

Independent Mid-term Evaluation of the WHO-Thailand Country Cooperation Strategy 2017-2021

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Abbreviations

AMR	Antimicrobial resistance (CCS Priority Programme)
CCS	Country Cooperation Strategy
CSC	Coordinating Sub-committee
EC	Executive Committee
FAO	Food and Agriculture Organization of the United Nations
GHD	Global health diplomacy (CCS Priority Programme)
GPW	General Programme of Work (WHO)
HSRI	Health Systems Research Institute
ITH	International trade and health (CCS Priority Programme)
MH	Migrant health (CCS Priority Programme)
MoPH	Ministry of Public Health
NCD	Noncommunicable disease (CCS Priority Programme)
NHCO	National Health Commission Office
NHSO	National Health Security Office
NSP	National Strategic Plan
PSC	Programme Sub-committee (PSC)
RS	Road safety (CCS Priority Programme)
RTG	Royal Thai Government
SEARO	WHO Regional Office for South-East Asia
ThaiHealth	Thai Health Promotion Foundation
UN	United Nations
UNICEF	United Nations Children's Fund
UNPAF	United Nations Partnership Framework for Thailand 2017-2021
WHO	World Health Organization

Executive Summary

The Country Cooperation Strategy (CCS) 2017–2021 for Thailand sets out the collaboration between the Ministry of Public Health of the Royal Thai Government and WHO, as well as other key partners. It is the fifth CCS in Thailand, with the first such strategy having been put in place in 2002. Successive CCSs have progressed towards more focused programming, more engagement of the Government in planning and execution, increased participation of non-government partners (including civil society organizations and even partners outside the health sector), enhanced programme prioritization, and heightened involvement of new participating agencies and donors.

The CCS 2017–2021 contains six priority programmes and involves a much larger number of partner organizations than the previous ones. Its distinctive characteristics include a new governance structure designed to facilitate participation of all stakeholders, annual audit by an international firm, and a pooled funding mechanism whereby donors place their funds into a common bank account and financial reporting for each of the priority programmes is streamlined into a single reporting requirement.

The governance structure of the CCS consists of an Executive Committee, a Coordinating Sub-committee, and six Programme Sub-committees corresponding to each of the six priority programmes (i.e. Antimicrobial resistance, Global health diplomacy, International trade and health, Migrant health, Noncommunicable diseases, and Road safety).

The objectives of this independent mid-term evaluation were to:

- identify and highlight best practices and lessons learned from the CCS 2017–2021 at mid-term so that these can be shared, adopted and built upon for the remainder of this CCS and for future CCSs;
- determine the progress in implementing the strategic priorities, whether the expected achievements are on track, and how has the CCS added value as a concept and as a mechanism; and
- identify challenges and areas for improvement that need to be addressed to improve the impact of the work of the CCS.

The evaluation team was comprised of two staff members of the WHO Evaluation Office at headquarters and two external consultants based in Thailand. Findings of the evaluation are derived from semi-structured interviews with 45 key informants representing all levels of the CCS and from extensive review of relevant documents. Findings were organized around three themes: (1) overall achievements of the CCS, (2) governance, and (3) financial matters and the pooled funding mechanism.

The main achievements identified at this early point in the implementation of this CCS are as follows:

- **Ownership:** The CCS has established country ownership, led by the Ministry of Public Health and shared by four participating agencies (i.e. the Health Systems Research Institute, the National Health Commission Office, the National Health Security Office and the Thai Health Promotion Foundation), with WHO in a supportive and facilitative role. This has been achieved through the CCS governance structures.
- **Programme achievement:** Comparing to the original proposals of the six programme areas, significant achievements have been noted in progress reports, although there have been delays in the implementation of some programmes.

- **Alignment:** CCS activities have been well aligned with national priorities. They support national systems, strategies and plans. This has been facilitated by well-designed national strategic plans in most programme areas.
- **Harmonization:** CCS programmes have been harmonized with the United Nations Partnership Framework for Thailand 2017–2021. Harmonization with national partners, including parastatal agencies, civil society and nongovernmental organizations and others, has been made possible by the wide participation of all stakeholders in CCS governance structures, from the Executive Committee to Programme Sub-committees and implementing partners.
- **Cooperation and contribution to the global health agenda:** Thailand has been visible and effective in the global setting. Strong capacity of the lead agencies and implementing partners has contributed to this achievement.

At the same time, there have been noteworthy challenges in the implementation of the CCS to date. Specifically:

- The Coordinating Sub-committee has a critical responsibility to monitor and evaluate programme performance and to provide analysis and corrective advice based on its findings. The Coordinating Sub-committee was operational only by the end of the second year and has not yet operated at its full potential. This gap might have contributed to implementation failures in some programme activities.
- The pooled funding mechanism shows great promise; however, there have been delays in the pooled funding process. The Ministry of Public Health budget has not yet been incorporated into the pooled funds. There have been delays in release of funds in several cases. In addition, those most closely involved in the day-to-day implementation of the CCS emphasize that such engagement still entails significant transaction costs (for example, in connection with reporting requirements), despite the implicit intention of this CCS approach to reduce such transaction costs.
- The complexity of an undertaking with the size and scope of the CCS has entailed human resources challenges. All aspects of financial management, including smooth functioning of the pooled funding mechanism and timely release of budgeted funds to the programmes, require attention and technical expertise. There are also critical human resources gaps at the levels of the Coordinating Sub-committee and the Programme Sub-committees.

Conclusions and Lessons Learned

While remaining cognizant of the implementation challenges highlighted in this midterm evaluation, it is important to keep sight of the achievements and the potential of this CCS approach. As an example of how government and WHO can work together to create a more fit-for-purpose instrument for targeting national health priorities – and stimulating broader partnership toward these goals with civil society, nongovernmental organizations, and donors – this CCS represents a case study and “proof of concept” of how WHO and its partners can take *risk-aware* and *risk-tolerant* (rather than merely *risk-averse*) and potentially innovative approaches of working together to achieve results in a contextually well-customized manner. As such, this proof of concept can be showcased more widely throughout the Organization, as well as other countries looking for new approaches – particularly at this juncture when the Organization has embarked on its Thirteenth General Programme of Work, in alignment with the Sustainable Development Goals, and is undergoing a major transformation in its way of working to achieve these ambitious goals.

The CCS 2017–2021 has shifted control in operations and funding to country actors, led by the Ministry of Public Health and exercised through a new governance structure. WHO’s role in this new setting has been to invest its intellectual capital in providing technical support, from the WHO Country Office and when needed from the Regional Office for South-East Asia and headquarters, for delivering results in programme implementation. It has also contributed its social capital to provide national and international visibility and to attract partners to support the CCS priority programmes. As with any

novel undertaking, there are risks, possibilities of failure, and lessons to be learned. This mid-term evaluation is aimed at early learning for mid-course correction and at documenting what has been learned.

Recommendations

Owing to the early nature of this formative evaluation, coupled with the innovative approach taken in this particular CCS, the recommendations below are intended to help (a) the WHO Country Office in Thailand in the remaining implementation period for this CCS, (b) the WHO Country Office in Thailand in the planning for the next CCS, and (c) WHO as a whole.

Recommendation 1: Reinvigorate the Coordinating Sub-committee and ensure that its dual role of intersectoral knowledge-sharing platform and monitoring and evaluation oversight body are fulfilled, and that it meets at least four times a year, as per its terms of reference.

This recommendation will require:

- The convening of regular Coordinating Sub-committee meetings, scheduled to ensure broadest attendance possible among its members;
- Clear agendas that consistently cover each of the two main roles assigned to the Coordinating Sub-committee, as well as any other aspects of its coordination and oversight role, along with a standing agenda item reserved for concrete actions, decisions and next steps to be undertaken subsequent to each meeting (coupled with a clear designation of who will undertake this follow-up and by what date);
- A strategy outlining the way forward on how this body will be used as a platform for promoting meaningful intersectoral knowledge-sharing across the six programmatic pillars;
- Implementation of the monitoring and evaluation framework established for the CCS, ideally through the establishment of a delegated monitoring and evaluation working group assigned to undertake the operational aspects of this work; and
- Dedicated capacity to support the work of this body (as per Recommendation 3 below).

Recommendation 2: Put in place critical measures to ensure optimal functioning of the pooled funding mechanism, in keeping with its intended objectives.

Given the multiple objectives the pooled funding mechanism is intended to achieve – i.e. catalyse more sustainable financing (in future CCS periods, potentially beyond the six pillars covered in the current CCS), streamline funding flows and reduce transaction costs (not least of all in connection with reporting requirements), and reduce earmarking and allow for more results-based funding decisions – the following actions should be taken as a matter of priority:

- Follow up on measures to eliminate the administrative and regulatory barriers currently hindering some prospective donors from contributing to the fund;
- Establish clear funding criteria, coupled with transparent processes, to guide individual funding decisions in a result-based manner (notwithstanding the constraints to some donors);
- Develop a funding strategy to attract additional funding from other sources, based on demonstrated successes showcased through monitoring and evaluation efforts;
- Identify and pursue a sunset arrangement (or exit strategy) whereby WHO's financial contributions to the fund will decrease or cease once its catalytic role in the fund is deemed to be complete by the Royal Thai Government, the WHO Country Office in Thailand and the WHO Regional Office for South-East Asia.

Recommendation 3: Ensure dedicated capacity for maximally effective support for the governance and funds management aspects of the CCS.

Given the considerable time and effort currently required to manage the governance mechanism and fund management, and the additional activities outlined in the foregoing recommendations, dedicated human resources should be deployed to fulfil the following two capacity needs:

- Dedicated funds management expertise to ensure the smooth functioning of the pooled funding mechanism, from facilitation of decision-making procedures to communication with awardees, funds tracking, consolidated reporting, and other aspects of funds management; and
- Technically qualified project management to support the CCS governance mechanisms, especially the Programme Sub-committees and a reinvigorated Coordinating Sub-committee.
- Consider creation of one or more full-time positions in areas of critical need.

Recommendation 4: Identify key lessons and best practices from this CCS approach and actively seek to showcase these in key platforms, both internally (i.e. within the South-East Asia Region and WHO) and externally (e.g. with the United Nations Resident Coordinator and United Nations Country Team partners), and through the International Health Diplomacy pillar), as a means of showcasing this CCS as a “proof of concept” for demonstrating (and enhancing) the Organization’s risk tolerance to other corners of the Organization and others, and as a model for incentivizing partnership to support national governments.

Introduction

The Independent Mid-term Evaluation of the Country Cooperation Strategy (CCS) 2017–2021 for Thailand is the first of two external evaluations which are part of the monitoring and evaluation plan for the CCS. This evaluation is intended to document progress of this unique initiative, identify obstacles, and point the way forward, suggesting mid-course corrections as needed.

Background

The World Health Organization's relationship with the Royal Thai Government (RTG) dates to 1947. In the intervening seven decades, the relationship has evolved as Thailand, with successes including its public health response to the HIV/AIDS epidemic and the establishment of universal health coverage in 2002, has emerged as a source of expertise in health services and systems rather than solely being recipient of such expertise.

In tandem with Thailand's health sector development, Thailand's working relationship with WHO has also evolved, as evident in the successive CCSs, which serve as the foundation for WHO's collaboration with the Ministry of Public Health (MoPH) of the RTG. The first CCS covered the period from 2002–2005, beginning a new collaboration process between WHO and the RTG; this was followed by the second CCS in 2004–2007, in which activities were organized in clearly defined priority areas; this CCS embodied little emphasis on adherence to national plans and strategies, however. The CCS 2008–2011 incorporated the principles of the 2005 Paris Declaration on Aid Effectiveness (i.e. *country ownership*, *alignment* with national priorities, *harmonization* with sister United Nations (UN) agencies and other partners, measuring *results*, and assuring *accountability*) but did not emphasize inter-agency and intersectoral collaboration. The CCS 2012–2016 signaled a “completely new way of working” — i.e. in seeking alignment with the national health plan, a multisectoral approach, and a clear identification of WHO as playing a facilitating role. Altogether the four CCSs covered a broad range of priority health areas, from health systems strengthening to emerging and re-emerging communicable diseases, health promotion, border health, roll-back malaria, community health, disaster preparedness, international trade and health, road safety and noncommunicable diseases.

The CCS 2017–2021 is based on five key principles, almost identical with the targets in the 2005 Paris Declaration, namely:

- **Ownership** of the development process by the country;
- **Alignment** with national priorities and strengthening national systems in support of the national health strategies/plans;
- **Harmonization** with the work of sister UN agencies and other partners in the country for better aid effectiveness;
- **Cooperation as a two-way process** that fosters Member States' contributions to the global health agenda; and
- **Catalyzation of action**, in that WHO work in the CCS 2017–2021 will catalyze broader national work in the CCS priority areas, and not be "the main fuel". WHO, the RTG and nongovernmental partners are united in a tripartite structure for implementation of the CCS.

The CCS 2017–2021 covers six programme areas, namely: (1) Antimicrobial resistance (AMR), (2) Global health diplomacy (GHD), (3) International trade and health (ITH), (4) Migrant health (MH), (5) Noncommunicable diseases (NCDs), and (6) Road safety (RS).

The current CCS does not represent a modality of collaboration between the MoPH and WHO alone, as was the case in the previous four CCSs. Rather, in the current CCS there are four additional main

partners which provide significant funding support for the programme implementation. These are: (1) Health Systems Research Institute (HSRI), (2) National Health Commission Office (NHCO), (3) National Health Security Office (NHSO), and (4) Thai Health Promotion Foundation (ThaiHealth). In a financial dialogue organized in December 2016, all six agencies had made preliminary estimated pledges. Table 1 summarizes these pledges.

Table 1 – Preliminary estimated pledges to the CCS from participating agencies, as of December 2016

Agency	AMR	GHD	ITH	Migrant Health	NCD	Road Safety	Total
HAI							
MOPH	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	
Thai Health	25,000,000	25,000,000	25,000,000	25,000,000	25,000,000	25,000,000	
NHCO		2,500,000	2,500,000				
NHSO	30,000,000	30,000,000	30,000,000		30,000,000	30,000,000	
HSRI	2,500,000			25,000,000	2,500,000		
WHO	20,300,000	29,400,000	13,300,000	24,960,000	28,500,000	20,000,000	
GAP	0	6,100,000	0	3,240,000	4,000,000	0	13,340,000
TOTAL	82,800,000	98,000,000	75,800,000	83,200,000	95,000,000	80,000,000	514,800,000

At the beginning of the CCS implementation, six Programme Sub-committees were established to be responsible for the implementation of the priority areas. In the process, each programme area had developed five-year proposals to identify the programme objectives, strategies and workplan. Lead agencies were identified and implementing agencies were selected and contracted to be responsible for the overall implementation. Table 2 provides an overview of these lead and implementing agency designations.

Table 2 – CCS lead agencies and implementing agencies

CCS area	Lead agency	Implementing agency
Antimicrobial resistance (AMR)	Thai Food and Drug Administration	Health Impact and Technology Assessment Program Foundation
Global health diplomacy (GHD)	Global Health Division, MoPH	International Health Policy Program Foundation
International trade and health (ITH)	International Health Policy Program, MoPH	International Health Policy Program Foundation
Migrant health (MH)	Health Systems Research Institute	Health Systems Research Institute
Noncommunicable diseases (NCD)	Department of Disease Control, MoPH	NCD Division, Department of Disease Control, MoPH
Road safety (RS)	ThaiHealth	Road Safety Foundation

Objectives

In the implementation process, each programme area has engaged a range of relevant key stakeholders to carry out activities identified in the workplan. The number of participating partners is significantly higher than those in the previous CCSs.

In 2019, an independent mid-term evaluation was organized by WHO in collaboration with CCS partners in order to monitor progress, identify constraints and provide recommendations for improvement of the CCS implementation as well as to collect lessons on the innovative characteristics of this CCS. The specific objectives of the evaluation were to:

1. identify and highlight best practices and lessons learned from the CCS 2017–2021 at mid-term, so that these can be shared, adopted and built upon for the remainder of this CCS and for future CCSs;
2. determine the progress in implementing the strategic priorities, whether the expected achievements are on track, and how has the CCS added value as a concept and as a mechanism; and
3. identify challenges and areas for improvement that need to be addressed to improve the impact of the work of the CCS.

Scope and Methods

The scope and objectives of this mid-term evaluation are laid out in the Terms of Reference (Annex I). Particular attention has been given in this evaluation to identifying problems and recommending possible solutions which are applicable to the remaining two years of this CCS. This evaluation is intended to be useful as a management tool.

A four-member evaluation team (Annex II) conducted interviews with 45 key informants from 25 to 29 November 2019 (Annex III). Respondents represented all priority areas and committees of the CCS, all participating agencies including MoPH and relevant departments, HSRI, NHCO, NHSO, ThaiHealth, the International Health Policy Program, the Road Safety Foundation, WHO and others. Interviewees were assured of absolute confidentiality and encouraged to speak frankly.

A WHO country office self-assessment questionnaire was reviewed, containing detailed information on: overall assessment of the CCS in achieving its strategic objectives, key outputs and outcomes; appropriateness of the six priority areas, governance and structure, financing and the pooled funding mechanism; implementation of the recommendations of the Thailand Country Office Evaluation, and achievements in each priority area.

A desk review of all relevant documents including the previous three CCSs; mid-term and final evaluations of CCS 2012–2016; the Thailand WHO Country Office evaluation; letters of agreement; financial, audit and closure reports; composition and terms of reference for the Executive Committee (EC), the Coordinating Sub-committee (CSC) and Programme Sub-committees (PSCs); annual funding dialogue meetings; various briefing notes and notes for the record; five-year proposals and budgets; annual programme reports and budgets; publications in the international literature on the CCS and priority areas; UN reports; and others.

Data management: an assessment matrix was created with information abstracted from interview transcripts and distributed throughout the matrix according to source and topic. This greatly facilitated the preparation of the final evaluation report.

Report writing: the final report was produced after team members returned to their home offices in Geneva and Thailand, with online conferencing as needed.

Limitations

This evaluation was framed as a rapid mid-term evaluation of the CCS, rather than a summative evaluation. Given the high level of cooperation and collaboration between the evaluation team and the WHO Thailand Country Office toward this end, there were no significant limitations affecting the team's ability to identify the key issues at this early stage. That said, there were three factors that affected the team's ability to obtain more detailed insights into the attendant issues. These are as follows:

- While the 45 interviewees are representative of all levels in the CCS governance and implementation structure, it is still possible that some useful information might have been missed.
- Some committee minutes and reports were not available in English.
- Several issues could not be investigated in detail due to time constraints; for example, detailed study of the impact of delays in release of funds on programme implementation and quantitative study of reduced transaction costs associated with pooled funding.

Findings

Theme 1: Overall success of CCS in implementing strategic objectives

The CCS 2017–2021 builds on innovations in previous planning cycles and adds new ones, for example, a pooled funding mechanism using a common bank account and common (single) reporting. The CCS must also be judged by its actual performance in achieving its objectives. The CCS monitoring and evaluation system (Monitoring and Evaluation Framework) was not fully operational in early 2019, and annual reports for 2018 did not fully comply with the Monitoring and Evaluation Framework template, which requires that actual activities during the reporting period be reported against planned progress of activities toward programme objectives. Inconsistency of reporting formats between priority programmes makes it difficult to directly compare performance of priority programmes.

Nevertheless, there is ample evidence for progress of the CCS as a whole, and in the priority programmes. The overall achievements of the CCS can be summarized as follows, according to the five CCS key principles provided in the CCS document:

With respect to **Ownership** of the development process by the country, the CCS 2017–2021 is clearly led by the MoPH, with WHO nominally in a co-leadership role but primarily looked to for technical inputs. The MoPH Permanent Secretary and the WHO Representative co-chair the EC. The PSCs are chaired by MoPH or a closely affiliated parastatal with the exception of Road Safety. WHO professional officers are members of each of the PSCs, providing technical input as requested.

With regard to **Alignment** with national priorities and strengthening national systems in support of the national health strategies/plans, the five-year time frame of the CCS is identical to the RTG 12th National Health Development Plan, and all CCS programmes follow national strategic plans where they exist. Examples of progress in this area include the following:

- AMR is in same planning cycle as the National Strategic Plan (NSP) on Antimicrobial Resistance 2017–2021-Thailand, is integrated with (and subordinate to) the NSP and adds value by filling gaps in the NSP (for example, for surveillance and management of AMR in hospitals and others). In this context, Thailand's first National Forum on Antimicrobial Resistance was

conducted on 31 January 2018 with participation of the WHO Director-General, the Director of the WHO Regional Office for South-East Asia (SEARO), the Chief Medical Officer of the United Kingdom and the Chief Veterinary Officer of FAO.

- GHD supported the institutionalization of the Global Health Division in the MoPH, which is now positioned to move from routine activities into global health policy development and implementation.

Regarding **Harmonization** with the work of sister UN agencies and other partners in the country for better aid effectiveness, the five-year time frame of the CCS is identical to the United Nations Partnership Framework (UNPAF) for Thailand 2017–2021, and CCS programmes contribute directly to UNPAF Outcome Strategies 1 and 4. The UN Thematic Working Group on Noncommunicable Diseases was established to support the national implementation of the CCS NCD programme and promote the role of UN agencies in the national response. The Working Group meets regularly. One significant achievement of the CCS NCD programme is the arrangement of the UN Inter-Agency Task Force mission on Noncommunicable Diseases to Thailand from 28 to 30 August 2018, with participation of eight UN agencies, seven Government ministries and four partner organizations. The joint mission met with Thailand's Prime Minister and high-level officials to advocate for the country's response to NCDs and provide recommendations to tackle NCDs through evidence-based multi-sectoral actions. Seventeen recommendations of the mission have provided strategic directions for an effective NCD response in the country.

With respect to **Cooperation** as a two-way process that fosters Member States' contributions to the global health agenda, two CCS priority programmes, GHD and ITH, are directly involved in global health issues, both in south and east Asia and beyond. Two prominent examples of progress in this area arose in the review. First, the GHD programme organized annual global health diplomacy workshops, with participation of relevant health personnel from SEARO, to strengthen diplomacy skills in preparation for the World Health Assembly. It also organized a training of trainers workshop on global health diplomacy, with invitations extended to neighbouring countries such as Bhutan, Japan, Iran (Islamic Republic of), Lao People's Democratic Republic, Maldives, Nepal, Philippines, and Viet Nam. Although some of this work precedes the current CCS, it has continued and expanded during its implementation. In addition, the ITH programme has commissioned research on the impact of Free Trade Agreements (Thai-Japan, Thai-EU) which has supported countries as they struggle to maintain health protections in trade negotiations.

With regard to **Catalyzation of action**, leadership of the CCS is vested in the governance structures. WHO provides facilitation and support. For programme areas where there is strong Government commitment and clear policy direction (AMR, NCD), WHO delivers intellectual capital (technical support). For programmes where Government commitment and policy direction might be less well developed or less effective (MH, RS), WHO's social capital and "brand" provide visibility and attract partners. As an example of progress in this area, the MH programme, despite absence of an institutional "home" in MoPH or elsewhere, has brought attention to the most vulnerable migrants and has collaborated with the National Immunization Programme, the Institute for Urban Disease control and UNICEF in conducting immunization outreach activities for migrant children.

A number of factors were identified which helped facilitate these gains. Broken down by achievement area, these are as follows:

Ownership of the development process by the country:

- There has been clear, strong political will and leadership on the part of the MoPH, WHO and the other participating agencies (HSRI, NHCO, NHSO and ThaiHealth).
- The governance structure and composition of the CCS EC, CSC and PSCs ensures Government leadership and broad participation in the CCS. PSCs are chaired by MoPH officials (Permanent Secretary in two cases) with the exception of the RS PSC, which is chaired by the director of a

provincial trauma care centre. Lead agencies for programme areas are MoPH departments, or parastatals closely allied with MoPH.

Alignment with national priorities and strengthening national systems in support of the national health strategies/plans:

- There is closer correspondence of CCS programming with the national health agenda than in the past, made possible by close working relationships among all CCS stakeholders. For example, the AMR and NCD programmes are fully aligned with their respective national plans.

Harmonization with the work of sister UN agencies and other partners in the country for better aid effectiveness:

- There is a high level of commitment to CCS objectives at programme level between MoPH, WHO, participating agencies, parastatals, UN agencies and other stakeholders. This results in part from design features of the CCS (participatory governance structure, pooled funding).
- Collaboration between MoPH and other ministries and Government bodies, for example Ministry of Foreign Affairs, Ministry of Commerce, Ministry of Transport and Royal Thai Police, are stronger than in the past, with stakeholders giving credit to the added credibility of the CCS and WHO.

Cooperation as a two-way process that fosters Member States' contributions to the global health agenda:

- WHO's worldwide visibility and credibility facilitates entry of CCS into the global arena.

Catalyzation of action within the broader national work in the CCS priority areas:

- Stakeholders were near-unanimous in their opinions that the CCS, with WHO contributing as: "catalyst", "influencer", "lubricant", "convener", brought together a broader array of partners and enabled new initiatives.
- There is equally high consensus among stakeholders that WHO's financial support is not a determining factor.

Other cross-cutting factors contributing to achievements of the CCS, namely:

- Responsible technical staff in the WHO Country Office have been active and enthusiastic in support of their assigned programmes. They have committed 80% of their time to the CCS priority programmes, despite many other responsibilities.
- Nongovernmental and civil society organizations, not typically active in WHO country programming elsewhere, have added unique perspectives and supported outreach at provincial and local level.

At the same time, the evaluation identified a number of factors limiting adherence to the CCS key principles. These factors are as follows:

Ownership of the development process by the country:

- All MoPH participants in the CCS are part-time. Stakeholders have noted instances where Government divisions or professional staff were not able to contribute sufficient time to CCS programmes and activities.

Alignment with national priorities and strengthening national systems in support of the national health strategies/plans:

- Alignment with national priorities was a straightforward process when active Government units were working according to a well-designed national plan (AMR, NCD). This was more difficult in the absence of clear national commitment (MH, RS).

Harmonization with the work of sister UN agencies and other partners in the country for better aid effectiveness:

- While the evaluation team found evidence of collaborative activities with sister UN agencies (AMR with FAO and MH with IOM), such engagements have been limited to date and are still evolving.

Prioritization of health issues for the CCS:

- Many stakeholders noted that some of the six areas of focus in the CCS (e.g. GHD, ITH) did not intuitively seem to focus on health priorities within Thailand, whereas other health priorities in the country had not been covered in the CCS, and that some of these (e.g. tuberculosis, HIV/AIDS, dengue hemorrhagic fever, sexual and reproductive health, etc.) should be included in the next CCS. The evaluation team uncovered evidence that there had in fact been a systematic process for selecting programme areas for inclusion in the CCS, but that many stakeholders had not been privy to this process. The evaluation team also learned that the intention for this initial change of CCS approach was not to include each and every health priority worthy of attention in an all-encompassing manner, but rather those that could demonstrate a proof of concept for the approach. However, some informants felt that the CCS should pay more attention to the funding and collaboration process – and, they consistently reiterated, to considering other health priorities in the next CCS.

Catalyzation of action within the broader national work in the CCS priority areas:

- Some CCS programmes have been more active in research and policy development than in engagement at provincial and local level, which is where services actually reach people in need. WHO, through the CCS, could have been more active in promoting and supporting activities at provincial level (MH, RS).
- PSC members as well as WHO technical staff, have other job responsibilities outside of the CCS priority programmes.
- Delayed provision of funds from participating agencies has led to uncertainty and delay in programme implementation.

Theme 2: Governance and structure

Implementation of the CCS is supported by a three-tiered governance structure.

Executive Committee (EC)

The functions of the EC are (among others): to formulate policy directions under WHO-RTG Collaborative Programmes and ensure alignment with those of the MoPH as well as the country's priority areas; to approve programmes and budget and oversee programme implementation; and to identify other key national health issues or problems to guide development of additional programmes/activities.

The EC is a high-level committee, co-chaired by the Permanent Secretary of the MoPH and the WHO Representative to Thailand. Committee members are heads of departments in the MoPH or of parastatal and independent institutions participating in the CCS.

The EC has succeeded in establishing authority over the CCS process as a whole. It has set up the CSC and the PSCs, including membership and terms of reference.

However, as a high-level body, it functions at a policy, not operational, level. EC membership is appropriate for policy work, but it does not meet regularly enough to provide consistent oversight on programme implementation.

Coordinating Sub-committee (CSC)

The CSC's functions are laid out in the announcement from the EC in February 2017 establishing the CSC and elaborated in a second announcement issued on July 2018. These include: monitoring progress of CCS priority programmes; *ensuring a monitoring and evaluation system for the CCS*; acting as a platform for sharing of experiences between key stakeholders; and monitoring, evaluating, and reporting progress, challenges and recommendations to the EC.

The central importance of monitoring and evaluation was recognized in the earliest stages of development of the CCS 2017–2021. Monitoring and evaluation were identified as weaknesses in the mid-term and final evaluations of the CCS 2012–2016, with the final evaluation recommending “more emphasis on developing strong monitoring frameworks ... that are monitored by the lead agency, the OSC [oversight committee, equivalent to CSC] and WHO Thailand”. A WHO Country Office Evaluation completed in August 2017 noted that “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.” Monitoring and evaluation were highlighted as one of six basic principles in the Letter of Agreement on the CCS 2017–2021, finalized in July 2017.

However, there were significant delays in developing and implementing monitoring and evaluation under the CSC. The EC did not announce the creation of the CSC until July 2018, and the first meeting of the CSC did not take place until September of that year. A draft Monitoring and Evaluation Framework which had been prepared by the WHO Country Office was reviewed at that meeting and a few changes suggested. The revised Monitoring and Evaluation Framework was sent to the PSCs in time for them to guide the preparation of 2018 annual reports. For 2018 reports, only the RS, NCD and ITH programmes used the Monitoring and Evaluation Framework reporting template. Only RS reported on programme indicators. The evaluation team found no evidence of follow-up by the CSC to obtain missing information.

Thus, it was only at end of the second year of the five-year CCS that a monitoring and evaluation system was in place, and even then, the critical monitoring and evaluation function was only partially implemented.

Furthermore, in addition to the Monitoring and Evaluation Framework annual reporting template, the CSC proposed to develop a standardized format for collecting quarterly information, but no tools or procedures for quarterly reporting have been implemented. More important, an aim of monitoring and evaluation in the CCS is to integrate “real-time, continuous monitoring and implementation at operational level.” The absence of continuous implementation monitoring and timely intervention by the CSC may in part account for implementation setbacks at several points, for example in the activities of the MH priority programme, which was unable to spend all funds received in 2018. A full-time staff of three persons devoted to monitoring and evaluation was proposed at the third EC meeting in December 2016, but this has not been implemented.

Although the CSC should be an intersection point for information, analysis, command and control, under the umbrella of the EC, it has not yet filled this role. It became operational only by the end of the second year of the five-year term of the CCS. It has not met on a regular scheduled basis, and while the CSC receives progress reports from the priority programmes, there is little evidence of active real-time monitoring, problem identification, recommendations for improvement, and follow-up.

There are no detailed standard operating procedures for the CSC.

Programme Sub-committees (PSCs)

The functions of the six PSCs are: to steer and make recommendations for the implementation of the programme; to monitor progress and outputs/outcomes of the programme; and to give advice on programme improvement and programme efficiency enhancement. PSCs are chaired by the head of the lead agency for the programme area or by high-level MoPH officials (Permanent Secretary or Deputy Permanent Secretary). Members include representatives from relevant Government departments and other agencies including participating agencies, national experts on relevant subject matter, the Programme Manager, and a representative from the WHO Country Office. The membership is appropriate to carry out the functions of the PSCs.

Some lead or contracting agencies are also implementing partners, creating a risk of conflict of interest.

The Programme Manager serves as secretary of the PSC and manages the day-to-day operations of programme implementers. The Programme Manager must have management, advocacy and communication skills as well as familiarity with the financial regulations of each programme funding agency. Several stakeholders have recommended that this be a full-time job.

Some meetings are conducted in Thai. In the past, this had been a limitation for many of the WHO technical staff, but now translators are available. PSC meeting minutes are recorded in Thai, and there are no official English translations for use in this mid-term evaluation.

Stakeholders describe considerable variation between PSCs in meeting frequency and content, and in performance of Programme Managers. Moreover, Programme Managers are part-time and, in some cases, would benefit from further training and support to carry out their technical, managerial and financial responsibilities.

There are no standard operating procedures for PSCs.

Theme 3: Financial matters and the pooled funding mechanism

Pooled funding with a common bank account and financial reporting is a major innovation in this CCS. It facilitates CCS principles of country *ownership*, *alignment* with national priorities, and harmonization with partners. Although no quantitative measures were available within the tight timeframe in which data collection was undertaken, a majority of stakeholders interviewed feel that pooled funding reduces transaction costs for the lead and contracting agencies and for the six programmes and brings funders into closer alignment with one another and with the objectives of the CCS. With pooled funding, a higher standard of accountability is expected both by participating agencies and by SEARO (and the Organization more broadly). This is provided by an international-standard financial audit of the six programme contracting agencies.

Initially four of the six participating agencies joined in the pooled funding mechanism; now all except MoPH pool their funds, due to Government regulations which make this difficult. Several avenues to enable MoPH to participate in the pooled funding mechanism are being explored. The pooled funding mechanism is not “pure”, as mandates of some agencies do not permit their funds to be used for some programme activities. This is handled by what could be described as “virtual earmarking”, which is compensated by fungibility of the unrestricted funds in the pool. There are also requirements in some cases for separate financing reports to individual participating agencies, which is also inconsistent with the pooled funding concept.

Despite these problems, most stakeholders have favourable views of the pooled funding mechanism.

International-standard audits conducted by the auditing firm BDO were a new and challenging experience for the six contracting agencies. An international standard audit (ISA) provides reassurance for participating agencies contributing into a pool.

Many areas for improvement were found by BDO, the external auditing firm. Initially there was considerable anxiety and difficulty in responding to the audit findings, although the auditor found no evidence of fraud or intentional misuse of funds. With reassurance and support from the WHO Country Office, adverse audit findings have mostly been resolved, with a few carried over into the next audit cycle. Some agencies were unable to release funds until negative audit findings were resolved, causing uncertainty and delay in programme implementation. However, most stakeholders now report satisfaction (if not enthusiasm) with the audit process and confidence that they will perform better next year.

Conclusions and Lessons Learned

The CCS 2017–2021 has shifted control in operations and funding to country actors, led by the MoPH and exercised through a new governance structure and strong policy involvement of the four participating agencies: HSRI, NHCO, NHSO and ThaiHealth. WHO's role in this new setting has been to invest its intellectual capital in providing technical support, from the Country Office and when needed from SEARO and headquarters, for delivering results in programme implementation. It has also contributed its social capital to provide national and international visibility and to attract partners to support CCS priority programmes. As with any novel undertaking, there are risks, possibilities of failure, and lessons to be learned. This mid-term evaluation is aimed at early learning for mid-course correction and at documenting what has been learned.

The main achievements identified at this early point in the implementation of this CCS are as follows:

- *Ownership:* The CCS has established country ownership, led by the MoPH, with WHO in a supportive and facilitative role. This has been achieved through the CCS governance structures.
- *Programme achievement:* Comparing to the original proposals of the six programme areas, significant achievements have been noted in progress reports, although there have been delays in the implementation of some programmes.
- *Alignment:* CCS activities have been well aligned with national priorities. They support national systems, strategies and plans. This has been facilitated by well-designed national strategic plans in most programme areas.
- *Harmonization:* CCS programmes have been harmonized with Thailand's UNPAF. Harmonization with national partners, including parastatal agencies, civil society and nongovernmental organizations and others, has been made possible by the wide participation of all stakeholders in CCS governance structures, from the EC to the PSCs and implementing partners.
- *Cooperation and contribution to the global health agenda:* Thailand has been visible and effective in the global setting. Strong capacity of the lead agencies and implementers has contributed to this achievement.

In some areas the CCS has not yet fully achieved its objectives, however. Specifically:

- The CSC has a critical responsibility to monitor and evaluate programme performance and to provide analysis and corrective advice based on its findings. The CSC was operational only by the end of the second year and has not yet operated at its full potential. This might have contributed to implementation failures in some programme activities.
- The pooled funding mechanism shows great promise; however, there have been delays in the pooled funding process. The MOPH budget has not yet been incorporated into the pooled funds. There have been delays in release of funds in several cases. In addition, those most closely involved in the day-to-day implementation of the CCS emphasize that such engagement still

entails significant transaction costs (for example, in connection with reporting requirements), despite the implicit intention of this CCS approach to reduce such transaction costs.

- The complexity of an undertaking with the size and scope of the CCS has entailed human resources challenges. All aspects of financial management, including smooth functioning of the pooled funding mechanism and timely release of budgeted funds to the programmes require attention and technical expertise. There are also critical human resources gaps at the levels of the CSC and the PSCs.

While remaining cognizant of the implementation challenges highlighted in this midterm evaluation, it is important to keep sight of the achievements and the potential of this CCS approach. As an example of how government and WHO can work together to create a more fit-for-purpose instrument for targeting national health priorities – and stimulating broader partnership toward these goals with civil society, nongovernmental organizations, and donors – this CCS represents a case study and “proof of concept” of how WHO and its partners can take *risk-aware* and *risk-tolerant* (rather than merely *risk-averse*) and potentially innovative approaches of working together to achieve results in a contextually well-customized manner. As such, this proof of concept can be showcased more widely throughout the Organization, as well as other countries looking for new approaches – particularly at this juncture when the Organization has embarked on its Thirteenth General Programme of Work, in alignment with the Sustainable Development Goals, and is undergoing a major transformation in its way of working to achieve these ambitious goals.

Recommendations

Owing to the early nature of this formative evaluation, coupled with the innovative approach taken in this particular CCS, the recommendations below are intended to help (a) the WHO Country Office in Thailand in the remaining implementation period for this CCS, (b) the WHO Country Office in Thailand in the planning for the next CCS, and (c) WHO as a whole.

Recommendation 1: Reinvalidate the Coordinating Sub-committee and ensure that its dual role of *intersectoral knowledge-sharing platform* and *monitoring and evaluation oversight body* are fulfilled, and that it meets at least four times a year, as per its terms of reference.

This recommendation will require:

- The convening of regular Coordinating Sub-committee meetings, scheduled to ensure broadest attendance possible among its members;
- Clear agendas that consistently cover each of the two main roles assigned to the Coordinating Sub-committee, as well as any other aspects of its coordination and oversight role, along with a standing agenda item reserved for concrete actions, decisions and next steps to be undertaken subsequent to each meeting (coupled with a clear designation of who will undertake this follow-up and by what date);
- A strategy outlining the way forward on how this body will be used as a platform for promoting meaningful intersectoral knowledge-sharing across the six programmatic pillars;
- Implementation of the monitoring and evaluation framework established for the CCS, ideally through the establishment of a delegated monitoring and evaluation working group assigned to undertake the operational aspects of this work; and
- Dedicated capacity to support the work of this body (as per Recommendation 3 below).

Recommendation 2: Put in place critical measures to ensure optimal functioning of the pooled funding mechanism, in keeping with its intended objectives.

Given the multiple objectives the pooled funding mechanism is intended to achieve – i.e. catalyse more sustainable financing (in future CCS periods, potentially beyond the six pillars covered in the current CCS), streamline funding flows and reduce transaction costs (not least of all in connection with

reporting requirements), and reduce earmarking and allow for more results-based funding decisions – the following actions should be taken as a matter of priority:

- Follow up on measures to eliminate the administrative and regulatory barriers currently hindering some prospective donors from contributing to the fund;
- Establish clear funding criteria, coupled with transparent processes, to guide individual funding decisions in a result-based manner (notwithstanding the constraints to some donors);
- Develop a funding strategy to attract additional funding from other sources, based on demonstrated successes showcased through monitoring and evaluation efforts;
- Identify and pursue a sunset arrangement (or exit strategy) whereby WHO's financial contributions to the fund will decrease or cease once its catalytic role in the fund is deemed to be complete by the Royal Thai Government, the WHO Country Office in Thailand and the WHO Regional Office for South-East Asia.

Recommendation 3: Ensure dedicated capacity for maximally effective support for the governance and funds management aspects of the CCS.

Given the considerable time and effort currently required to manage the governance mechanism and fund management, and the additional activities outlined in the foregoing recommendations, dedicated human resources should be deployed to fulfil the following two capacity needs:

- Dedicated funds management expertise to ensure the smooth functioning of the pooled funding mechanism, from facilitation of decision-making procedures to communication with awardees, funds tracking, consolidated reporting, and other aspects of funds management; and
- Technically qualified project management to support the CCS governance mechanisms, especially the Programme Sub-committees and a reinvigorated Coordinating Sub-committee.
- Consider creation of one or more full-time positions in areas of critical need.

Recommendation 4: Identify key lessons and best practices from this CCS approach and actively seek to showcase these in key platforms, both internally (i.e. within the South-East Asia Region and WHO) and externally (e.g. with the United Nations Resident Coordinator and United Nations Country Team partners), and through the International Health Diplomacy pillar), as a means of showcasing this CCS as a “proof of concept” for demonstrating (and enhancing) the Organization’s risk tolerance to other corners of the Organization and others, and as a model for incentivizing partnership to support national governments.

Annex I: Terms of Reference for the Independent Mid-term Evaluation of the WHO-Thailand Country Cooperation Strategy 2017–2021

Background and Objectives of mid-term CCS evaluation

An independent, mid-term evaluation of any Country Cooperation Strategy is critical.

Three major objectives for the mid-term evaluation of the WHO-Thailand CCS are proposed as follows:

1. To identify and highlight best practices and lessons learned from the 2017–2021 CCS at mid-term, so that these can be shared, adopted and built upon for the remainder of this CCS and for future CCS
2. To determine the progress in implementing the strategic priorities, whether the expected achievements are on track, and how has the CCS added value as a concept and as a mechanism
3. To identify challenges and areas for improvement that need to be addressed to improve the impact of the work of the CCS

These objectives for the mid-term evaluation are consistent with those described in the draft WHO 2018 CCS guidelines. This evaluation will complement existing monitoring and evaluation mechanisms, overseen by the CCS Coordinating Sub-Committee, and will consider annual technical and financial reports submitted by the 6 programme areas, as well as progress made on recommendations from the Executive Committee, the CSC and from other independent reviews such as the annual audits of the CCS programmes.

Evaluation Themes:

To achieve the above goals, the evaluation should focus on 3 themes:

Theme 1. Assessment of overall CCS in implementing strategic objectives

- Has the CCS been successful in its overall strategic objective – to more effectively mobilize partners around priority health issues in Thailand?
- What important outcomes and outputs have the CCS programmes produced – what is their expected impact?
- Are the current 6 priority areas appropriate?
- What are the important lessons that can be shared between priority areas?

Theme 2. Governance and structure

- How could the annual planning, implementation and evaluation cycle improve the efficiency and effectiveness of the CCS programme areas?
- Are the current instruments (plans, technical/financial reports) fit for purpose?
- How can the governance structures (EC, CSC and PSCs) further support programme implementation?
- Have governance mechanisms succeeded in reduction transaction costs?

Theme 3. Financial matters and the pooled funding mechanism

- Has the pooled funding mechanism succeeded in its primary objective – reducing transaction costs for funders and implementers?
- Have the flow and amount of funds been sufficient to achieve the programmes objectives? If not, how can this be improved?

- What changes can be made to the pooled mechanism to improve its efficiency and effectiveness?

Modalities and timing

The CCS mid-term evaluation will support the sharing of experiences between key stakeholders in a constructive manner with the aim to promote learning and make mid-course modifications. It will analyze and document the contribution of the Funding Organizations and the implementing Lead Agencies against the goals and goals set in the programme documents approved by the EC.

The evaluation will be conducted by a hybrid team of WHO and external reviewers consisting of a Team Leader and two to three additional experts.

To align the outcome of the review with the future planning processes of RTG and WHO the review will be conducted during the last quarter of 2019.

The evaluation will take 5-8 working days in-country. The team must familiarize themselves with progress reports and other relevant documents prior to the review and this is estimated to take 3 to 4 working days. During the review, the review team will interview Funding agencies, lead agencies, CCS members, WHO staff.

A set of recommendations and the preliminary findings will be presented to the Coordinating Sub-Committee (CSC) at the end of the review following the functions of the CSC.

A final report will be submitted to RTG and WHO 3 weeks after the completion of the review. Evaluation recommendations will be implemented within 2 months.

Annex II: Evaluation Team

Dr Robert J. McCouch, Chief Evaluation Officer / Coordinator, Evaluation Office, World Health Organization

Ms Carol Drayton, Programme Officer, Evaluation Office, World Health Organization

Dr Wiwat Rojanapithayakorn, Director, Center for Health Policy and Management; Executive Director, ASEAN University Network–Health Promotion Network (AUN-HPN), Faculty of Medicine, Ramathibodi Hospital, Mahidol University

Dr William L. Aldis, Adjunct Professor Faculty of Public Health, Thammasat University, Bangkok

Annex III: Stakeholders Interviewed

Name	Title and Organization	Area in the CCS	Date of meeting/interview
Dr Daniel Kertesz	WHO Representative to Thailand	EC, CSC	25 Nov
Dr Richard Brown	Programme Officer, WHO	AMR	25 Nov
Mrs Phiangjai Boonsuk	National Professional Officer, WHO	AMR	25 Nov
Dr Renu Garg	Medical Officer, WHO	NCD	25 Nov
Ms Sushera Bunluesin	National Professional Officer, WHO	NCD	25 Nov
Ms Isabelle Walhin	Administrative Officer, WHO		25 Nov
Ms Aree Mounsookjarean	National Professional Officer, WHO	MH	25 Nov
Ms Rattanaorn Tangthanaset	National Professional Officer, WHO	RS (ITH, GHD)	25 Nov
Dr Viroj Tangcharoensathien	Secretary-General Inter Foundation	AMR, EC	26 Nov
Dr Liviu Vedrasco	Programme Officer, WHO	RS, ITH, GHD, CSC	26 Nov
Dr Supakit Sirilak	Deputy Permanent Secretary, MoPH	EC	26 Nov
Dr Wannee Nitiyanant	President, Thai NCD Alliance	NCD	26 Nov
Dr Cha-aim Pachanee	Senior Researcher, International Health Policy Program	ITH	26 Nov
Dr Siriwat Tiptaradol	Senior Advisor, NHCO	EC, CSC, ITH, RS	26 Nov
Dr Kumnuan Ungchusak	Advisor to the Department of Disease Control	NCD, RS	26 Nov
Dr Siriwan Pitayangsarit	Deputy Director, Division of NCDs, Department of Disease Control	NCD (for the Programme Manager)	26 Nov
Dr Nopporn Chuenklin	Secretary-General HSRI	Donor	26 Nov
Dr Attaya Limwattanayingyong	Deputy Director National Vaccine Institute	Former GHD Programme Manager	27 Nov
Dr Niyada Kiatying-Angsulee	Manager, Drug System Monitoring and Development Center, Chulalongkorn University	AMR, CSC	27 Nov
Dr Nithima Sumpradit	Pharmacist (professional), Bureau of Drug Control,	AMR Programme Manager, CSC	27 Nov

Name	Title and Organization	Area in the CCS	Date of meeting/interview
	Food and Drug Administration		
Dr Weerasak Putthasri	Deputy Secretary-General, NHCO	Donor, CSC	27 Nov
Dr Thaworn Sakunphanit	Advisor, Division of Health Economics and Health Security, MoPH	MH	27 Nov
Dr Witaya Chadbunchachai	Director, Trauma and Critical Care Center	RS	28 Nov
Dr Nuttapun Supaka	Director, Partnership and International Relations, ThaiHealth	Donor	28 Nov
Ms Dana Graber Ladek	Chief of Mission, International Organization for Migration	MH	28 Nov
Dr Warisa Panichkriangkrai	Researcher, International Health Policy Program	GHD	28 Nov
Mr Putthipanya Ruengsom	Research Coordinator, International Health Policy Program	GHD	28 Nov (observer)
Dr Suriya Wongkongkathep	Former Deputy of Permanent Secretary, MoPH	AMR	28 Nov
Dr Wiwat Sitamanotch	Vice President, Road Safety Promotion at Provincial level	RS Programme Manager	28 Nov
Dr Phusit Prakongsai	Expert in Health Promotion, Technical Health Office, Office of the Permanent Secretary, MoPH	Chair, CSC	28 Nov
Dr Boonyawee Auesiriwan	Research Manager HSRI	MH Programme Manager	28 Nov
Ms Deirdre Boyd	UN Resident Coordinator	Overall UNCT coordination	27 Nov
Mrs Sirinad Tiantong	Advisor Global Health Division, Office of the Permanent Secretary, MoPH	GHD	29 Nov (Focus group discussion)
Ms Nanoot Mathurapoj	Head of Global Collaboration Unit, NHCO	GHD	29 Nov (Focus group discussion)
Ms Khanitta Saeiew	Senior Technical Officer, NHCO	GHD	29 Nov (Focus group discussion)

Name	Title and Organization	Area in the CCS	Date of meeting/interview
Ms Oranit Orachai	Administrative assistant, NHCO	GHD	29 Nov (Focus group discussion)
Mr Rungsun Munkong	International Relations Expert Partnership and International Relations	GHD	29 Nov (Focus group discussion)
Mrs Wilailuk Wisasa	Bureau of International Affairs on UHC, NHSO	Donor	29 Nov
Dr Prakit Vathisathokij	Executive Secretary, Action on Smoking and Health Foundation Thailand	NCD	29 Nov
Dr Katinka de Balogh	Senior Animal Health and Production Officer, Regional Office for Asia and the Pacific Food and Agriculture Organization of the United Nations	AMR	29 Nov
Mrs Ganokrat Teachanuntra	Programme Assistant, NCD (and partially MH), WHO	NCD (and partially MH)	29 Nov
Mrs Nathaporn Wongsantativanich	Associate to WHO Representative	WHO	29 Nov
Dr Suwit Wibulpolprasert	Vice Chair, International Health Policy Program Foundation	EC, CSC, MH, GHD, NCD	6 Dec
Dr Pem Namgyal	Director, Programme Management, SEARO	WHO	9 Dec
Mr David Allen	Director, Administration and Finance, SEARO	WHO	9 Dec