thailand with the objective of bringing all ongoing and planned activities together within one systematic strategic framework (CCS MTR) - WHO contributed mostly to build a momentum in engaging MOPH, the NIEM and other stakeholders in enhance focus and work on disaster preparedness and response	- Adaptation and piloting of the hospital safety index - Development of the public health emergency operation centre - MOPH developed a disaster response plan for people with disabilities with the support of WHO, placing Thailand among the first countries in the world with such a specific plan.
2.3 Regional and HQ contributions	- RO contribution to the assessment of national emergency preparedness in Thailand using the regional WHO benchmarks (CCS MTR)	
2.5 National ownership of results	- According to NIEM, WHO funding through the direct financial contribution mechanism implies less strict rules on use of the funds compared to other mechanisms of financial support from WHO (CCS MTR)	
3.1 core functions		
- Technical support	- WO provided a technical officer, much appreciated by the key partners, which created a momentum in engaging various national stakeholders in enhanced focus and work on disaster preparedness and response (CCS MTR)	
- Leadership	- WHO used its convening power to call events at national or regional level (international conference on the implementation of the health aspects of the Sendai framework for disaster risk reduction. (CCS FE)	
- Norms & standards	- Adaptation and piloting of the hospital safety index (CCS FE)	
- Research	- Emphasis on studies and research (CCS	

	MTR) - WCO has played a recognized role in knowledge sharing, including in research (e.g. Technical Officer cooperating with Mahidol University), and there were repeated requests for WHO to further develop its work in knowledge management (CCS FE) - WHO played a significant advocacy role in the DM programme. WHO was the initiator of the Global Hospital Safety initiative (CCS FE)	
3.2 Partnerships	- Establishment of the Bureau of Public Health Emergency Response within MOPH showed increased priority by MOPH but also created some ambiguity among stakeholders in understanding the different roles and responsibilities of all partners (CCS MTR) - Concern over the bicephalic management of the programme which caused delays and misunderstandings. (CCS FE)	- Issues or roles not resolved across the CCS duration
3.3 Funding	- Pooled funding from WHO and various national agencies has created national ownership and is perceived as more sustainable compared to the traditional manner in which WHO supported programme implementation (CCS MTR)	
3.5 Monitoring	- Further reporting according to the indicators and set targets in the agreed monitoring framework would be an advantage. Limited documentation on potential outcomes and impact of the programme. Request from MOPH to WHO to enhance skills in designing general monitoring and evaluation frameworks for the programme. (CCS MTR)	

International trade and health

CCS 2008-2011	CCS 2012-2016		CCS 2017-2021
Not included	Priority		Global Health Diplomacy sub-programme
	Objective:	- Build individual and institutional capacities and generate evidence to support coherent policy decisions on international trade and health for positive health outcomes of the population.	**Impact:** - Evidence-based and participatory policy decisions and trade negotiation process towards coherent trade and health policies for positive health outcomes
	Main focus area:	Build national capacity in trade and health negotiation	
	Approach:	- Knowledge generation - Capacity building - Network strengthening	**CCS deliverables** - Concrete and timely evidence to support international trade policy decisions and preparedness - International trade and health information clearing house accessible by the networks and general public - Strengthened capacities for

		knowledge generation and policy advocacy - Strong networks and collaboration with partners and stakeholders to enable better knowledge generation and participatory trade negotiation process where health is of concern
Lead agencies:	International Health Policy Programme	International Health Policy Programme

Source: CCS 2012-2016 and CCS 2017-2021

Summary of key observations per sub-evaluation question

EQ sub-question	Key CCS MTR and final evaluation observations	Key COE observations (documents & interviews)
1.2 Coherence with national health plans (NHDP), strategies,. etc.	- Consistent with the national economic development plan (CCS MTR)	
1.4 Coherence with GPW	- Various WHA resolutions have urged Member States to consider linkages of trade-related policies with health policies. (CCS MTR)	- Though not a priority, issues related to trade are brought up regularly in the GPW.
1.5 WHO adaptation capacity to evolving context		- Thailand is one of the few countries where international trade and health is one of the CCS priorities
1.6.1 WHO comparative advantage		- Following the experience of the CCS 2012-2016, the proposal for international trade and health for the CCS 2017-2021, considers that WHO will add value, among others, in the following areas: extensive technical knowledge, access to international expertise, guidance, access to experience from other countries. - International trade and health issues are not very well known in Thailand. According to the RTG, without the CCS progress in this area could not have been made. The credibility of WHO on this issue has been pivotal to enable work of the health sector with the ministry of commerce.
2.2 Main results achieved	- Major outcomes are the collaborative engagement of health and non-health government officials and policy makers and the enhancement of capacities of all partner organizations related to the interface between international trade and health (CCS MTR) - Increased knowledge and evidence available on topics surrounding trade negotiations and health. (CCS FE)	- Availability of evidence to inform trade negotiations and political decisions - WHO support for the first national conference on international trade and health - Recognition by Ministry of Commerce and Ministry of Foreign Affairs that their knowledge on health issues and global health agreements is limited -
2.3 Regional and HQ contributions		- RO contributions of expertise have been critically important to RTG as the WCO did not have the relevant expertise.
2.5 National ownership of results	- Trade negotiations are almost exclusively a Thai undertaking but contribution of WHO considered useful. (CCS FE)	
3.1 core functions		
- Technical support	- Mobilisation of individual experts (CCS MTR)	- Mobilisation of expertise and provision of technical support to generate evidence proved to be critically important.

- Leadership	- Recognized leadership of WHO in coordinating other stakeholders (outside health) in programme implementation and establishing linkages with international experts and organizations (CCS MTR)	
- Research	- Importance of generating evidence especially around tobacco control, alcohol and access to medicines where there are powerful national and international interests lobbying against public health interests (CCS FE)	
3.4 Staffing		- The WCO contributed to this issue but was not able to meet all the expectations in terms of technical expertise. According to the RTG, it would be important for the WCO to ensure availability of expertise in areas of other determinants of health (economics, trade, etc.)

Road safety

CCS 2008-2011	CCS 2012-2016		CCS 2017-2021
Not included	Priority		Priority
	Objective:	- 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.	**Impact:** - Reduced morbidity and mortality from road traffic injuries
	Main focus area:	- Improve national road safety programme effectiveness through multisectoral and international collaboration.	- Strengthen road safety management and coordination - Improve national traffic data system - Improve legislation and enforcement
	Approach:	- Identify a lead agency in government to guide the national road traffic safety effort and a mechanism for intersectoral action; - Undertake an assessment of the problem in terms of its magnitude, policy, and institutional settings; - Strengthen the national master plan on road safety on aspects of behavioural and legislative strategies and actions and; allocate the needed human and financial resources; - Implement specific actions to prevent road traffic crashes, minimize injuries and their consequences, and evaluate the impact of these actions as they relate to motorcyclists; - Maintain high-quality, real-time information on road traffic accidents in order to accurately monitor levels and trends; and - Support the development of national capacity and international cooperation.	**CCS deliverables** - Effective coordination and management through reorganization of the Road Safety Directing Center into a robust government agency capable of leading road safety action in Thailand toward Vision Zero implementation - Excellence in road safety data integration with timely analytics supporting evidence based investments in road safety action. The quality of data will be improved to the degree that WHO will not need to estimate the fatality rate for the next Global Report on Road Safety in 2019 and will use data submitted by Thailand. - Road safety legislation meets international best practice for all risk factors and improves enforcement leading to improved behaviours, reduction in crashes and reduced fatalities.

Lead agencies:	Thai Health	Thai Health

Source: CCS 2012-2016 and CCS 2017-2021

Summary of key observations per sub-evaluation question

EQ sub-question	Key CCS MTR and final evaluation observations	Key COE observations (documents & interviews)
1.1 Priority based on population health needs	- Road traffic injuries is a an important public health problem.	- The WHO's 2015 global report on Road Safety ranked Thailand 2nd in the world as regards mortality rates for road accidents: 24,000 annual deaths, while RTG estimate was about 14,000. This led to in-depth joint analysis of death certificates, police reports and insurance data....and a revised national estimate of 21,000 deaths/yr.
1.2 Coherence with national health plans (NHDP), strategies, etc.		- Coherence with the 11th NHDP strategy for further development of systems for monitoring, warning and management of disasters, accidents and health threats.
1.4 Coherence with GPW		- Coherence with GPW as road safety is a clear component of noncommunicable disease priorities
1.6.2 WHO positioning of health priorities		- WHO pushed to have road safety included in the CCS and also proved to be a strong advocate for road safety in the country.
2.2 Main results achieved	- At the time of the CCS MTR, progress was still far from satisfactory mainly because: coordination was an issue for implementation; no funding was available for joint implementation of overall activities; the lead agency has no legal authorities and powers to implement programmes, regulations and activities; and the lead agency was not accepted by all partners. (CCS MTR) - Initial focus of the programme was predominantly on campaigns but these were not countrywide, visible and continuous but occurred more during festival times. (CCS MTR) - Although the stated objectives were not achieved, the programme completed a set of planned and useful activities. (CCS FE)	- Despite a slow start, a productive period of legislative activities, starting in late 2015 through 2016, has been instrumental in putting Thailand on the way towards stronger road safety laws and regulations. In December 2016, amendments to driver licensing regulations were adopted and announced in the Royal Gazette, effective 1 January 2017. - WHO commissioned Thailand's Road Safety Institutional and Legal Assessment with the financial support from the Bloomberg Initiative. The assessment revealed legislative improvement needs for speed, drink driving enforcement, helmets, seatbelts and child restraints. WHO also successfully advocated for the establishment of the Working Group to Review Road Safety Legislation under the national Road Safety Directing Center. The Working Group submitted to the Cabinet for approval a set of road safety legislative amendments with an aim that they are effective and enforced by the end of 2016.
2.3 Regional and HQ contributions		- The Bloomberg funding is managed by HQ and Thailand is one of the countries benefitting from the second phase of this initiative. - WHO support, both through the WCO and RO/HQ, has been critical in influencing national policy, including through direct contact with the minister to promote road safety.
2.4 Contribution to long term changes		- Major overhaul, most significant in the last 40 years of the legislation related to road safety, directly attributable to WHO advocacy efforts and technical support

3.1 core functions		
- Technical support		- Translation (into Thai) and dissemination of major technical documents has also been a component of project coordination to make these materials accessible to the Thai audience and use them to provide needed technical support
- Leadership		- WCO leveraged various opportunities – a National Road Safety Seminar in December 2015, a national road safety conference following the 2nd Global High Level Conference on Road Safety in Brasilia in 2016, and the formation of the Embassy Friends of Road Safety to advocate for improvements in road safety including strengthening laws, regulations and enforcement.
- Research		- WHO commissioned Thailand's Road Safety Institutional and Legal Assessment.
- Policy options		- WHO support, both through the WCO and RO/HQ has been critical in influencing national policy, including through direct contact with the minister to promote road safety.
- Monitoring health trends		
3.2 Partnerships	- Road safety was undertaken as an independent and joint activity by several stakeholders without significant coordination, with each organization pursuing its own independent agenda until these stakeholders were brought together under the CCS. The preparation of a proposal on road safety meant that road safety would now be addressed through a coordinated programme of work. (CCS MTR) - Explicit role of a WHO collaborating centre in the implementation of this programme. It mainly played a role in advocacy and capacity building. - Need for further clarity on role and responsibilities of all members of the partnerships. With nearly 15 ministries and departments involved in road safety, this represents a major challenge. (CCS MTR)	- A new stakeholder assessment was completed in December 2015 to provide better understanding of key road safety players and their roles, help guide the strengthening of existing coordination mechanisms, and help to define strategies to push the improvements forward.
3.3 Funding	- WHO was able to use the Thailand road safety programme to mobilise resources from the Bloomberg Initiative.	
3.4 Staffing	- WHO should ensure that one technical staff member is assigned to the WCO work with national counterparts throughout the term of the CCS.	

Border and migrant health programme

CCS 2008-2011	CCS 2012-2016		CCS 2017-2021
Included	Part of unfinished agenda and became a priority after ending of community health component		Priority
	Objective:	Ensuring equitable access to health services among migrants and mobile populations	**Impact:** Improved health service delivery and health status of migrants in Thailand
	Approach:	- Conducting a systematic literature review on migrants health - Encourage and promote collaboration among partners involved in developing health system for migrants	**CCS deliverables** - Timely strategic information is generated to guide policy decisions related to the health security of border and migrant populations. - Clear administrative structure established to respond to the health needs of border and migrant population at national and sub-national levels - Increased health and insurance coverage among migrant and vulnerable populations - Migrant friendly health services promoted
	Lead agencies:	Bureau of Policy and Strategy	International Health Policy Program

Source: CCS 2012-2016 and CCS 2017-2021

Summary of key observations per sub-evaluation question

EQ sub-question	Key CCS MTR and final evaluation observations	Key COE observations (documents & interviews)
1.1 Priority based on population health needs	- Thailand is the primary host country for low-skilled workers (about 2.7 million) from three neighbouring countries: Cambodia, Laos and Myanmar. In addition, there are refugees living in camps and Myanmar displaced persons all living in the four border provinces (about 428,000 people). (CCS MTR)	
1.2 Coherence with national health plans (NHDP), strategies, etc.	- Although migrant-related public health challenges and concerns are well documented and recognized, policies to better attend to migrant health lag behind this recognition and are incoherent. (CCS MTR) - A major development was the launching of the MOPH Border Health Development Master Plan 2012-2016 aligned with the NHDP. (CCS MTR)	
1.3 Coherence with UNPAF		- Migrant issues explicit in the UNPAF and regular collaboration with UNICEF, UNFPA and IOM observed
1.6.2 WHO positioning of health priorities		- WHO played a critical role to position migrant health in the CCS though it is not considered a major issue by the MOPH in terms of burden of disease.
2.2 Main results achieved	- As part of the programme, border health units were established and staffed in the targeted provinces; guidelines and monitoring and evaluation framework were developed; capacity building was provided in all 31 provinces. Migrant	

	health information centres are operational in the four border provinces and at central level, establishing a foundation for data on border and migrant health. In depth analysis of financing mechanisms for migrant health care was carried out. (CCS MTR) - All planned studies were undertaken but these represent only a small part of activities undertaken and to which WHO provided support.	
2.3 Regional and HQ contributions	- Access to knowledge and expertise of other parts of the Organization and similarly WHO Thailand shared experience with other countries and regions (CCS MTR)	- WR Mekong group provides a venue to work on migrant health at a sub-regional level covering countries in SEARO and others in WPRO (which is sometimes perceived as a challenge by some external stakeholders) . - Direct support to country office from either the Regional or HQ level has been very limited.
2.5 National ownership of results	- Migrant health is gaining importance in the RTG's agenda. (CCS FE)	- Increasing engagement of RTG with policies and broader support for migrant health, including increasing resource allocation over time
3.1 core functions		
- Technical support	- WHO support to the Border Health Development Master Plan 2012-2016 (CCS MTR) - Technical assistance in and out of refugee or displaced persons encampments (CCS FE)	- WHO provided technical advice mostly on communicable diseases which are at the centre of the work on migrant health.
- Leadership	- Neutral space to bring together various stakeholder groups and to ensure health messages are included in multisectoral debates (CCS MTR) - Convening power of WHO to call all stakeholders for migrant health-related national, sub-regional or regional events (CCS FE)	- 2015 meeting of the ASEAN included an agenda item related to migrant health
- Norms & standards	- Provision of guidelines and protocols for NGOs assisting migrants (CCS FE)	
- Research	- Evidence-based advice (CCS MTR)	
- Policy options	- Support for the development of the border health development master plan (2012-2016)	
- Monitoring health trends	- WHO support for the development of information systems (CCS MTR)	
3.2 Partnerships	- Ability of WHO to connect partners with relevant persons in the government is pertinent. (CCS MTR)	- Initially WHO was not included in the programme management board
3.3 Funding	- Programme 80% funded by the EU and 20% by WHO (CCS MTR)	
3.4 Staffing	- 1 international, 1 national and 1 support staff in WCO (CCS MTR)	

Other CCS activity: communicable disease control

CCS 2008-2011	CCS 2012-2016		CCS 2017-2021
Included	Part of the major public health challenges and the unfinished agenda		Not included
	Main focus areas:	- TB control - HIV prevention and care - Malaria control	

Source: CCS 2012-2016 and CCS 2017-2021

Summary of key observations per sub-evaluation question

EQ sub-question	Key CCS MTR and final evaluation observations	Key COE observations (documents & interviews)
1.1 Priority based on population health needs	- Although incidence of mortality from many communicable diseases has decreased, some diseases of this group continue to pose major challenges to health development in the country (CCS MTR)	
1.2 Coherence with national health plans (NHDP), strategies, etc.		- Strong ownership by MOPH of communicable disease control and therefore not considered a priority for WHO involvement through the CCS
1.6.2 WHO positioning of health priorities	- WHO contribution has been perceived as bringing the success in communicable disease control. These are no longer leading causes of mortality in the general population. This however resulted in communicable disease control becoming a lower priority in the CCS. But WHO support has continued.	- WHO continues to prioritize malaria and tuberculosis though not a priority of the CCS.
1.6.3 Partnerships	- The department of disease control is hosting 2 WHO collaborating centres active in this area.	
2.2 Main results achieved	- 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, had 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. (CCS MTR)	- As per global polio end-game strategy, technical advice and support in-country provided by WHO - Technical advice and support in the development of national plans reflecting the global/regional strategies on malaria elimination provided by WHO - Lead agency for the national malaria program review (MPR) 2011 and 2015 - National Operational Plan to End AIDS supported by WHO - Development of the National Strategic Plan for Tuberculosis Control supported by WHO. - Completion of surveillance and epidemiological assessment of tuberculosis in Thailand supported by WHO - Support to the Bureau of AIDS Tuberculosis and STIs for the development of guidelines on National Anti-Retroviral Treatment and Elimination of Congenital Syphilis. These are now completed. - Support for completion of National Tuberculosis Prevalence Survey, and

		coordination of revised epidemiological estimates for the burden of tuberculosis in Thailand.
2.3 Regional and HQ contributions		- Contribution of WCO to global reporting processes (Universal Access, UNGASS (2015 and 2016), Global Tuberculosis Report (2015), SEARO Tuberculosis Report (2015) and SEARO HIV Report (2015) - HQ and regional office have been most effective at providing the "WHO brand". WHO has credibility in the country and regional and global WHO experts have influence.
2.4 Contribution to long term changes		- Elimination of mother-to-child transmission of HIV and syphilis, only the 2nd country after Cuba to do so
3.1 core functions		
- Technical support	- Technical assistance has been provided in almost all communicable disease areas. Most support is in the form of technical advice and participation by experts from the WCO and the RO (CCS MTR)	- WCO instrumental in advocating and providing technical guidance in the updating of the national malaria treatment guidelines.
- Leadership	- 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. (CCS MTR)	
- Norms & standards		- Guideline development and consensus generation on the treatment regimen for extensively drug resistant to tuberculosis.
- Research	- Research and reviews to inform policy decision-making in selected areas such HIV treatment	
- Policy options	- Factilitate upstream policy implementation through high level consultations	

Annex 5: List of people met

WHO Country Office	
Kritsiam Arayawongchai	National Professional Officer
Richard Brown	Programme Officer
Sushera Bunluesin	National Professional Officer
Daniel Kertesz	Country Representative
Aree Moungsookjareaoun	National Professional Officer
Renu Marg	Medical Officer
Mukta Sharma	Programme Manager
Liviu Vedrasco	Technical Officer
Isabelle Walhin	Administrative Officer
WHO Regional Office	
Yonas Tegen	Planning Officer and former WHO Representative in Thailand
Arun Bhadra Thapa	Director Programme Management
WHO Headquarter	
Shambhu Acharya	Director, Country Cooperation & Collaboration with UN System
Georgia Galazoula	Planning Officer, Planning Resource Coordination and Performance Monitoring
Malgorzata Grzemska	Coordinator, Technical Support Coordination
Imre Hollo	Director, Planning Resource Coordination and Performance Monitoring
Etienne Krug	Director, Management NCDs, Disability, Violence and Injury Prevention
Evelyn Murphy	Technical Officer, Unintentional Injury Prevention
Bernard Tomas	Planning Officer, Planning Resource Coordination and Performance Monitoring
Marianna Trias	Public Health Officer, Country Cooperation & Collaboration with UN System
Rui Vaz	Coordinator, Country Cooperation & Collaboration with UN System
National partners	
Dr Bundit Sornpaisarn	Director, Thai Health Promotion Foundation
Dr Chutima Akaleephan	Researcher, International Health Policy Programme Foundation
Dr Kumnuan Ungchusak	Former Senior Expert, Department of Disease Control, MOPH
Dr Nakorn Premsri	Director, Principal Recipient Administrative Office, Department of Disease Control, MOPH
Dr Nithima Sumpradit	Pharmacist, Professional Level, Bureau of Drug Control, Thai Food and Drug Administration (FDA), MOPH
Dr Orapan Srisookwatana	Deputy Secretary General, National Health Commission Office
Dr Pathom Sawanpanyalert	Senior Expert in Health Promotion (Public Health Physician), MOPH
Dr Phalin Kamolwat	Director, Bureau of Tuberculosis, Department of Disease Control, MOPH
Dr Phumin Silapunt	Deputy-Secretary General, National Institute of Emergency Medicine
Dr Phusit Prakongsai	Director, Bureau of International Health, MOPH
Dr Siriwan Pitayarangsarit	Director, International Health Policy Programme Foundation

Dr Somsak Akksilp	Deputy Permanent Secretary, Office of the Permanent Secretary, MOPH
Dr Suchada Chaivooth	Director HIV/Aids and Tuberculosis Program, National Health Security Office
Mr Suksunt Jittimanee	Chief of Strategy and Evaluation, Bureau of Tuberculosis, Department of Disease Control, MOPH
Dr Supakit Sirilak	Inspector General, Office of the Inspector General, MOPH
Dr Supamit Chunsuttiwat	Former Senior Expert, Department of Disease Control, MOPH
Dr Supattra Srivanichakorn	Director, Center for Policy & Strategy Development for NCDs, Senior Expert and Chief NCDs Planning and Strategy Office, Department of Disease Control, Ministry of Public Health
Dr Supreda Adulyanon	Chief Executive Officer, Thai Health Promotion Foundation
Dr Suriya Wongkongkatep	Former Deputy Secretary, MOPH
Dr Suwit Wibulpolprasert	Vice Chair, International Health Policy Programme Foundation
Dr Thanapong Jinvong	Manager, Road Safety Group Thailand
Dr Wittaya Wongkongkatep	Chair, Road Safety Policy Foundation
Dr Wiwat Rojanapithayakorn	Director, Centre for Health Policy and Management, Faculty of Medicine, Mahidol University

International partners	
John MacArthur	Director US CDC Collaboration
Nenette Motus	IOM, Regional Director for Asia and the Pacific
Tatiana Shoumilina	Country Director UNAIDS
Luc Stevens	UN resident coordinator & Representative UNDP
Dr Wassana Im-em	Assistant Representative, UNFPA

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