
Country Office Evaluation

- Thailand -

(Volume 1: Evaluation Report)

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Acronyms

AMR	antimicrobial resistance
ASEAN	Association of Southeast Asian Nations
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
COE	country office evaluation
EQ	evaluation question
GPW	Global Programme of Work
HQ	WHO headquarters
IHR	International Health Regulations
IOM	International Organization for Migration
MDG	Millennium Development Goal
MOPH	Ministry of Public Health
MTSP	Medium-Term Strategic Plan 2008-2013
NCD	noncommunicable diseases
NESDP	National Economic and Social Development Plans
NHDP	National Health Development Plan
NIEM	National Institute for Emergency Medicine
NPO	National professional officer
ODA	Official Development Assistance
PB	Programme budget
RO	Regional Office (WHO Regional Office for South-East Asia)
RTG	Royal Thai Government
SDG	Sustainable Development Goal
THE	total health expenditure
TOC	Theory of Change
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

UNPAF	United Nations Partnership Framework
USAID	United States Agency for International Development
WCO	WHO country office
WHA	World Health Assembly
WHO	World Health Organization

Executive summary

Evaluation features

Country office evaluations (COE) were included in the Organization-wide evaluation workplan for 2016-2017, approved by the Executive Board in January 2016. They encompass the entirety of WHO activities during a specific period. The COEs aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

The main purpose of this evaluation was to identify and document best practices and innovations of WHO in Thailand on the basis of its achievements over the period 2012-2016. These included not only results achieved by the WHO Country Office (WCO) but also contributions at the regional and global levels to the country programme of work. Its main objectives were to:

- a. Demonstrate achievements against the objectives formulated in the Country Cooperation Strategy (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 the 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 (RTG) and WHO. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

The main expected use for this evaluation is to support the WCO as it operationalizes the new CCS 2017-2021 and develops its next biennial work plan. It should also assist the Regional Office for South-East Asia (RO) and WHO headquarters (HQ) when deciding how best to support to the WCO. Finally, over the medium-term, it will contribute to build a body of evidence around possible systemic issues to be addressed corporately.

Guided by the *WHO Evaluation Practice Handbook*, the evaluation was based on a rigorous and transparent methodology that served the dual objectives of accountability and learning. The methodology ensured impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using mixed methodological approaches (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means. The evaluation was conducted between January and June 2017 by a core team of four members.

Relevance of WHO's strategic choices

The priorities identified in both the CCS 2012-2016 and the CCS 2017-2021 were strategic to address Thailand's major health needs and were coherent with government and partners' priorities expressed in the United Nations Partnership Framework (UNPAF). Overall, the CCS 2012-2016 introduced a major shift from a fragmented approach through many small projects to a much stronger focus around five priorities and three main activities. This shift has been further strengthened in the design of the CCS 2017-2021 which includes only five main strategic priorities. This prioritization process for the CCS 2017-2021 was strengthened based on experience gained during the CCS 2012-2016 as follows: i) it included a very large number of stakeholders, reflecting the multiplicity of actors in the health sector in the country, and ii) it benefitted from a transparent consultation and a priority setting based on predefined selection criteria known to all relevant partners. This led to: i) some issues such as noncommunicable diseases (NCD) or border and migrant

health (WCO focus areas) becoming a priority for the Ministry of Public Health (MOPH) in the CCS; ii) the sunsetting of certain activities as appropriate; and iii) introduction of new ones such as global health diplomacy, reflecting a RTG priority. The CCS provides the strategic framework for WHO's work in and with Thailand. However, the priorities and activities therein do not necessarily cover the totality of the WCO's contribution to health in Thailand. For example, communicable diseases are no longer a CCS priority, but Thailand is still one of the 30 high burden countries for tuberculosis. Staff in the WCO continue to provide support to Thailand as necessary in this and other technical areas. There is a discrepancy between the WHO programme and funding structure, to which WCO workplans must conform, and the priorities elaborated in the CCS, making it challenging for the WCO to develop its workplans in line with the CCS priorities.

Gender. A gender analysis was not done in the CCS 2012-2016 and, though gender was given substantial attention in the CCS 2017-2021 analysis, it did not lead to the priorities retained paying explicit attention to the gender issues identified in the analysis.

WHO's intellectual and social capital. The CCS 2017-2021 provides a unique opportunity for both the RTG and WHO to engage in a strategic partnership of a new kind where funding is no longer the main commodity but the means by which both partners contribute their respective added value. Building on its well-established and recognized intellectual capital, WHO now has to strengthen its positioning in terms of social capital and branding, thereby enabling the RTG to consolidate the achievement of its universal health coverage by more systematically addressing the social determinants of health while at the same time enhancing Thailand's role in global health. Many national partners indicated clear expectations of WHO's strategic contribution in this respect. In their opinion, intellectual capital broadly refers to WHO's leading role in technical health expertise, while social capital refers more to WHO's reputation, influence, authority, name and trust. More widely, Thailand and other countries in similar situations are facing issues that require tailored approaches and support from their respective regional office and HQ. Resource mobilization in such countries might require a specific strategy and the new financing mechanism being developed for the CCS 2017-2021 in Thailand may offer lessons for other countries with a similar WHO presence.

WHO's contribution and added value

Main achievements. Overall, during the period 2012 to 2016, the WCO in Thailand provided a valuable contribution in supporting the RTG's national health sector plans. The CCS 2012-2016 created an enabling environment for various players in the Thai health sector to form partnerships around key health issues and this positive environment was strengthened for the CCS 2017-2021, based on the experience gained from the CCS 2012-2016. Results have been documented for all four main expected outcomes identified in the Theory of Change (TOC). Positive results were noted in the area of NCD, international trade and health, road safety, border and migrant health and communicable diseases. Community health and ageing were sunsetted as priorities while the disaster preparedness and response priority made limited progress over the course of the CCS.

Programme management challenges. The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. This weakens WHO's capacity to demonstrate results and contribution to health improvements in any given country. Furthermore, it appears that, over the course of the CCS 2012-2016, the WCO was not able to develop its own mechanism to monitor the effects of its contribution to the various objectives defined for each priority of the CCS when developing its country workplans.

Processes to achieve the results

Key contributions of core functions. Technical support stands out as the key core function contributing to the WCO work in support of the RTG and the implementation of the CCS 2012-2016.

This core function enabled research activities, facilitated the adaptation of norms, standards and guidelines and provided evidence to inform policy options for decision makers. The other core function which played a major role was WHO's leadership and convening power, allowing Thailand to avail of international expertise, and contributing Thai health expertise abroad. These functions form the foundation of WHO's intellectual and social capital. The WCO contribution to monitoring of health trends seems to have been more limited but, in the future, this core function is expected to play a much bigger role, both in the monitoring of CCS implementation and to support the country to monitor its progress towards the health-related Sustainable Development Goals (SDGs).

Partnerships. With respect to the work of the WCO with partners, the major shift introduced with the CCS 2012-2016 has been critical. Bringing together various actors around key priorities understandably takes time and, despite the mixed results obtained so far, it is considered by all as the way forward, establishing firm foundations for the design of the CCS 2017-2021. The initial collaboration with non-health actors that was introduced in the CCS 2012-2016 has been confirmed in the CCS 2017-2021.

Funding remains a critical means for WHO's catalytic engagement in the country. It ensures that certain priorities remain high on the agenda, as has been the case with border and migrant health and with road safety. Funding mechanisms will need to follow the strategic shift from small projects to priority areas initiated with the CCS 2012-2016 and confirmed in the CCS 2017-2021, and new approaches through pooled funding mechanisms are being considered. Such mechanisms require even stronger attention to planning and monitoring as indicators at outcome level need to be identified and their achievements documented in order to release funding instalments at specific times of the CCS 2017-2021 implementation.

Staffing. The WCO team composition and skills mix has evolved over time and been strengthened with a doubling of the number of international staff over the CCS 2012-2016 period. It is important to be able to match staff profiles and expertise with the priorities set out in the CCS. The increase in the number of international technical professionals in the WCO is a welcome initiative, and there is also a need for appropriately skilled national professional officers (NPOs) in support of technical issues but also to facilitate discussions when language barriers are an issue. This can also be supplemented with locally sourced translation services. The rationale for organizing teams around programme categories, rather than around the CCS priorities plus communicable diseases, remains a challenge for the WCO. Considering the weaknesses in planning and monitoring observed during the CCS 2012-2016 and the expectations from national counterparts in this area, the WCO needs to ensure that it can very quickly mobilize adequate levels of expertise in this area, either through the support of HQ or RO colleagues, or through short-term experts.

Best practices and innovations. This evaluation highlighted a certain number of emerging good practices and innovations framing WHO's engagement in Thailand. Indeed the WCO's role has clearly evolved during the period evaluated and is continuing to do so. For instance, the approach taken in the design of the CCS 2012-2016 and the lessons learned strengthened the design of the CCS 2017-2021, highlighting partnerships with national actors beyond the health sector and instituting a transparent and consultative priority setting process for the CCS 2017-2021. The fact that the RTG has increased its funding to become the main funding source for the CCS 2017-2021 also represents a major shift in its collaboration with WHO. Finally, the new funding mechanism being explored could also be used, if proven effective, in the future in other similar countries.

Recommendations

On the basis of the above analysis, the evaluation would like to make the following recommendations:

- A. The Head of the WHO Country Office and the WHO Country Office team to contribute actively to Country Cooperation Strategy governance activities and to engage with other national partners to support implementation of Country Cooperation Strategy priorities and activities, in particular in the area of programme management and monitoring.
 - i. Review the Country Cooperation Strategy workplans for each priority and define targets (qualitative or quantitative) for both the expected outcome and output levels and clarify expected WHO contribution in a measurable manner.
 - ii. Ensure adequate technical capacity for planning and monitoring Country Cooperation Strategy implementation.
- B. The WHO Secretariat to ensure that the WHO Country Office has the capacity to implement its workplans beyond the Country Cooperation Strategy priorities and activities, including through appropriate funding mechanisms and staffing of the Office.
 - i. Ensure that new Country Cooperation Strategy priorities such as antimicrobial resistance are adequately covered with financial and human resources
 - ii. Ensure that language is never a barrier for the active engagement of the WHO Country Office with national partners.
 - iii. Headquarters and the Regional Office to support the WHO Country Office in the review and consideration of the Royal Thai Government's request to support the implementation of the Country Cooperation Strategy 2017-2021 through the national pooled funding mechanism, and explore the possibility of linking a pooled funding mechanism with indicators of achievement.
- C. The WHO Country Office to build on a Theory of Change for the period 2017-2021 to better link the Country Cooperation Strategy 2017-2021 with the entire planned country-level results and deliverables and with the Country Office staff and activity workplans during operational planning for Programme budgets 2018-2019 and 2020-2021.
 - i. Develop a Theory of Change for 2017-2021 to frame more specifically the pathway for change (it should include all Country Office activities, not only those of the Country Cooperation Strategy).
 - ii. Clarify for each relevant corporate output the targets relevant for Thailand in the current biennium and for each biennium thereafter.
 - iii. Set up an internal monitoring framework to measure WHO's progress towards targets over the Country Cooperation Strategy implementation period.
- D. The WHO Country Office and the Royal Thai Government to strengthen inclusion of the gender and other social determinants of health dimension(s), as relevant, in the implementation of the Country Cooperation Strategy and other Country Office activities.
 - i. Review programmes of work of each Country Cooperation Strategy priority with a gender lens, possibly with the support of the Regional Office or of headquarters, and amend as necessary to ensure the gender dimension is appropriately taken into consideration.
- E. The WHO Secretariat (Department of Country Cooperation and Collaboration with the UN System and the Country Support Unit network) to review the evolution of the Country Office's contribution to, and relationship with, the Royal Thai Government over the recent Country Cooperation Strategy cycles, in order to consider the lessons learned, innovation and best practices for Country Office interaction with, and contribution to, other upper-middle-income countries and emerging economies.

- i. Reflect further on the implications of the expectations of counterparts in terms of social capital, in particular with other Country Offices active in upper-middle-income countries. WHO should deploy experts with profiles and experience matching the Country Cooperation Strategy priorities.
- ii. Develop a strategic note framing WHO's engagement in upper-middle-income countries from the intellectual and social capital perspective.
- iii. Document the prioritization process followed for the Country Cooperation Strategy 2017-2021 and share within the Organization.

1. Introduction

1. COEs were included in the Organization-wide evaluation workplan for 2016-2017, 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 aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

1.1 Evaluation features

2. **Purpose.** This COE was the first of this type undertaken by the WHO Evaluation Office. Its main purpose was 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 at the regional and global levels to the country programme of work. As with all evaluations, this COE meets accountability and learning objectives endorsed by the Executive Board of the World Health Organization. It will be publicly available and reported on through the annual Evaluation Report.

3. **Objectives.** This evaluation built 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 work plans, 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 the 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 RTG and WHO. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

4. **Expected use.** The main expected use for this evaluation is to support the WCO as it operationalizes the new CCS 2017-2021 and develops its next biennial work plan. It should also assist the RO and HQ when deciding how best to support to the WCO. Finally, over the medium-term, it will contribute to build a body of evidence around possible systemic issues to be addressed corporately, such as the development of models of WCOs work/presence in upper-middle-income countries.

5. **Scope.** The evaluation covered the period 2012-2016 and included all contributions from the WCO in Thailand, the RO and HQ over the same period. It focused on WHO's contribution to the objectives and the expected results defined in the CCS and the biennial country work plans as a whole rather than individual activities which have taken place during the period evaluated.

6. The CCS document for the period 2012-2016 and the new one for the period 2017-2021 (drawn up during 2016) served as the references to frame the evaluation scope but were not the only ones. All other strategic contributions made by WHO were also included.

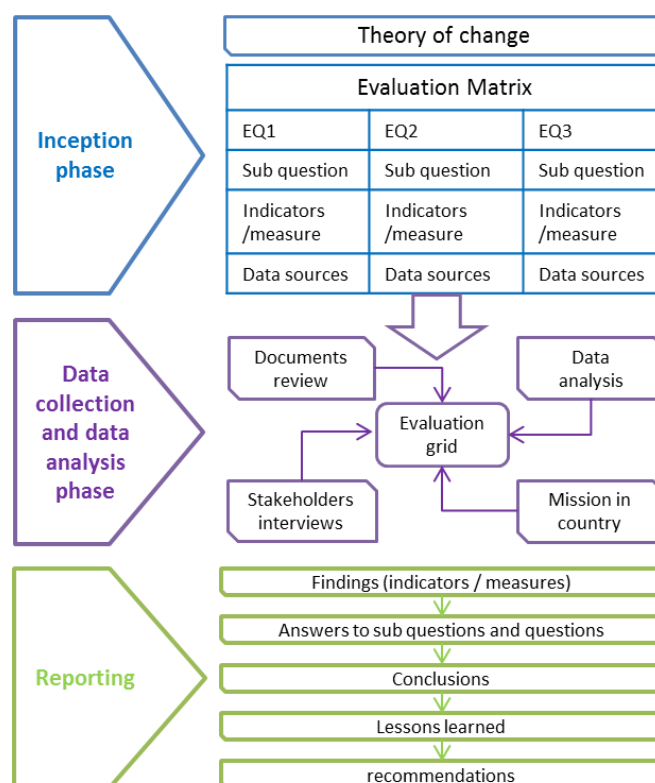
7. **Evaluation questions.** All COEs address the 3 main evaluation questions (EQ) identified below. The sub-questions are then tailored according to country specificities and detailed in an evaluation matrix (see Annex 2).

- **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). 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 assesses both the CCS 2012-2016 and the new CCS 2017-2021 design.
- **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). To address this question, the evaluation used the results per programme area already presented in the CCS 2012-2016 mid-term review and CCS final evaluation and focused on the best practices and innovations observed.
- **EQ3 – How did WHO achieve the results?** (efficiency) In this area the evaluation sub-questions cover the contribution of the core functions, the partnerships and allocation of resources (financial and staffing) to deliver the expected results and, for each, seek to identify best practices and innovations.

1.2 Methodology

8. Guided by the WHO evaluation practice handbook, the evaluation was based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. The methodology (summarized in Figure 1 below and developed further in Annex 2) ensured impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using mixed methodological approaches (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means.

Figure 1: Methodological approach



9. The evaluation was conducted between January and June 2017 by a core team of four members. The WHO Evaluation Office formed a team led by Dr Elil Renganathan (DG Representative for Evaluation and Organizational Learning) and supported by Anne-Claire Luzot (Chief Evaluation

Officer), Dr Mohamed Jama and Kathryn Tyson (consultants). During the inception phase, the team reconstructed the TOC (see Figure 2) framing WHO's engagement in-country, which was then validated by the Head of the WCO and the WCO team during the field mission. The TOC is aligned with the one validated by WHO in the context of the evaluation of WHO's presence in countries.¹ Using the TOC, the team developed an evaluation matrix, unpacking for each evaluation question of the Terms of Reference (TOR) specific indicators/measures for assessing each sub-question, the data collection method and data sources used. The evaluation mainly used existing data collected by WHO and partners during the timeframe evaluated. Therefore during the data collection phase, the team, after a comprehensive document review, conducted a one-week mission in-country and 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. All the data were then analysed to produce the present report.

10. 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 were 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.

11. The evaluation encountered a few other relevant issues already identified to some extent in the CCS mid-term review and in the CCS final evaluation and further elaborated in Annex 2:

- Though there are broad linkages between the CCSs and other WHO corporate planning and reporting tools, these are not clear enough to identify outputs and outcomes specific to the CCSs within the WCO work plans.
- In the absence of a clear TOC or of a logical or result framework, the corporate outcomes and outputs defined in the Programme budget (PB) are not systematically translated at country level with corresponding benchmarks and quantified targets.
- Considering that the expected contribution of WHO to national programmes prioritized in the CCSs 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.

1.3 Country context²

12. Despite having undergone much social and political unrest during the last decade, with the Coups d'Etat in 2006 and 2014 and very severe floods in 2011, Thailand has enjoyed sustained economic growth and social development during the last several decades thanks to, among other things, the implementation of national policies and strategies articulated in successive National Economic and Social Development Plans (NESDP) and, in the case of the health sector, the National Health Development Plan (NHDP) which is a subset of the national development plan. The country has made remarkable progress and is, since 2011,³ an upper-middle-income country in the high development category with a human development index of 0.726 (for both men and women) in 2014.⁴

13. Though Thailand has achieved many of the global Millennium Development Goals (MDGs), some challenges remain, especially at sub-national level, and the Government has expressed strong commitment to achieving the SDGs. Poverty and inequality have declined substantially over the past

¹See WHO, 2015, Evaluation of WHO's presence in countries.

² The information in the section is mainly summarized from the WHO Country Cooperation Strategy Thailand 2017-2021.

³ <http://www.worldbank.org/en/news/press-release/2011/08/02/thailand-now-upper-middle-income-economy> (accessed 20 March 2017).

⁴ http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/THA.pdf (accessed 20 March 2017).

decades. However, 11% of the population still remains below the poverty line and the poorest 10% of the population accessed only 1% of the country total income in 2013.⁵ Thailand promotes gender equality, including for career development, jobs and income, but women remain significantly underrepresented in public decision-making roles even though the national women's development plan (2012-2016) has set ambitious goals to address this issue.

14. Thailand has shown concrete achievements in health over the last 25 years (see Table 1). Improvement in the health of the Thai population, as measured by health indicators such as maternal mortality ratio per 100 000 live births and infant mortality rates per 1 000 live births, have seen dramatic decline while life expectancy has risen to 79 years for females and 72 years for males.

15. NCDs (71% of deaths in 2014)⁶ and road traffic injuries are well-recognized challenges. The health of migrants (about 4 million migrants in the country)⁷, though recognized as an issue, does not figure prominently in the national health agenda. Antimicrobial resistance (AMR) is an emerging problem receiving national attention, while other issues, such as tuberculosis, malaria, and HIV/AIDS, climate change and adolescent health, require continued attention.

16. Universal health coverage for Thai citizens (migrant population not fully covered yet) was achieved in 2002 and since then public expenditure on health has increased consistently to represent 86% of total health expenditure in 2014.

Table 1: Selected population and health indicators

Indicators	1990	2000	Latest available statistics
Total population (x 1 000)	54 548	62 056	67 959 (2015)
Population < 15 years (%)			17.7 (2016)
Population > 60 years (%)	7.4	9.2	16.5 (2016)
Population in urban areas (%)	19	35	48 (2016)
Life expectancy Female	68.8	75	78.6 (2016)
Life expectancy Male	63.5	70	71.8 (2016)
Fertility rate (births per woman)	2.14	1.82	1.6 (2016)
Contraceptive prevalence rate (%)			79.3 (2012)
Infant mortality /1 000 live births	35	25	6.4 (2013)
Maternal mortality /100 000 live births		44.5 (2003)	20 (2015) ⁸
Deliveries attended by health staff (%)	90.8		99.6 (2012)
Total health expenditure (THE) as proportion of Gross Domestic Product	3.5% (1994)	3.4%	6.5% (2014)
Public expenditure as a proportion of THE	45% (1994)	56%	86% (2014)
THE per capita (USD)	86 (1994)	67	256 (2012)

Source: CCS 2017-2021

17. Thailand has taken solid steps to strengthen its health system through a dedicated policy framework, increased public funding for health and improved performance of health services delivery. Being an upper-middle-income country, Thailand's health system relies mainly on domestic funds; donor or development partners represent less than 0.5% of total health expenditures, mainly focused on technical support in few highly specialized areas.

⁵ <http://www.worldbank.org/en/country/thailand/overview> (accessed 20 March 2017).

⁶ http://www.who.int/nmh/countries/tha_en.pdf

⁷ National Health Commission of Thailand, Royal Thai Government 2012.

⁸ Global Health Observatory <http://apps.who.int/gho/data/node.country.country-THA>

18. There are 17 independent public health agencies⁹ outside the MOPH that wield considerable influence in both shaping the health policy options of the country and the subsequent priority setting which has a huge impact on the health of the Thai people. These agencies are financed by public funds.

1.4 WHO activities in Thailand

19. WHO has been present in Thailand since its inception and, since 2002, the cooperation between WHO and the RTG has been framed through a series of CCSs. In the preparation of the CCS for 2012-2016, it was decided to move away from the very fragmented approach in the CCS 2008-2011, and focus on 5 key health priorities where WHO could add value to the national efforts. The CCS identified additional collaborative programmes in the area of normative functions, a selected number of communicable diseases and Thailand's role in health beyond borders.

20. The CCS 2012-16 includes four clusters of activities: i) five priority areas;¹⁰ ii) normative functions; iii) major public health challenges and unfinished agendas; and iv) support to Thailand's role in health beyond its border. In addition, the WCO is engaged in activities outside the CCS framework.

21. Table 2 below clarifies the main areas of cooperation of both the CCS 2012-2016 and 2017-2021. Reference is also made to the CCS 2008-2011 to provide a longer-term perspective. It shows clear continuity in some priority areas, such as NCD and international trade and health, while others, such as global health diplomacy and AMR, have become priorities more recently. It also shows that some priorities of the CCS 2012-2016 have been discontinued, such as disaster preparedness and response and ageing.

Table 2: WCO main activities across 3 CCS periods

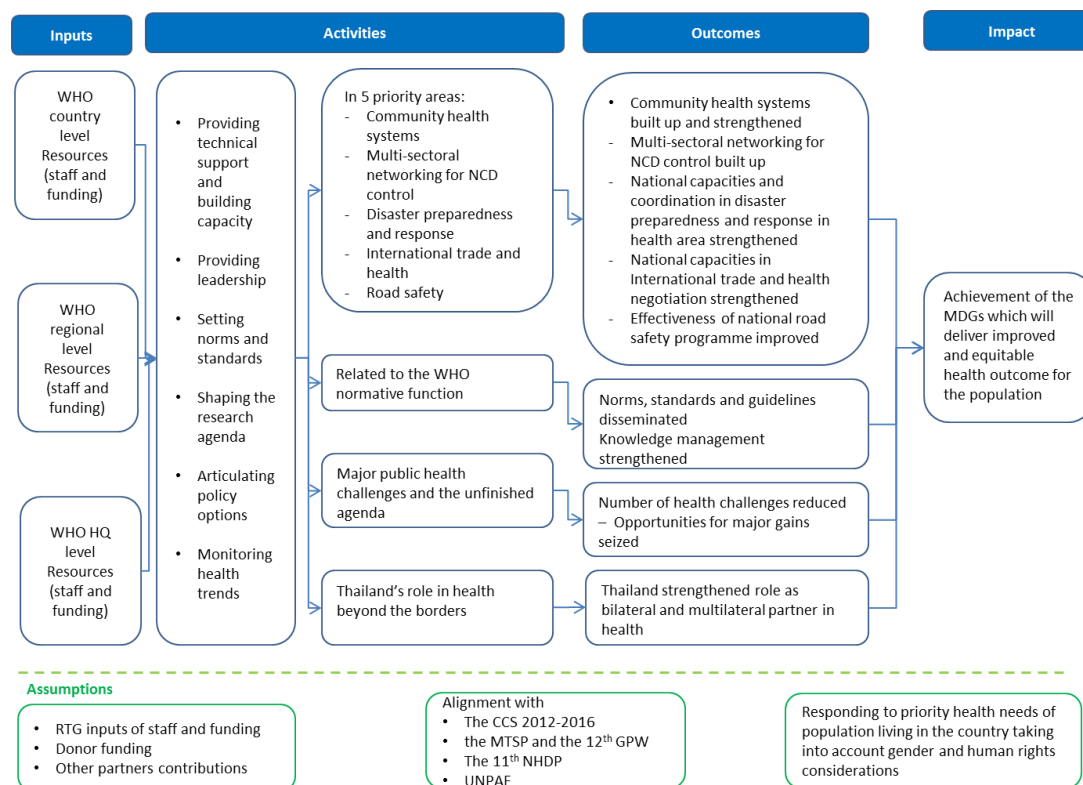
Main activities	2008-2011	2012-2016	2017-2021
Community health system	Included in CCS	CCS Priority until 2013	
Multisectoral networking for NCD control	Included in CCS	CCS Priority	CCS Priority
Disaster preparedness and response		CCS Priority	
International trade and health		CCS Priority	CCS sub-programme of priority on global health diplomacy
Road safety		CCS Priority	CCS Priority
Ageing		CCS priority included in 2013-2014 when priority on community health system was sunsetted	
Border and migrant health	Included in CCS	CCS activity prioritized when priority on community health system was sunsetted	CCS Priority
International health regulations (IHR)		CCS activity	Other WCO activity
Communicable diseases	Included in CCS	CCS activity	Other WCO activity
Global health diplomacy		CCS Activity	CCS Priority
AMR		Other WCO activity	CCS Priority

⁹ WHO, 2012, Country Cooperation Strategy for Thailand 2012-2016.

¹⁰ Annex 3 provides a short summary of the CCS priorities as described for both the CCS 2012-2016 and the CCS 2017-2021.

22. The TOC¹¹ (Figure 2) 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 2012-2016 and the biennial work plans. It encompasses contributions from all levels of the Organization and all strategic contribution areas of WHO in the country. The TOC was reconstructed by the evaluation team during the inception phase, then validated by the Head of the WCO and WCO team during the field mission.

Figure 2: Theory of Change – WHO contributions in Thailand 2012-2016



23. The diagram below indicates the level of investment in the various activities over the period 2012-2016. The highest financial investment went to border and migrant health followed by NCDs and communicable diseases (even though not a CCS 2012-2016 priority).

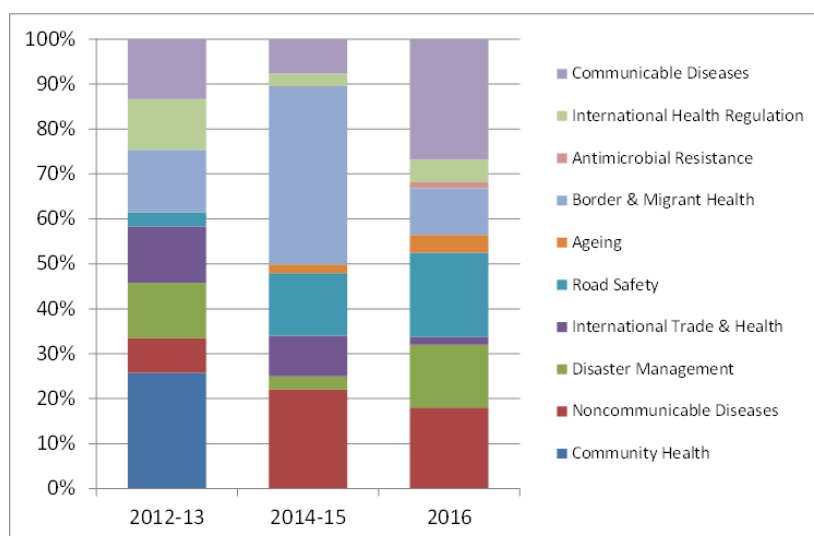
24. The overall WCO expenditure (activities and staff costs)¹² for the period 2012-2016 amounted to US\$ 20,7 million. The main sources of funding¹³ over the period were assessed contributions (67.3%), the European Commission (8.3%), the Bloomberg Family Foundation (2.7%), the RTG (1.9%), the United States Agency for International Development - USAID (1.7%), and the United States Centers for Disease Control and Prevention - US CDC (1.4%). Both US CDC and USAID stopped their funding in 2016, while the RTG contributions started in 2014.

¹¹ Theory of Change is a description and illustration of how and why a desired change is expected to happen in a particular context. It is focused in particular on mapping out or "filling in" what has been described as the "missing middle" between what a program or change initiative does (its activities or interventions) and how these lead to desired goals being achieved (for further details see <http://www.theoryofchange.org/what-is-theory-of-change/>)

¹² Data on expenditures and funding were extracted from the WHO Global Management System.

¹³ Data on funding sources were extracted from the WHO Global Management System.

Figure 3: Estimated¹⁴ proportion of WCO expenditures 2012-2016 for main activities (activity & staff costs combined)



Source: WHO Global Management System (data extracted in 2017)

25. The CCS 2012-2016 was the object of a CCS mid-term review in 2014¹⁵ and of a CCS final evaluation¹⁶ in 2016, the main conclusions and recommendations of which are summarized in the table below.

Table 3: Main recommendations of evaluative exercises related the CCS 2012-2016

Mid-term review	<ul style="list-style-type: none"> • Internal review process with partners prior to next biennium plans • Continuing evaluation of the priority programmes • More active involvement of the MOPH in priority programmes • Application of the priority programme approach • Flexible approach to CCS by WCO thereby accommodating new emerging priorities within the CCS framework
CCS final evaluation	<ul style="list-style-type: none"> • Clear development process to select new priority programmes for the next CCS and careful identification of lead agencies to manage them • Multisectoral committees to be continued • Importance of partnerships beyond MOPH • Lighter management process for the CCS needed • Technical assistance to be identified early on in the process • Staff turnover is an issue to be considered if use of subcommittees is to be pursued • Considering the social determinants of health, multisectoral work is indispensable and justifies the added complexity in programme implementation

26. The RO and HQ also have direct relationships with Thai entities, for instance WHO collaborating centres (currently 34 in Thailand). These include, among others, Government entities such as departments within the MOPH, academia and civil society organizations. These relationships lead to activities outside of the WCO work plans, usually undertaken with minimum involvement and knowledge of the WCO.

¹⁴ Estimated by the evaluation (see section 2.2 first sub-section for further explanation).

¹⁵ WHO, 2014, 'Mid-term review of the WHO Country Cooperation Strategy -Thailand 2012-2016'.

¹⁶ WHO, 2016, 'Final Evaluation of the WHO country Cooperation Strategy Thailand 2012-2016'.

2. Findings

27. The findings of the evaluation are presented following the three main evaluation questions and sub-questions identified in the TOR (see Annex 1 for the full list). More detailed observations per CCS priority are available in Annex 4.

2.1 Relevance of WHO's strategic choices

Relevance of WHO's strategic choices in view of Thailand's population health needs

28. Both the 2012-2016 and 2017-2021 CCSs include, as per the corporate guidelines, an overview of the health situation and trends in the country. A comprehensive consultation process with all stakeholders and a thorough review and analysis of the social, economic and health indicators contained in the background documents were conducted. This process has allowed a better understanding of the health challenges and needs of the Thai population. The CCS 2017-2021 is also informed by a comprehensive health needs assessment undertaken in 2016, to enlighten the selection of its priorities.¹⁷ According to this needs assessment and based on the MDG report for Thailand,¹⁸ it is clear that, while the country made significant progress towards achieving the MDGs, disparities across regions and social groups remain, requiring further effort within the SDG framework. Overall, reference to gender remains largely limited to sex disaggregated data, which is a first step but the CCS guidance calls for further gender analysis as well as analysis of health equity and human rights.

29. NCD, included in the CCS since 2008, is a critical health issue in Thailand as NCD deaths accounted for 71% of deaths in Thailand in 2014.¹⁹ According to WHO's 2015 global report on road safety, Thailand has the second highest incidence of road traffic fatalities in the world and both the CCS 2012-2016 and the CCS 2017-2021 identified road safety as a priority. AMR is becoming very problematic worldwide and is now a priority of the CCS 2017-2021.

30. In addition to refugees from Myanmar, Thailand is the primary host country for low-skilled workers from three neighbouring countries. While initially not a priority for the RTG, due to significant concern among some partners, including WCO, border and migrant health was part of the strategic agenda of the 2008-2011 CCS, then part of the CCS 2012-2016, first as an activity, then a priority when the community health programme was sunsetted. It is again a priority in the CCS 2017-2021.

31. Despite positive trends in terms of reducing malaria incidence and the elimination of mother-to-child transmission of HIV and syphilis, Thailand remains one of the 30 high burden countries for tuberculosis.²⁰ Communicable diseases, which were a priority in the CCS 2008-2011, became an activity in the CCS 2012-2016 and are not included in the CCS 2017-2021. Some parts of MOPH consider that Thailand can now take care of this issue by itself while others, including key partners outside Government, consider it important to continue benefitting from WHO's technical support. The WCO indicated a clear continued commitment to providing high level international technical expertise particularly in the area of multi-drug resistant tuberculosis.

¹⁷ WHO, 2016, 'Needs assessment for the selection of priorities for the Thailand-WHO Country Cooperation Strategy 2017-2021' draft for comments and discussion.

¹⁸ Office of the National Economics and Social Development Board, 2015, 'Millennium Development Goals Thailand 2015'.

¹⁹ WHO, 2014, 'Noncommunicable disease country profiles'.

²⁰ WHO, 2016, 'Global tuberculosis report – 2016'.

Coherence with the national health priorities and the relevant MDG and SDG targets

32. The CCS 2012-2016 was developed after comprehensive consultations with the MOPH, 17 public health agencies, line ministries, academia, nongovernmental organizations, civil society organizations and relevant UN agencies. As the CCS 2012-2016 was developed at the same time as the NHDP, WHO closely coordinated with the national team responsible for its formulation to ensure that it informed the CCS 2012-2016 document adequately.

33. This approach was further strengthened for the CCS 2017-2021 as follows:

- The objective was defined from the onset to have at most five or six priorities included in the CCS, building on the CCS 2012-2016 experience
- 75 stakeholders from inside and outside the MOPH were consulted
- 38 comprehensive proposals on potential priorities to be included in the CCS 2017-2021 were reviewed on the basis of predefined criteria.

Box 1 - Good practice - definition of CCS 2017-2021 priorities based on predefined criteria:

- Contribute to the NESDP strategies
- Address public health issues identified by the MOPH and the UNPAF
- Contribute to achieving targets of WHO leadership and flagship priorities
- Contribute to targets of SDG 3
- Support achievement of current CCS

34. Consequently, and as also shown in Annex 3, **the priorities of both CCSs are well aligned with MDG and SDG targets, the NHDPs and with other national policies or strategies as relevant.** For instance, the border and migrant health component was well aligned with the MOPH Border Health Development Master Plan 2012-2016, the priority on NCDs is aligned with the Thai Healthy Lifestyle Strategic Plan 2011-2020, AMR with the national strategic plan on AMR and global health diplomacy with the national global health strategic framework issued by the MOPH and the Ministry of Foreign Affairs.

Coherence with the UNPAF

35. All UN agencies have the obligation to coordinate with the UN-wide country programmes for Thailand under the umbrella of the UNPAF 2012-2016,²¹ which has a very broadly defined result framework to accommodate all participating agencies. In this regard, WHO identified three relevant outcomes where joint action and synergy was envisaged: climate change; capacity building and promotion of Thailand as a global partner; and the area of social reform with particular focus on health equity. It should also be noted that the CCS 2012-2016 priorities are recognized as part of the UNPAF alongside those of other agencies.

36. Effective collaboration within the UNPAF is partially hampered by the different accountability and governance structures and mandates of each UN agency, which require them to report back to their respective governing bodies.

37. UN Partners report that strategic engagement of WHO within the UNPAF framework and thematic working groups is somewhat limited. There is a perception that WHO remains too focussed on health issues. Also, the geographic location of the WCO in the MOPH and away from the other UN agencies contributes to limited participation in the various UNPAF working groups and a perception on the part of the other agencies of the very specialized role of WHO in health.

38. However, partners also clearly recognize WHO's technical leadership and convening power, for instance in the area of border and migrant health and communicable diseases where effective collaboration with IOM, UNAIDS, UNFPA and UNICEF was reported.

²¹ United Nations Country Team in Thailand, 2011, 'Partnership Framework (UNPAF) for Thailand 2012 -2016'.

39. With the UNPAF 2017-2021 there is a need for a strong strategic and policy level positioning of the UN agencies in the country which can be a challenge for agencies when positioned mostly at technical level. There is a clear call from partners for WHO to engage more substantively and strategically in support of the SDGs.

Coherence with the General Programme of Work

40. The CCS 2012-2016 coincided with the last 2 years of the 11th General Programme of Work (GPW).²² The five priorities in the CCS were aligned with the strategic objectives articulated in the 11th GPW and explicit linkages were made in the document between each priority and several strategic objectives of the Medium-Term Strategic Plan (MTSP).²³ Since the 12th GPW²⁴ took on board most of the priorities identified in the previous GPW, there was a good alignment between the CCS 2012-2016 and the 12th GPW. Similarly the CCS 2017-2021 priorities are explicitly linked to specific outcomes of the 12th GPW. These priorities also conformed with WHO international commitments as expressed in World Health Assembly (WHA) resolutions.

Box 2 - Good practice – Validation matrix aligning CCS strategic priorities with national, WHO, United Nations and global priorities

In the CCS 2012-2016, each priority was associated with several strategic objectives of the MTSP (see further details in Annex 4). The CCS 2017-2021, as suggested in the CCS 2016 Guide, includes a validation matrix which establishes linkages between each CCS priority and a specific GPW outcome and also with the national SDG targets, the NHDP, the UNPAF outcomes and the Regional Flagship areas.

Support to gender equality and the empowerment of women

41. When it comes to gender there is a clear shift between the two CCS documents. While gender equality and empowerment of women were only addressed in a limited manner in the CCS 2012-2016 document, they were given substantial attention in the analysis of health-related issues in CCS 2017-2021. However, there is as yet no clear advocacy for these issues in the strategic agenda implementation.

WHO's evolving approach

42. The health sector in Thailand is characterized by a large number of actors from both the public and the private sector. Several other public health agencies with autonomous or semi-autonomous status operate side by side with the MOPH, as well as 34 WHO collaborating centres and 35 other institutions considered as centres of excellence.²⁵

43. The CCS 2008-2011 implementation was highly fragmented with many different small projects across the MOPH. This changed with the CCS 2012-2016 and the identification of five priorities from 21 concept papers initially submitted. Seventeen major public health agencies voted and identified four priorities. WHO added the fifth one, on road safety. The MOPH led one of the priorities, three health agencies and one WHO centre of excellence were identified to lead the others. A subcommittee was created to manage each priority as well as a steering committee to govern the entire CCS 2012-2016. This represented another shift from the CCS 2008-2012 to foster multi-agency collaboration. It implied new governance mechanisms which worked with varying degrees of success across the priorities. For instance, the international trade and health programme lead agency developed solid workplans and the subcommittee widened the influence of the programme beyond MOPH. On the other hand, the community health programme was stopped after

²² WHO, 2005, '11th General Programme of Work 2006-2015'.

²³ WHO, 2007, 'Medium-Term Strategic Plan 2008-2013'.

²⁴ WHO, 2013, '12th General Programme of Work 2014-2019'.

²⁵ See CCS 2012-2016.

the lead agency withdrew from the programme. **The choice of the lead agency is critically important, needing strong leadership and convening capacity as well as a highly competent programme manager to lead the programme implementation.** The CCS 2012-2016 final evaluation made a certain number of recommendations in that regard which have largely been taken on board in the design of the CCS 2017-2021.

44. The prioritization process was further strengthened for the CCS 2017-2021. Following a comprehensive consultation process, five priorities plus one sub-programme were selected on the basis of predefined criteria (see Box 1) out of 38 proposals. The lead agencies for the CCS 2017-2021 include the MOPH, health agencies and one WHO collaborating centre and more than 66 ministries, agencies and organizations will be participating directly in its implementation. This time around the CCS reached out to other ministries, making it a truly multisectoral approach from the onset. **The implementation of the CCS 2017-2021 will therefore require very strong governance and financing²⁶ mechanisms reflecting increasing country ownership.**

45. Considering the constantly growing strength of the health sector in Thailand, WHO's role is becoming gradually more that of a catalyst, for instance, bringing together traditional health actors with other non-health actors on the social determinants of health, who had not been included in the previous CCSs.

46. **WHO was also instrumental in highlighting, in the CCS 2017-2021, health-related issues which might not have originally been MOPH priorities, such as road safety or border and migrant health;** and in ensuring that health concerns that are not prioritized by the MOPH as a priority for WHO support within the CCS continue to benefit from WHO technical support (e.g. tuberculosis).

Strategic positioning of WHO when it comes to...

47. ... **WHO's comparative advantage.** This was one of the criteria used to prioritize programmes within the CCS 2017-2021 (see Box 1). WHO is highly valued for :

- **the access it provides national partners to international regional or corporate health technical expertise;**
- the exposure it gives Thai health experts to regional and international health issues;
- its "brand" name and the steer it can provide to national initiatives;
- its convening capacity, especially for health-related issues requiring collaboration and partnership with non-health actors in-country.

48. These are often presented as intellectual and social capital by the RTG (see para 52 below).

49. The above elements are much more important to the RTG partners than the funding that WHO can bring into the country. The funding from the RTG will increase from less than 2% in the CCS 2012-2016 to about 70% in the CCS 2017-2021. In this context WHO is expected to play a catalytic and proactive role and support :

- the governance of the programmes as they require engagement with, and coordination of, numerous partners in various sectors
- the CCS 2017-2021 at a policy and strategic level and not just at the technical level as in the past.

50. ... **Positioning health priorities in the national agenda.** As mentioned earlier, border and migrant health as well as road safety are recognized as two areas which have consistently been prioritized by WHO when designing the CCSs. WHO also remains committed to support the unfinished agenda related to communicable diseases. However, the evaluation did not find any strong evidence of WHO's proactive engagement supporting gender equality and empowerment of

²⁶ Financing mechanism discussed in section 2.3 with funding

women.

51.Partnership between WHO and the RTG. Historically, the MOPH was the only WHO counterpart. With the emergence of numerous health agencies and in order to reach out to non-traditional health actors, WHO is increasingly playing a convening and coordination role between the various national partners in country. Partnership is a key element of CCS 2012-2016 and this is confirmed in the CCS 2017-2021.

52.... WHO's contribution in terms of intellectual and social capital. Many national partners indicated clear expectations with regard to WHO's strategic contribution in this respect. In their opinion, intellectual capital broadly refers to WHO's leading role in health technical expertise, while social capital refers more to WHO's reputation, influence, authority, name and trust. The CCS 2012-2016 benefitted from WHO's contribution in terms of intellectual capital and the CCS 2017-2021 design depended to some extent on WHO's social capital to facilitate the transparent consultation and selection of priorities process among a very large group of national partners from health sector and beyond.

Summary of key findings

- ✓ Overall, both CCSs are based on critical health issues for the country, especially in the area of NCDs and road safety. The CCS 2017-2021 prioritizes AMR, a new major global health issue, and border and migrant health. Though no longer a CCS priority, a remaining area of concern is tuberculosis, considering Thailand is one of the 30 remaining high burden countries.
- ✓ The priorities of both CCSs are well aligned with MDG and SDG targets, the NHDPs and with other national policies or strategies, as relevant. Both CCSs benefitted from a design process ensuring alignment with national health priorities through extensive consultations. The CCS 2017-2021 selection of priorities was based on transparent criteria.
- ✓ The CCS is an innovative model mobilizing both the financial resources and social intellectual capital of WHO and Thailand's key health agencies to support the implementation of national health priorities. Its basic principles are aligned with Paris Declaration on Aid Effectiveness, based on single program development management and reporting.
- ✓ The CCS 2012-2016 is coherent with the UNPAF 2012-2016 which provides a large umbrella framework for all UN agencies. Technical collaboration with other UN agencies is perceived positively by partners, recognizing WHO's specialized role. But there are also strong expectations that WHO will position itself at a more strategic and policy level within the UN country team with the start of the UNPAF 2017-2021.
- ✓ Both CCSs were aligned with the prevailing GPWs at the time of their design and included explicit linkages with specific corporate objectives and outcomes.
- ✓ Reference to gender remains limited to sex-disaggregated data for some indicators. Indeed, gender equality and empowerment of women issues were not addressed in the CCS 2012-2016, and only included in the analytical part of the CCS 2017-2021.
- ✓ Since 2012 a strategic shift occurred to change the CCSs from very fragmented support to numerous projects within MOPH, to a clearly prioritized catalytic approach developed through a comprehensive and transparent consultative process.
- ✓ The choice of the lead agency is critically important, needing strong leadership and convening capacity as well as a highly competent programme manager to lead the programme implementation. The implementation of the CCS 2017-2021 will require very strong governance and financing mechanisms.
- ✓ WHO also pushed for some issues such as road safety and border and migrant health to be consistently included in the CCSs, though initially not necessarily a priority for the RTG.
- ✓ WHO's comparative advantage, namely, in technical areas and as convening power, is well recognized. However, the RTG also expects WHO to play a catalytic role at policy and strategic multisectoral levels.

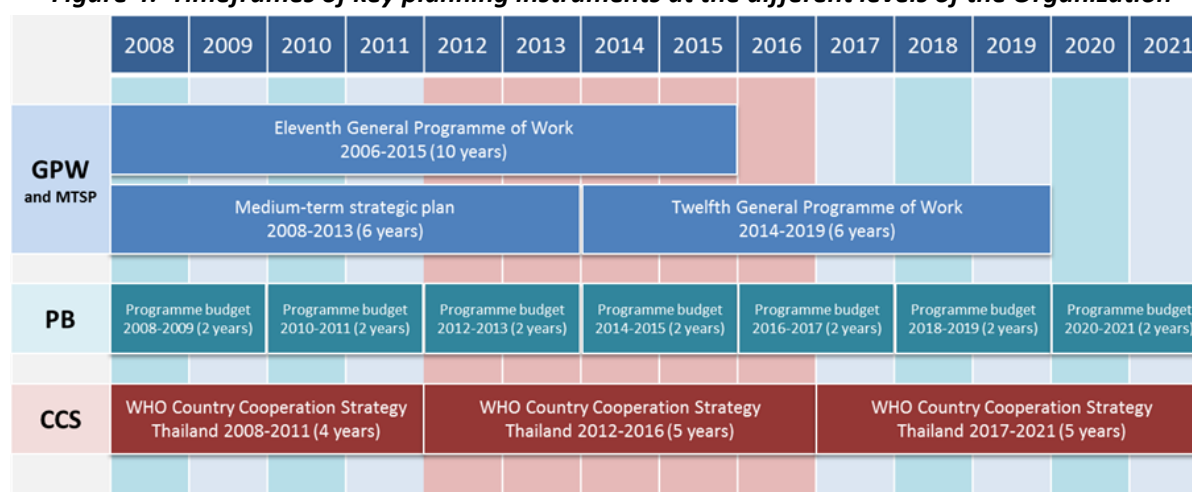
- ✓ *Partnerships were at the core of the CCS 2012-2016 and are reconfirmed in the CCS 2017-2021.*
- ✓ *The focus of the CCS 2012-2016 was mainly on advancing coordination and networking among the many health partners, both national and international, with the aim of building the delivery capacity of the public health agencies and other partners to the Thai population to improve health outcome. The CCS 2017-2021 takes the WHO collaborative programme to the next stage where the CCS articulates clear deliverables under each of the five priorities. Measurable indicators are still under development.*
- ✓ *There are strong expectations from the RTG when it comes to WHO's contribution in terms of intellectual and social capital. It means WHO needs to remain on the cutting edge technically and consolidate its emerging social capital role.*

2.2 WHO's contribution and added value (effectiveness)

Articulation of the WCO biennial work plans with the focus areas as defined in the CCS 2012-2016

53. As shown in Figure 4, the CCS 2012-2016 timeline overlapped with the MTSP and the 12th GPW timelines. While the CCSs for Thailand are for a period of five years, the workplans are organized per biennium, which coincided with the start of CCS 2012-2016, but CCS 2017-2021 starts in the middle of a PB and GPW. Though unavoidable, as CCSs can have different durations depending on national and UN in-country planning time frames, this makes direct alignment of workplans and reporting with the CCS challenging. As mentioned earlier, the CCS timeframe is aligned with the UNPAF timeframe.

Figure 4: Timeframes of key planning instruments at the different levels of the Organization



54. As currently available in the WHO Global Management System, the workplans at country level are all explicitly connected with the corporate outputs as defined in the PB. The 2012-2013 workplan is connected to the MTSP while the subsequent workplans are connected to the 12th GPW outcomes and outputs. The CCS document however links each priority to several strategic objectives of the MTSP. Therefore, as explained in Annex 3, there is a missing link between workplans drafted at country level and the strategic priorities established in the CCS. The WCO has not explicitly translated the PB corporate outcome and output targets as measurable outcomes and outputs at country level nor has it developed any clear results framework (or logical framework or impact pathway or theory of change) for each of the priorities of the CCS, identifying its expected contribution to each priority for the CCS period with corresponding baselines and targets.

55. It was only by manually mapping the tasks included in the workplans against the CCS 2012-2016 priorities that the evaluation was able to assess which tasks and expenditures could be allocated to each CCS 2012-2016 priority. This mapping was used to inform both estimates on planned costs and expenditures and the analysis of results presented below.

56. According to this mapping, the evaluation estimated that CCS 2012-2016 priorities and activities represented more than two thirds of the WCO activity expenditures over the CCS period. The rest of the activity expenditures are mostly related to strategic activities of the WCO and the running of the office.

Main results achieved²⁷

CCS 2012-2016 priorities

57. **Community health system.** Unanimously ranked top priority during the planning process of the CCS 2012-2016, it was sunsetted following governance issues.²⁸ The CCS mid-term review reported a certain number of activities completed but no major results achieved during the period of implementation of about 18 months.

58. **Multisectoral networking for NCD control.** NCD is a continued priority for both the RTG and WHO. Progress was noted both in the CCS mid-term review and in the CCS final evaluation and confirmed through interviews, such as: the inclusion of four risk factors and diseases in the integrated national NCD plan in order to have it aligned with the global NCD plan approved by the WHA in 2013; the development of the first national NCD guidelines; and the formalization, in 2016, of the NCD alliance of Thailand (a network of academia, NGOs and professional bodies). However, the CCS final evaluation also found that the main objective of building a multisectoral network for NCDs to facilitate the implementation of the Thai Healthy Lifestyle Strategic Plan was not achieved. WHO's research mainly supported national policy development on tobacco control. Overall, the results achieved during the CCS 2012-2016 are perceived by most stakeholders as good foundations for the CCS 2017-2021.

59. **Disaster preparedness and response.** There was a shift in the objectives identified in the CCS during the planning process from establishing a network on disaster health emergency management, to mainstreaming disaster risk reduction in the health sector. According to the CCS mid-term review, WHO contributed mostly to building a momentum in engaging MOPH, the National Institute for Emergency Medicine (NIEM) and other stakeholders in enhanced focus and work on disaster preparedness and response. Finally the MOPH developed a disaster response plan for people with disabilities with the support of WHO, placing Thailand among the first countries in the world to have such a plan.

60. **International trade and health.** This was a new priority of the CCS 2012-2016. According to the CCS mid-term review, the initial 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. The CCS final evaluation confirmed that the programme had achieved most of its objectives while recognizing that impact on trade agreements could not be documented considering the natural opacity of trade negotiation processes. WHO technical and policy contributions in the promulgation of laws and

²⁷ Considering the limitations identified in previous section, the evaluation assessed progress for each of the four main groups of outcomes as presented in the TOC (Figure 2) but was not able measure them against planned targets as they were not identified in a measurable manner.

²⁸ According to the CCS mid-term review, the MOPH issued the Ministerial order 272/2526, dated 10 February 2013, which effectively cancelled the steering committee of the RTG-WHO CCS, and established the new executive committee to oversee the CCS. The Health Systems Research Institute, the lead agency for the community health programme, was not included in this committee and it later notified WHO that it would like to terminate its contract signed with WHO, effective 1 July 2013.

regulatory frameworks in the area of tobacco control, alcohol abuse and access to medicines were found useful.

61. **Road safety.** At the time of the CCS mid-term review, progress was still far from satisfactory. The initial focus of the programme was on campaigns which were neither countrywide, visible nor continuous. The CCS final evaluation confirmed that the stated objectives were not achieved but nevertheless recognized a certain number of achievements. Indeed the second part of the CCS implementation saw a productive period of legislative activities which were instrumental towards stronger road safety laws and regulations. WHO commissioned Thailand's Road Safety Institutional and Legal Assessment which revealed the need for various legislative improvements. WHO also successfully advocated for the establishment of the Working Group to Review Road Safety Legislation under the national road safety directing centre. This group submitted for Cabinet approval a set of road safety legislative amendments aimed for implementation by the end of 2016.

62. **Border and migrant health.** WHO has been active in this area since the early 1980s. Included as an activity in the CCS 2012-2016, it became a priority along with ageing, as community health was sunsetted. The CCS final evaluation found that planned activities were achieved and that WHO's advocacy in various relevant committees and task forces had been critically important. These included WHO support to establish and scale up border health information centres for migrants in a province and helping to maintain a health information system operating in camps along the Thai-Myanmar border.

63. **Ageing.** This is an issue of increasing importance for Thailand as it is going through a demographic transition. It was introduced mid-course in the CCS but activities remained marginal around literature reviews. The activity was sunsetted at the end of the CCS 2012-2016.

Dissemination of norms, standards and guidelines and generating knowledge

64. The WCO has been active across the CCS priorities to ensure adaptation of norms and standards at national level across relevant areas of work. It has also produced studies and research in various areas relevant to the health agenda in the country, thus contributing to build the evidence base to inform decision-making processes.

Major public health challenges

65. Communicable diseases were a priority of the CCS 2008-2011 and the country has registered notable progress in this area especially in HIV/AIDS control and reduction of incidence of malaria. However, malaria and tuberculosis require continued attention and, though no longer a CCS priority, the WCO continued to support the country in these areas. WHO is the lead agency for the national malaria programme reviews and provided technical and policy advice on the development of national plans reflecting the global and regional strategies on malaria elimination (i.e the national strategic plan for malaria elimination (2017-2026)). Following the joint international monitoring mission review conducted in 2013, the WCO and MOPH decided to continue prioritization of tuberculosis control under the auspices of the CCS 2012-2016 and the WCO provided continued technical support. Although the CCS 2017-2021 does not include tuberculosis as a priority and considering Thailand is still a tuberculosis high burden country, the WCO remains committed to continue to provide support in this area.

66. AMR, though not referred to in the CCS 2012-2016, was already supported by the WCO and is now a priority of the CCS 2017-2021. The WCO contributed to the development of the draft national strategic plan which will serve as the basis for engagement for the forthcoming period.

Strengthened role of Thailand as a bilateral and multilateral partner in health

67. Over the last few years, Thailand has played an increasingly important role in health development beyond its borders. Among other things, the WCO regularly provided opportunities for Thai expertise to contribute regionally and internationally through participation in relevant

conferences and workshops. For instance, Thailand is now in a position to offer some support to neighbouring countries in terms of vaccine and drug supply in response to outbreaks in these countries. These elements laid the foundations for the CCS 2017-2021 priority on global health diplomacy.

In brief

68. The CCS moved from a high number of small projects to a set of priorities and a small number of additional activities for the period 2012-2016. Though confronted by a number of challenges in planning and clarity on the expected contributions of WHO and in governance, notable progress and results have been consistently reported, as summarised in Table 4, from document reviews, WCO self-assessments and interviews conducted with partners.

Table 4: Indication of progress towards results for main CCS 2012-2016 priorities and activities²⁹

CCS priorities and main activities	Indications of		
	Good progress	Some progress	Limited progress
Community health			
Multisectoral networking for NCD control			
Disaster preparedness and response			
International trade and health			
Road safety			
Border and migrant health			
Ageing			
Communicable diseases			

Key to ratings - **Good progress**: when document reviews, interviews and WCO reporting provide converging information towards results even though nuances were also provided and there were indications that further work was needed; **Some progress**: when information included elements of progress combined with clear issues related to implementation; **limited progress**: when information recognized implementation but also sunsetting of the priority or of the activity.

Added value of regional and headquarters contributions to achievement of results

69. **Regional and headquarters contributions to the WCO.** The main added value recognized across the board related to the overall access to regional or international expertise in specific technical areas as well as the possibility for Thai health expertise to contribute regionally and globally through WHO's convening power. The RO and HQ both provided support to the WCO at the time of the CCS design. Access to timely and relevant international health expertise from the RO and HQ or from outside WHO was found critically important for an appropriate implementation of the CCS, for instance, in the areas of international trade and health, nutrition, reduction in salt intake and tobacco control. It is also recognized that the need for technical contributions from RO and HQ are highly dependent on the level of expertise already present in the WCO. While all partners acknowledge and appreciate the technical contribution received from the RO and HQ, it was, however, difficult to quantify it as it was not possible to capture the relevant expenditure data (covering technical visits and staff time expended) from these offices, thus making it difficult to assess the totality of WHO input to the country programme.

70. **WHO norms and standards.** These regularly served as a framework/guide for implementation activities in-country (see Annex 4). Corporate initiatives can also benefit countries, such as the road safety priority which benefited from funding and technical support as part of the Bloomberg Initiative managed by HQ. The Regional Director's strategic vision and 7 flagship priorities for South-East Asia were also found useful to embed CCS priorities within a larger framework.

²⁹ Detailed information available in Annex 4. Information for other areas was too limited to be useful, and is neither included in Annex 4 nor Table 4 above.

71. **Regional collaboration across the South-East Asia and Western Pacific Regions of WHO.** Thailand and Myanmar are the only countries in the Mekong sub-region that are part of the South-East Asia Region of WHO, the rest being members of the Western Pacific Region of WHO. The evaluation noted that there is a need to better harmonize the contributions from the two regional offices in the Mekong sub-region. The Thailand WCO also needs to play a significant role in the Association of Southeast Asian Nations (ASEAN), to supplement regional collaboration between the two WHO Regions which, while providing strategic regional perspectives, takes time away from national priorities.

72. **WCO contribution to the RO and to HQ.** Thailand being a regional hub for many other UN agencies, the WCO is regularly required to represent the RO in various regional meetings which is on the one hand very enriching for the WCO but also time consuming.³⁰ The WCO is also regularly expected to provide data to the RO and HQ without these requests necessarily being coordinated in terms of timing or methodology, sometimes putting heavy pressure on a relatively small team.

Contribution of WHO results to long-term changes in health status

73. It is largely recognized that the WHO long-term presence in-country and active role for a long period of time has certainly contributed to major results in communicable disease control. WHO has also been active since 2004 in the area of border and migrant health and has consistently ensured attention to this area as part of the CCS 2012-2016 priorities or activities. Finally, in the area of road safety and NCD, new legislation directly benefitted from WHO advocacy efforts and technical support.

National ownership of the results and capacities developed

74. Thailand has made substantial progress in health. Its positioning internationally in the area of health is a strong indication of capacities developed through WHO contributions over time. For example, in the area of immunization and vaccine development, the programme previously supported by WHO has now become self-reliant with 100% government funding.

75. Interviews largely confirmed that the comprehensive consultations between more than 75 stakeholders from within and outside the MOPH and the bottom-up approach, with 38 proposals submitted from the national partners for inclusion in the CCS 2017-2021, constituted an indication of strengthened national ownership, building on that already initiated during the design of the CCS 2012-2016.

76. While RTG funding for the CCS 2012-2016 amounted to only 1.9 % of overall funding, it is now expected to become the main source of funding of the CCS 2017-2021, showing a very clear sign of national ownership of the CCS priorities.

Summary of key findings

- ✓ *The country office workplans do not have an explicit link with the strategic priorities established in the CCS 2012-2016. The WCO has not explicitly translated the PB corporate outcome and output targets at country level nor has it developed any clear results framework for each of the priorities of the CCS, identifying its expected contributions to each priority for the CCS 2012-2016 with corresponding baselines and targets.*
- ✓ *Good progress has been observed for three of the main CCS 2012-2016 priorities; some progress made in one area; and two priorities have been sunsetted. Good progress can be reported in the area of communicable diseases, even though no longer a CCS 2012-2016 priority.*

³⁰ The WCO has at least 2 administrative staff who work almost full-time on regional programmes while part of the country office workplan.

- ✓ *The main added value of RO and HQ is the provision of access to high-level technical expertise regionally and internationally as well as the regional and global exposure it provides for Thai health expertise.*
- ✓ *WHO long-term contributions to health changes in the country were observed mostly in the area of communicable diseases and prioritization of border and migrant health issues in the national agenda*
- ✓ *Increasing ownership by the RTG of the CCS is especially noticeable in the design and funding of the CCS 2017-2021*

2.3 How did WHO achieve the results? (Elements of efficiency)

Contribution of the core functions

77. WHO core functions are substantially interconnected: to advance the research agenda or develop policy options requires technical support. Document reviews and interviews all show very strong linkages between these three core functions and leadership. Nevertheless an attempt has been made in Annex 4 to clarify to the extent possible the contributions of each core function to the CCS 2012-2016 priorities and main activities. These are briefly summarized below.

78. **Technical support.** Most technical support under the CCS 2012-2016 came from two main sources of expertise: i) internally within WHO, mostly from the WCO, but also from the other levels of the Organization; and ii) from WHO's ability to access highly relevant regional and global technical expertise. This happened across the board and remains a strong expectation from the RTG when it speaks of WHO's "intellectual capital".

Box 3 - Good practice – WCO's convening role beyond the health sector.

The WCO brought together a very large number of actors of the health sector who had not worked together before to partner around CCS 2012-2016 priorities. Beyond this it also played key role in bringing together the MOPH and other ministries dealing with the economic and social determinants of health, especially in the areas of road safety and international trade and health.

79. **Leadership.** Considering the high level of fragmentation of the health sector in Thailand, all stakeholders and documents reviewed recognized the **key role played by WHO to convene and facilitate dialogue among partners, both within the health sector between the MOPH and the various health agencies and also with sectors dealing with the economic and social determinants of health**, especially in the areas of road safety and international trade and health. That said, several stakeholders found that WHO could better use its reputation and technical clout to influence national policies as well as the role of health partners. In addition, there are strong expectations from the RTG that in future WHO's convening power will provide a platform to showcase Thai public health experience to the wider world.

80. **Norms and standards** developed by WHO corporately have been adapted/translated in various national guidelines, as relevant. When working on international health regulation in the past there was an overall lack of public confidence in the MOPH, which was successfully bolstered by the support of WHO's normative authority.

81. **Research** and contribution of evidence to inform decision-making by the MOPH have played a key role across the CCS 2012-2016 agenda. Research took place to inform traditional health-related issues in the area of communicable diseases as well as newer areas of work such as international trade and health. This core function remains critically important even in a country such as Thailand with its substantial progress in health and its own international health experts.

82. **Policy options.** Technical support and research have regularly been provided and undertaken to support policy options in the five priorities in the CCS and other health issues. This has

happened especially in the area of road safety but also in NCD for instance where the WCO contributed towards the promulgation of tobacco laws/regulations and processes to effectively implement the sin tax to strengthen government efforts to control tobacco use.

83. **Monitoring health trends** appears to be the least important core function at country level. According to the report of the taskforce on the roles and functions at the three levels of WHO, this refers to WHO's leadership to monitor and evaluate national policies and programmes as well as to support the collection, analysis, dissemination and use of data for monitoring the national health situation. Key national partners have expressed strong expectations for the WCO to lead on setting up a strong monitoring and evaluation mechanism for the CCS 2017-2021.

Table 5: Level of contributions of the core functions to the results of the 2012-2016 period

Priorities - activities	Technical support	Leadership	Norms and standards	Research	Policy options	Monitoring health trends
Community health system	+	+				
Multisectoral networking for NCD control	+	+++	+	++	+++	
Disaster preparedness and response	++	+	+	+		
International trade and health	+++	+++		++		
Road safety	+++	+++		+	+++	
Border and migrant health	+++	++	+	+	+	+
Ageing	+			+		
Communicable diseases	+++	++	++	+	+	+

Note: rating relates to information available (for further details see Annex 4) on the contribution of core functions and this information here is reflected in terms of: +++ substantial contribution, ++ some contribution and + limited contribution. The intent is not to be exhaustive but reflect where emphasis has been laid during the 2012-2016 period.

Contribution of strategic partnerships to the results achieved

84. Three main types of partnership have played a key role in WCO activities between 2012 and 2016.

85. **National partnerships.** The CCS final evaluation undertook a systematic analysis of the partnerships, the results of which have been largely confirmed through the evaluation team's interviews. At the time of CCS 2012-2016 design, the option was taken to have the lead agency for each CCS priority outside the MOPH in order to foster inter-agency collaboration from the onset, while the MOPH would keep the overall oversight of the CCS through a steering committee. This represented a major shift from the CCS 2008-2011 and produced mixed results. In some cases, for instance in international trade and health, the lead agency had experience in dealing with multiple agencies and produced collaboratively a solid work plan, organized regular and well documented meetings and overall made good progress over the course of the CCS 2012-2016. On the other hand, the lead agency for the community health priority was side-lined following internal political changes and finally withdrew mid-course of the CCS implementation. At a time of a major governance shift taken with the CCS 2012-2016, the numerous internal changes in leadership of the WCO during this

period (three heads of WCO and one officer in charge for almost a year) represented an additional constraining factor to the smooth implementation of the CCS.

86. While some partnerships have been less fruitful than others, this was overall recognized as being the way forward for the CCS 2017-2021, where partners are in even greater number, thus intensifying the importance of learning from the governance successes and failures of the CCS 2012-2016 to move forward.

87. **Partnerships with national WHO collaborating centres.** In 2017, Thailand counted 34 active WHO collaborating centres, some of them playing a key role as the lead agency for the road safety priority or as a key partner in other activities such as AMR.

88. **Partnerships with UN agencies and other partners in-country.** The WCO and UN agencies reported useful collaboration on specific CCS 2012-2016 priorities, among other things, in the area of border and migrant health where there is a long-standing positive partnership with the IOM regional office. Partnerships with UNICEF and UNDP were mentioned as useful to move forward the agenda on nutrition and tobacco control. Partnership with US CDC mainly focused on communicable diseases and border health.

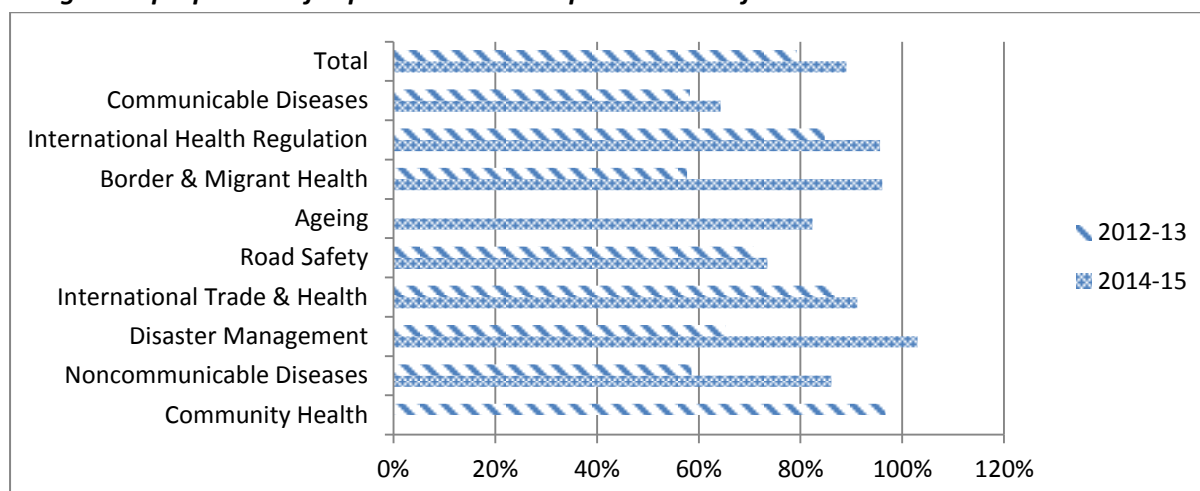
Funding

89. According to the CCS 2012-2016, as WHO is not a funding agency, its main contribution would be to exert its technical power, its “social credit” and its neutral convening power. It would, however, use its modest financial support in a catalytic way to leverage additional funds (when needed) from donors to fully support selected areas of work. The CCS 2012-2016 does not include any information about the size or magnitude of expected funding through its duration or across the various elements of the CCS. It is therefore not possible to assess whether budgets were appropriate or funding levels timely.

90. Figure 5 below compares, for the two biennia completed during the CCS 2012-2016, the level of expenditure compared with the planned costs for the main activities undertaken and shows clearly that expenditure rates have consistently improved, reflecting very understandably a slower expenditure rate at the start of the CCS as the partnerships and workplans were being developed.

Box 4 - Towards good practice – learning from governance challenges of the CCS 2012-2016

- Importance of solid work plans at the onset of the CCS agreed by all relevant partners
- The work plan to clarify expected contributions of all partners for each expected result or objective, including expected contributions from WHO.
- Lead agency to have credibility among the partners and be used to leading inter-agency processes
- Selection of a full-time competent programme manager
- Proactive role to be played by all partners
- Appropriate funding mechanism to be identified.

Figure 5: proportion of expenditures versus planned costs for PB 2012-2013 and PB 2014-2015

Source: GSM

91. The overall proportion of expenditures versus planned costs increased from 79% during the 2012-2013 biennium to 89% during the 2014-2015 biennium. Considering limited resources available to the WCO, close monitoring facilitates full expenditure at the end of each biennium. That said, the data available do not shed light on the flow or the timing of the funding which might well have been intermittent or released towards the end of the biennium and might therefore partially explain the expenditure rates. Staff represented 62% of the overall costs.

92. The WHO financial contribution to the national programmes was modest though recognized as critically important to leverage support or to launch new initiatives. Funding came from both assessed contributions and voluntary grants for specific initiatives. These played a major role in funding activities in the areas of border and migrant health as well as road safety.

93. Increased transparency in budget planning has been observed for the CCS 2017-2021 which has identified ahead of its finalization an overall financial requirement of US\$ 13,7 million. This CCS will be mainly funded by the RTG (increasing over time to become about two-thirds of the planned budget while WHO will fund only up to 30% of it). This is meant to achieve two complementary objectives: i) to increase country ownership and engagement by having national agencies active in the health sector contribute to jointly set national priorities; and ii) to encourage WHO to not just be a financial partner but also to leverage its intellectual and social capital to advance goals in the priority areas set out in the CCS.

94. Early in 2017, however, WHO funding for the first year of the CCS 2017-2021 was challenged by resource constraints at the regional level. It remains to be seen whether or not this has any significant impact on the “leveraging” power of the catalytic funding.

95. Finally, the overall financing mechanism used for the CCS 2012-2016 was found cumbersome and far from the Paris Declaration Principles. Many national partners are actively seeking another approach to facilitate a more appropriate and predictable funding of the CCS 2017-2021. Box 5 highlights the main characteristics of a possible new financing mechanism. It will be important to identify clear

Box 5 - Towards good practice – Piloting of a new CCS financing mechanism

WHO and Thai authorities have agreed in principle to a unique funding mechanism for the CCS 2017-2021 which should reduce transaction costs and include the following key elements:

- Un-earmarked funding from all funders, including WHO, is pooled annually for each of the five priority areas
- All funds are provided against a single annual plan for each priority area
- A single technical and financial report is produced for each priority area.

triggers (baselines and targets) to release the funds in order to ensure that WHO fulfils its obligation with regard to Member States in terms of accountability and transparency of the use of funding.

Staffing

96. The composition of the WCO evolved considerably over the CCS 2012-2016 period with a very strong international staff presence mostly at P4 and P5 level. The team has also been confronted with various changes (and vacancy) in leadership over the 2012-2016 period as well as a high staff turnover which, according to the CCS final evaluation and interviews, affected levels of implementation.

Table 6: Profile of WCO staff in 2011 and 2017

	Organigram Q3 2011	Organigram Q1 2017
International professional officers	4	8
National professional officers	7	4

Source: WCO organigrams

97. The CCS final evaluation assessed positively the capacity of the WCO to dedicate national professional officers to some of the CCS 2012-2016 priorities. Also confirmed during the interviews, the knowledge of Thai is critically important to ensure active engagement of the WCO in technical meetings. The increase in the number of international technical professionals in the WCO is a welcome initiative, and there is also a need for appropriately skilled NPOs, not only in support of technical issues but also to facilitate discussions when language is an issue (this can also be supplemented with locally sourced translation services).

98. The WCO requested a review of individual staff functions and team structure at the end of 2016³¹ to ensure an appropriate staffing to implement the CCS 2017-2021. The WCO has now developed an organigram around the six programme categories identified in the 12th GPW and has identified a focal point per CCS priority.

99. The implementation of the CCS 2012-2016 faced issues of governance but also of weaknesses in monitoring (see below). Strong expectations in this regard on the part of national partners confirmed this CCS final evaluation finding. However, at the moment there does not seem to be any profile in the organigram with professional capacities in programme management to advise on planning issues and develop a comprehensive, strong monitoring and evaluation framework for the entire CCS 2017-2021. This might be a missed opportunity at a critical point in WHO's engagement in the country.

Monitoring mechanisms

100. Each component of the CCS 2012-2016 included a workplan which, according to the CCS final evaluation, was more or less solid depending on the CCS priorities. For instance, in international trade and health, the lead agency developed a solid work plan. However, in road safety, the workplan did not provide clearly defined activities that identified responsible agencies, indicators and budget lines.

101. The varied quality of workplans directly impacted on the monitoring frameworks. While a good quality workplan does not guarantee an operational monitoring framework, it is a necessary precondition to actually develop one. The CCS final evaluation reviewed all monitoring frameworks of the CCS and did not identify one that was working appropriately in delivering regular data on progress towards targets. This was confirmed during the interviews when most national partners confirmed the need for stronger monitoring of the CCS 2017-2021 implementation.

³¹ Burkholder, Dr Brent, 2016, 'Review of individual staff functions and team structure at WHO country office'.

102. The CCS 2017-2021 now includes a monitoring and evaluation sub-committee and there are strong expectations on the part of the MOPH to see WHO play a key role here.

103. At the WCO level, the monitoring of WHO's contribution and progress towards targets has also not taken place in a systematic manner. Reporting through the corporate management tool currently does not constitute an adequate monitoring mechanism to support programme management, mainly because it does not clarify the targets to be achieved nor does it report at output or outcome level but rather at the level of tasks.

Use of the CCS 2012-2016 to inform WHO country workplans, budget allocations and staffing

104. The staffing review conducted in 2016 clearly refers to the CCS priorities in order to identify technical staffing requirements to implement the CCS 2017-2021. On the other hand, no evidence of use of the CCS 2012-2016 could be established by our evaluation to inform the WCO workplans or the budget allocations during the 2012-2016 period.

Summary of key findings:

- ✓ *The core function which contributed the most to progress in the CCS 2012-2016 is technical assistance, used to inform adaptation of research findings, norms, standards and guidelines, as well as to bring evidence to the table to inform policy options. The other critical core function during the course of the CCS is the leadership function and the convening power of WHO to bring regional and international expertise in-country through conferences, workshops etc. and to engage Thai expertise to support regional and international health conferences and workshops. Monitoring of national health programmes, on the other hand, did not receive adequate attention.*
- ✓ *The major shift introduced with the CCS 2012-2016 of building multi-agency partnerships and putting health agencies as lead of CCS priorities produced mixed results and contributed to important lessons for the design and implementation of the CCS 2017-2021.*
- ✓ *WHO is no longer perceived as a funding agency but as one that can play a catalytic role using its modest financial support to leverage additional funds (when needed) to fully support selected areas of work. It also keeps the ability to fund support in areas not prioritized in the CCS. Its funding mechanisms were however found to be rather cumbersome for the amounts at stake and alternative funding mechanisms are envisaged for the CCS 2017-2021.*
- ✓ *The staffing profile and structure evolved during the CCS 2012-2016 period. The team is becoming more international and high-level than it was five years ago there is also a need for appropriately skilled NPOs, not only in support of technical issues but also to facilitate discussions when language is an issue (this can also be supplemented with locally sourced translation services). Finally, a high-level international profile on planning and monitoring is of critical importance.*
- ✓ *Planning of the CCS 2012-2016 was of varying quality across the priorities; and monitoring has been overwhelmingly found weak in all areas of the CCS. Furthermore, the WCO has not developed any mechanism to monitor its own contribution to the CCS against clear targets.*
- ✓ *Evidence of use of the CCS was found for staffing purposes but not for budgeting or work planning.*

3. Conclusions

105. Based on the findings presented in the previous section, the following conclusions are articulated around the three main evaluation questions (EQs) all of which inform the recommendations presented in Section 4.

106. **Relevance of the strategic choices.** The priorities identified in both the CCS 2012-2016 and the CCS 2017-2021 were strategic to address Thailand's major health needs and were coherent with government and partners' priorities expressed in the UNPAF. They were also coherent with WHO's GPW as per the assumptions made in the theory of change (see Figure 2) in terms of health needs and alignment.

107. Overall the CCS 2012-2016 introduced a major shift from a fragmented approach through many small projects to a much stronger focus around five priorities and three main activities. This shift has been further strengthened in the design of the CCS 2017-2021 which includes only five main strategic priorities.

108. The prioritization process for the CCS 2017-2021 was strengthened based on experience gained during the CCS 2012-2016 as follows: i) it included a very large number of stakeholders, reflecting the multiplicity of actors in the health sector in the country, and ii) it benefitted from a transparent consultation and priority setting based on predefined selection criteria known to all relevant partners. This led to: i) some issues such as NCD or border and migrant health (WCO focus areas) becoming a priority for the MOPH in the CCS; ii) the sunsetting of certain activities, as appropriate; and iii) introduction of new ones such as global health diplomacy, reflecting a RTG priority.

109. The CCS provides the strategic framework for WHO's work in and with Thailand. However, the priorities and activities therein do not necessarily cover the totality of the WCO's contribution to health in Thailand. For example, communicable diseases are no longer a CCS priority, but Thailand is still one of the 30 high burden countries for tuberculosis. Staff in the WCO continue to provide support to Thailand as necessary in this and other technical areas.

110. There is a discrepancy between the WHO programme and funding structure, to which WCO workplans must conform, and the priorities elaborated in the CCS, making it challenging for the WCO to develop its workplans in line with the CCS priorities.

111. **Gender.** A gender analysis was not done in the CCS 2012-2016 and, though gender was given substantial attention in the CCS 2017-2021 analysis, it did not lead to the priorities retained paying explicit attention to the gender issues identified in the analysis.

112. **WHO's intellectual and social capital.** The new CCS provides a unique opportunity for both the RTG and WHO to engage in a strategic partnership of a new kind where funding is no longer the main commodity but the means by which both partners contribute their respective added value. Building on its well-established and recognized intellectual capital, WHO now has to strengthen its positioning in terms of social capital and branding, thereby enabling the RTG to consolidate the achievement of its universal health coverage by more systematically addressing the social determinants of health while enhancing at the same time Thailand's role in global health. Many national partners indicated clear expectations with regard to WHO's strategic contribution in this respect. In their opinion, intellectual capital broadly refers to WHO's leading role in the provision of technical health expertise, while social capital refers more to WHO's reputation, influence, authority, name and trust.

113. More widely, Thailand and other countries in similar situations are facing issues that require tailored approaches and support from their respective regional office and HQ. Resource mobilization in such countries might require a specific strategy and the new financing mechanism being

developed for the CCS 2017-2021 in Thailand may offer lessons for other countries with a similar WHO presence.

114. **Main achievements.** Overall, during the period 2012 to 2016, the WCO in Thailand provided a valuable contribution in supporting the RTG's national health sector plans. The CCS 2012-2016 created an enabling environment for various players in the Thai health sector to form partnerships around key health issues and this positive environment was strengthened for the CCS 2017-2021, based on the experience gained from the CCS 2012-2016. Results have been documented for all four main expected outcomes identified in the TOC. Positive results were noted in the area of NCD, international trade and health, road safety, border and migrant health and communicable diseases. Community health and ageing were sunsetted as priorities while the disaster preparedness and response priority made limited progress over the course of the CCS.

115. **Programme management challenges.** The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. This weakens WHO's capacity to demonstrate results and contribution to health improvements in any given country. Furthermore it appears that, over the course of the CCS 2012-2016, the WCO was not able to develop its own mechanism to monitor the effects of its contribution to the various objectives defined for each priority of the CCS when developing its country workplans.

116. **Key contributions of core functions.** Technical support stands out as the key core function contributing to the WCO work in support of the RTG and the implementation of the CCS 2012-2016. This core function enabled research activities, facilitated the adaptation of norms, standards and guidelines and provided evidence to inform policy options for decision-makers. The other core function which played a major role was WHO's leadership and convening power, allowing Thailand to avail of international expertise, and contributing Thai health expertise abroad. These functions form the foundation of WHO's intellectual and social capital.

117. The WCO contribution to monitoring of health trends seems to have been more limited but, in the future, this core function is expected to play a much bigger role, both in the monitoring of CCS implementation and in supporting the country to monitor its progress towards the health-related SDGs.

118. **Partnerships.** With respect to the work of the WCO with partners, the major shift introduced with the CCS 2012-2016 has been critical. Bringing together various actors around key priorities understandably takes time and, despite the mixed results obtained so far, it is considered by all as the way forward, establishing firm foundations for the design of the CCS 2017-2021. The initial collaboration with non-health actors that was introduced in the CCS 2012-2016 has been confirmed in the CCS 2017-2021.

119. **Funding** remains a critical means for WHO's catalytic engagement in the country. It ensures that certain priorities remain high on the agenda, as has been the case with border and migrant health and with road safety.

120. Funding mechanisms will need to follow the strategic shift from small projects to priority areas initiated with the CCS 2012-2016 and confirmed in the CCS 2017-2021, and new approaches through pooled funding mechanisms are being considered. Such mechanisms require even stronger attention to planning and monitoring as indicators at outcome level need to be identified and their achievements documented in order for funding instalments to be released at specific times of the CCS 2017-2021 implementation.

121. **Staffing.** The WCO team composition and skills mix has evolved over time and been strengthened with a doubling of the number of international staff over the CCS 2012-2016 period. It is important to be able to match staff profiles and expertise with the priorities set out in the CCS. The increase in the number of international technical professionals in the WCO is a welcome

initiative, and there is also a need for appropriately skilled NPOs in support of technical issues but also to facilitate discussions when language barriers are an issue. This can also be supplemented with locally sourced translation services. The rationale for organizing teams around programme categories rather than around the CCS priorities plus communicable diseases remains a challenge for the WCO. Considering the weaknesses in planning and monitoring observed during the CCS 2012-2016 and the expectations on the part of national counterparts in this area, the WCO needs to ensure that it can very quickly mobilize adequate levels of expertise in this area, either through the support of HQ or RO colleagues, or through short-term experts.

122. **Best practices and innovations.** This evaluation highlighted a certain number of emerging good practices and innovations framing WHO's engagement in Thailand. Indeed the WCO's role has clearly evolved during the period evaluated and is continuing to do so. For instance, the approach taken in the design of the CCS 2012-2016 and the lessons learned strengthened the design of the CCS 2017-2021, highlighting partnerships with national actors beyond the health sector and instituting a transparent and consultative priority setting process for the CCS 2017-2021. The fact that the RTG has increased its funding to become the main funding source for the CCS 2017-2021 also represents a major shift in its collaboration with WHO. Finally, the new funding mechanism being explored could also be used, if proven effective, in the future in other similar countries.

4. Recommendations

123. Based on the findings and conclusions elaborated in the previous sections, the evaluation would like to make the following recommendations:

- A. The Head of the WHO Country Office and the WHO Country Office team to contribute actively to Country Cooperation Strategy governance activities and to engage with other national partners to support implementation of Country Cooperation Strategy priorities and activities, in particular in the area of programme management and monitoring.
 - i. Review the Country Cooperation Strategy workplans for each priority and define targets (qualitative or quantitative) for both the expected outcome and output levels and clarify expected WHO contribution in a measurable manner.
 - ii. Ensure adequate technical capacity for planning and monitoring Country Cooperation Strategy implementation.
- B. The WHO Secretariat to ensure that the WHO Country Office has the capacity to implement its workplans beyond the Country Cooperation Strategy priorities and activities, including through appropriate funding mechanisms and staffing of the Office.
 - i. Ensure that new Country Cooperation Strategy priorities such as antimicrobial resistance are adequately covered with financial and human resources
 - ii. Ensure that language is never a barrier for the active engagement of the WHO Country Office with national partners.
 - iii. Headquarters and the Regional Office to support the WHO Country Office in the review and consideration of the Royal Thai Government's request to support the implementation of the Country Cooperation Strategy 2017-2021 through the national pooled funding mechanism, and explore the possibility of linking a pooled funding mechanism with indicators of achievement.
- C. The WHO Country Office to build on a Theory of Change for the period 2017-2021 to better link the Country Cooperation Strategy 2017-2021 with the entire planned country-level results and deliverables and with the Country Office staff and activity workplans during operational planning for Programme budgets 2018-2019 and 2020-2021.
 - i. Develop a Theory of Change for 2017-2021 to frame more specifically the pathway for change (it should include all Country Office activities, not only those of the Country Cooperation Strategy).
 - ii. Clarify for each relevant corporate output the targets relevant for Thailand in the current biennium and for each biennium thereafter.
 - iii. Set up an internal monitoring framework to measure WHO's progress towards targets over the Country Cooperation Strategy implementation period.
- D. The WHO Country Office and the Royal Thai Government to strengthen inclusion of the gender and other social determinants of health dimension(s), as relevant, in the implementation of the Country Cooperation Strategy and other Country Office activities.
 - i. Review programmes of work of each Country Cooperation Strategy priority with a gender lens, possibly with the support of the Regional Office or of headquarters, and amend as necessary to ensure the gender dimension is appropriately taken into consideration.
- E. The WHO Secretariat (Department of Country Cooperation and Collaboration with the UN System and the Country Support Unit network) to review the evolution of the Country Office's contribution to, and relationship with, the Royal Thai Government over the recent Country Cooperation Strategy cycles, in order to consider the lessons learned, innovation and best practices for Country Office interaction with, and contribution to, other upper-middle-income countries and emerging economies.

- i. Reflect further on the implications of the expectations of counterparts in terms of social capital, in particular with other Country Offices active in upper-middle-income countries. WHO should deploy experts with profiles and experience matching the Country Cooperation Strategy priorities.
- ii. Develop a strategic note framing WHO's engagement in upper-middle-income countries from the intellectual and social capital perspective.
- iii. Document the prioritization process followed for the Country Cooperation Strategy 2017-2021 and share within the Organization.