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Thailand

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Preface

The Fourth Country Cooperation Strategy (CCS) presents the partnership in health between the Royal Thai Government and the World Health Organization (WHO) for the period 2012 – 2016.

It is with great pride and satisfaction that we introduce this innovative and unique approach to the partnership between Thailand and WHO.

The new CCS builds on two pillars that cement WHO's contribution to health development in Thailand: the National Health Development Plan and WHO's 11 Global Programme of Work.

The document has been developed through a comprehensive process involving key agencies involved in the health sector in Thailand and all levels of WHO. It addresses top priorities on the national health agenda. This consultative process has resulted in a strategy that aims to have true and equal partnership, with well-defined roles and responsibilities for all key partners.

The core component of the strategy identifies five priorities for the partnership: 1) community health system; 2) multisectoral networking for NCD control; 3) disaster preparedness and response; 4) international trade and health; and 5) road safety.

Other important programme areas include the normative functions of WHO, important public health challenges and unfinished public health agendas in Thailand and support to Thailand's role in health beyond its borders.

The Ministry of Public Health and key national health agencies recognize the need to focus strategically on a few programme areas that require more attention in the next plan period. These agencies welcome this strategy towards better health outcomes.

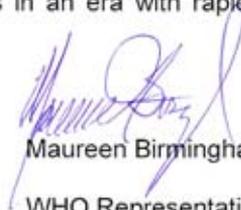
The WHO Regional Office for South-East Asia, which spearheaded the introduction of CCS's in the Member States, welcomes this innovative process as a necessary development of the CCS instrument, which will benefit both national and international health development.

It is our hope that this approach will stimulate similar advances in other countries and provide inspiration to new types of partnerships in an era with rapid national and global health developments.



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Acronyms and abbreviations

AC	assessed contributions
AEFI	Adverse Events Following Immunization
AHA	Area-Based Health Assembly
AMS	Activity Management System
ART	antiretroviral treatment
ASEAN	Association of South East Asian Nations
BCG	Bacillus Calmette-Guérin
CC	Collaborating Centre
CCS	Country Cooperation Strategy
CDC	Centre for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CMU	Community Medical Unit
CRC	Committee on the Rights of the Child
CSC	Country Steering Committee
CSMBS	Civil Servant Medical Benefit Scheme
DDPM	Department of Disaster Prevention and Mitigation
EHA	Emergency and Humanitarian Action
EMIT	Emergency Medical Institute of Thailand
EPR	emergency preparedness and response
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCTC	Framework Convention on Tobacco Control
FETP	Field Epidemiology Training Programme
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, TB and Malaria
GMS	Greater Mekong Sub-region
GPW	General Programme of Work
GSM	Global Management System
HELLIS	Health Literature Libraries and Information Services
HIA	health impact assessment
HITAP	Health Intervention and Technology Assessment Programme
HSRI	Health Systems Research Institute

IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IHA	Issue-Based Health Assembly
IHPP	International Health Policy Programme
IHR	International Health Regulations
ILO	International Labour Organization
IMR	infant mortality rate
INFOSAN	International Food Safety Authority Network
IOM	International Organisation for Migration
LEB	life expectancy at birth
MCA	multicountry activities
MDG	Millennium Development Goals
MIC	middle income country
MMR	maternal mortality ratio
MOI	Ministry of Interior
MOL	Ministry of Labour
MoPH	Ministry of Public Health
MTSP	Medium-term Strategic Plan
NCD	noncommunicable disease
NEHAP	National Environmental Health Action Plan
NESDB	National Economic and Social Development Board
NESDP	National Economic and Social Development Plan
NEW-CCET	Network for WHO Collaborating Centres and Centres of Expertise in Thailand
NGOs	nongovernmental organizations
NHA	National Health Assembly
NHC	National Health Commission
NHCO	National Health Commission Office
NHP	National Health Plan
NHSO	National Health Security Office
PHC	primary health care
PPP	purchasing power parity
SEAPHEIN	South-East Asian Public Health Education Institutes Network
SEAR	South-East Asia Region of WHO
SEARAME	South East Asia Regional Association of the World Federation for Medical Education

SEARO	South-East Asia Regional Office
SO	Strategic Objective
SRM	Strategic Route Map
SSS	Social Security Scheme
STI	sexually transmitted infection
ThaiHealth	Thai Health Promotion Foundation
THAIPHIN	Thai Public Health Institute Network
TICA	Thai International Technical Cooperation Agency
TRIPS	Agreement on Trade Related Aspects of Intellectual Property Rights
TWG	thematic working groups
UCS	Universal Coverage Scheme
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organisation
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNPAF	United Nations Partnership Framework
VC	voluntary contributions
VHC	village health communicator
VHV	village health volunteer
WB	World Bank
WCO	WHO Country Office
WCS	worker compensation scheme
WHO	World Health Organization
WPR	Western Pacific Region of WHO
WR	WHO Representative

Executive summary

The fourth Country Cooperation Strategy (CCS) describes the partnership in health between the Royal Thai Government and the World Health Organization (WHO) and covers the period 2012–2016.

An extensive consultation process involving all stakeholders and high-level decision makers was undertaken to formulate the priorities and the working modalities for the future Thailand - WHO partnership. The process comprised documentary reviews, situation analysis and extensive consultations with key national and international stakeholders in health, including UN agencies within Thailand, the WHO Regional Office and WHO Headquarters.

The review of earlier CCSs identified some major problems. The cycles between WHO programme planning and the CCS development were overlapping. By the time a CCS was completed, the next WHO programme development had already started and the CCS did not guide the development of the workplans as envisaged. Moreover, many high-level decision makers and stakeholders in health were not familiar with the WHO CCS, leading to lack of coherence between strategic intents and programme activities.

Thailand is now a middle-income country (MIC) and has made remarkable progress in health over the past years. Thailand is also increasingly providing development support to other countries and is playing a very active role in global and regional health forums. In view of the achievements, the review findings, the changing landscape and great challenges ahead, it was agreed to profoundly change the way WHO and the government collaborate, using a participatory and evidenced-based approach for a more innovative collaboration in terms of setting strategic priorities for greater impact, as well as the modalities.

Among the principle outcomes of the process are:

- Identification of five priority areas of work for collaboration;
- Agreement on key objectives and outcomes/outputs for each priority area;
- Identification of key stakeholders, potential implementers, and institutional coordinators for each priority area;
- Consensus among the key public health bodies in Thailand and WHO regarding modalities of cooperation.

Unlike previous CCSs that identified several broad strategic agendas for the period of four years, this CCS has a five-year horizon in order to align the strategic plan with the country's next National Health Plan (2012–2016) and with the new United Nations

Partnership Assistance Framework (UNPAF) and it focuses on a few strategic priorities that will be implemented collaboratively.

This signifies a completely new way of working in health and the modalities identified for the partnership operations focus on a multisectoral approach involving a number of national health agencies, with WHO in a key facilitating role.

Thailand has achieved considerable gains in the health status of its population over recent decades. The MDG targets in health have mostly been reached nationally and the health system has moved from strength to strength. Despite these gains, considerable social inequities remain between different parts of the country and between urban and rural populations affecting, in particular, people living in poverty and migrant populations.

While considerable gains have been made against communicable diseases, there has been a steady rise in noncommunicable disease (NCD). Among the top ten conditions in the disease burden ranking in Thailand, nine are NCDs, including road traffic injuries.

A small number of major public health issues also persist, such as the lack of universal access to health care, environmental health issues, teenage pregnancies and unsafe abortions, and some elements of HIV, TB and malaria control.

The new Thailand-WHO partnership that is described in this CCS identifies *five priority programmes of work*. These programmes will provide the main focus for partnership activities over the next planning period and are summarized below:

Community Health System

Objectives: Empower and strengthen the subdistrict health system so that the community health system will be more effective and responsive to the health needs of the population.

Multisectoral networking for NCD control (NCD network)

Objectives: 1) Promote collaboration, partnership and integration among various sectors to tackle NCDs, including health-related and non-health-related sectors in Thailand; 2) strengthen national policies, plans and interventions for prevention and control of five main NCDs: cardiovascular diseases, diabetes, cancers, chronic respiratory diseases and hypertension.

Disaster preparedness and response

Objectives: 1) Establish coordination and collaboration mechanisms in the Disaster Health Emergency Management System among various national and international agencies; 2) further support the development of the Disaster Health Emergency Management System to be effectively and efficiently integrated and linked with

relevant agencies at all levels in institutional, legislative frameworks, policies, SOPs, contingency plans and capacity building; 3) engage various sectors systematically to establish mechanisms for disaster prevention, preparedness, response, recovery and rehabilitation.

International trade and health

Objectives: Build individual and institutional capacities and generate evidence to support coherent policy decisions on international trade and health for positive health outcomes of the population.

Road safety

Objectives: 1) Establish international coordination and knowledge sharing on strengthening of Thailand's road safety network, particularly in relation to motorcycle safety; 2) substantially reduce the rate of motorcycle-related injuries and death.

An innovative governance and steering structure has been put in place to oversee the implementation. Various national health agencies have been identified as focal points for each priority. WHO will collaborate in a steering, technical, facilitating and funding role. It is expected that priority-setting and implementation will be a dynamic process wherein certain projects finish when targets have been reached and are replaced with new priorities during the CCS period.

These five priorities constitute the main focus for WHO. However, other important programme areas will not be neglected. They include the *normative functions, the public health challenges and unfinished agendas in Thailand* and *support to Thailand's role in health beyond its borders*.

WHO Thailand will also continue to facilitate a number of programmes (Mekong Malaria, vaccine supplies and quality, stockpile management and water and sanitation) that serve countries both inside and outside the region. The WHO Country Office (WCO) provides operational and administrative support to these programmes.

The CCS will be aligned and harmonized with the UN-Royal Thai Government agenda, which is currently described in a new United Nations Partnership Assistance Framework (UNPAF) for 2012-16.

The impact of these changes on budgets and staffing of WHO in Thailand are expected to be moderate. In order to build on current momentum, some reprogramming for 2011 will take place to support the initiation of the priority programmes.

The new CCS is an innovative and dynamic strategic tool for future collaboration between Thailand and WHO. This model may inspire future collaboration between WHO and other MICs in the spirit of harmonized and aligned country-led partnership.

1 — Introduction

The broad directions for the work of WHO as the world's health agency are set out in the General Programme of Work (GPW)¹. The current Eleventh GPW identifies the agenda for international public health for the period of 2006 through 2015, which is linked to the Millennium Development Goals (MDGs). WHO's specific priorities are described in the WHO Medium-term Strategic Plan (MTSP), 2008-2013², where they are defined as strategic objectives (Annex 2), and as expected results in the two-year workplans.

The Eleventh GPW notes that there have been substantial improvements in health over the last 50 years. However, significant challenges remain, as described in the following four gaps: a) Gaps in social justice; b) gaps in responsibility; c) gaps in implementation; and d) gaps in knowledge. In order to reduce these gaps over the coming ten years, the Eleventh GPW outlines a global health agenda consisting of seven priority areas:

- Investing in health to reduce poverty
- Building individual and global health security
- Promoting universal coverage, gender equality, and health-related human rights
- Tackling the determinants of health
- Strengthening health systems and equitable access
- Harnessing knowledge, science and technology
- Strengthening governance, leadership and accountability.

The global health agenda is intended for everyone working in the field of health development. WHO will contribute to this agenda by concentrating on its core functions, which are built on the comparative advantages of the Organization. In accordance with the global health agenda and WHO's core functions (Annex 1), the Organization has set the following priorities:

- Providing support to countries in moving to universal coverage with effective public health interventions;

- strengthening global health security;
- generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
- increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
- Strengthening WHO's leadership at global and regional levels and supporting the work of governments at the country level.

WHO will pursue these priorities through its MTSP and the biennial plans of the Organization. The Director-General of WHO has clearly put a major emphasis on the work of the Organization at the country level in order to implement these priorities in Member States, especially where the health needs are greatest.

The South-East Asia Region (SEAR) of WHO has the second-highest population among the six WHO regions and has the greatest burden of disease. While there has been great economic development in this Region in recent years, the problems of poverty and poor health remain significant. Many countries have faced health emergencies in the past decade, and the threat of disease outbreaks is ever-present. At the same time, noncommunicable diseases have become an increasingly important cause of morbidity and mortality in South-East Asia. The global policy framework of WHO is, therefore, appropriate for the countries of the Region, with special attention given to strengthening the capacity of Member States to support cost-effective public health interventions.

The Country Cooperation Strategy (CCS) is an Organization-wide reference for country work, which guides planning, budgeting, resource allocation and partnership. The CCS reflects the overarching values of the United Nations which underpin WHO's Constitution and contributions to improving global health, health-related human rights, equity and gender equality.

The key principles guiding WHO cooperation in countries and on which the CCS is based are:

- *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.

The CCS is a medium-term vision for its technical cooperation with a given Member State, in support of the country's national health policy, strategy or plan. The time-frame is flexible to align with national cycles. It is generally 4-6 years. It is the main instrument

for harmonizing WHO cooperation in countries with that of other UN Agencies and development partners.

The first Thailand CCS covered the period 2002-2005, and was later updated for 2004-2007. The third and current CCS³ covers the period 2008-2011.

A review⁴ of the usefulness and benefits of these CCSs identified some major problems. The cycles between WHO programme planning and the CCS development were overlapping, so that by the time a CCS was completed, the next WHO programme development had already started and the CCS did not guide the development of the workplans as envisaged. Moreover, many high-level decision-makers and stakeholders in health were not familiar with the CCS, leading to a lack of coherence between strategic intents and programme activities.

Thailand is now a middle-income country (MIC) and it has made remarkable progress in health over the recent years. In view of the achievements, changing landscape and great challenges ahead, there is a need to profoundly change the way WHO and the Royal Thai Government collaborate, using a participatory and evidenced-based approach for a more innovative collaboration in terms of setting strategic priorities for greater impact, as well as modalities.

The current CCS development process involves documentary reviews, situation analysis and extensive consultation with key national and international stakeholders in health, including UN agencies within Thailand, the WHO Regional Office and WHO Headquarters. Important documents such as the tenth National Health Development Plan⁵, the National Health Policy⁶, the WHO GPW, WHO MTSP, and the current United Nations Partner Assistance Framework (UNPAF), 2007–2011⁷ were reviewed and used as a basis for identifying national health problems and priorities.

An extensive consultation process involving all stakeholders and high-level decision-makers was undertaken to formulate the priorities and the working modalities for the future. This process coincides with the development of a new UN Partnership Framework (UNPAF) for Thailand enabling a close coordination and cross-fertilization of the CCS and the UNPAF.

Among the principal outcomes of these consultations are:

- Identification of five priority areas of work for Thailand-WHO collaboration;
- agreement on key objectives and outcomes/outputs for each priority area;
- identification of key stakeholders, potential implementers, and institutional coordinators for each priority area;
- consensus among the key public health bodies in Thailand and WHO regarding modalities of cooperation, and
- a new Country Cooperation Strategy.

Unlike previous CCSs that identified several broad strategic agendas over the period of four years, this CCS has a five-year horizon in order to align the strategic plan with the next National Health Plan (2012–2016) and with UNPAF, and it focuses on a few, strategic priorities that will be implemented collaboratively.

2 — Health and development challenges, attributes of the national health plan, system and services

2.1 Macroeconomic, political and social context

Thailand's population was 63.4 million in 2008. The population is quite homogeneous; about 95% are of Thai ethnicity, with the remainder comprising Chinese, Indians and others. About 94.6% of the people are Buddhist and 5.4% are Muslim, Christian, Hindu and other religions. Changes in the demographic profile and characteristics of the population from 1960 to 2000 and 2020 (projection) are shown in Table 1. The Thai population is aging over time due to the decreasing fertility rate from 5.58 births per woman in 1970 to 1.82 in 2000 and the increasing life expectancy. The proportion of the population above 60 years is expected to rise from 9.2% in 2000 to 16% in 2020. Currently, about 35% of the population lives in urban areas, and this is expected to increase to 40% in 2020.

Over the past 50 years the Thai economy has changed from agriculture to services and manufacturing. The share of agriculture has decreased from 23% of gross domestic product (GDP) in 1970 to 8.9% in 2009, and manufacturing has increased from 21% to 39% of GDP over the same period.^{9,10} Economic growth has been impressive in the past three decades though slumps have occurred in connection with the financial crises in 1996-1997 and in 2008-2009. The main income of the country comes from three sources: industry, agriculture, and tourism. According to the International Monetary Fund, Thailand's GDP (PPP) for 2008 and 2009 were US\$ 8239 and US\$ 7998 per capita, respectively.¹¹

As with other emerging economies in Asia, Thailand has long depended on international trade as an engine of growth. Exports account for about 70% of GDP indicating it is among the economies most vulnerable to global financial or economic crises.

The country has been hit by the recent global economic crisis, but it appears to have suffered relatively less compared to western economies. Today, it has cushioned itself against such turmoil with foreign reserves exceeding US\$ 110 billion, and with a low debt-to-GDP ratio, well-capitalized banks, better corporate balance sheets and modest property price appreciation.

Table 1: Population characteristics, 1990–2000 and 2020 (projection)

	1960	1970	1980	1990	2000	2020
Total population (x 1000)	26 260	34 397	44 825	54 548	62 056	70 821
- Male	13 154	17 124	22 329	27 062	30 885	34 631
- Female	13 104	17 274	22 496	27 487	31 171	36 631
Dependency ratio (%)	92.0	85.0	75.0	57.7	53.3	54.0
Population < 5 years (%)	10.2	16.4	12.1	8.2	8.3	6.1
Population 15-60 years (%)	52.2	49.8	56.4	63.4	60.0	64.9
Population > 60 years (%)	4.5	5.1	5.3	7.4	9.2	15.9
Population in urban area (%)	12.5	13.2	17.0	18.7	35	40
Population per km ²	51	70	87	106	121	134
Life expectancy at birth (years)						
- Male	53.6	57.7	60.3	63.5	70.0	72.2
- Female	58.7	61.6	66.3	68.8	75	76.5
Fertility rate (births per woman)		5.58	3.39	2.14	1.82	
Infant mortality/1000 live births	84.3	56.3	48.0	35	25	7
Maternal mortality/100000 live births*				25.0	13.2	

Source: a) Bureau of Policy and Strategy 2007 b) Institute of Population and Social Research, Mahidol University 2009; c) National Statistical Office 2007; d) World Bank Indicators – Thailand – Reproductive Health

While the government ably minimized the impact of the global economic crisis, the impact of political turmoil on the economy is evident. During the violence in 2010, Thailand experienced a negative impact on the tourism industry, one of the major sources of national income.

Thailand has achieved some overall success in its poverty alleviation demonstrated by a reduction in the poverty incidence (ratio of total number of poor households to total number of households) from 14.9 in 2002 to 9.5 in 2006 as shown in Table 2.

Despite the gains, disparities among regions and urban/rural localities are evident; the poverty incidence in the northeast is about five times greater than that of the central region and almost 34 times that of Bangkok. Over time, the gap between rich and poor has not narrowed; according to the Thailand Human Development Report 2009, the wealth of the richest quintile is 3-4 times greater than the wealth of the poorest quintile. To address health inequities and social determinants of health, a National Health Act was passed in 2007, which led to the establishment of the National Health Commission Office, Health Impact Assessments, and the National Health Assembly (described in more detail in section 2.5). Nevertheless, social inequity remains one of

the underlying causes of political unrest in Thailand in recent years. Moreover, the frequent changes of the government and cabinet since 2006 led to continued shifts and uncertainties in national policies, including health policies such as on decentralization as well as termination of the “Healthy Thailand” strategy and a food safety project called “Clean Food, Good Taste”. In 2010, the government therefore established two National Reform Committees and a participatory process to formulate proposals to reform Thailand. In addition, the Eleventh National Economic and Social Development Plan (NESDP), for 2012-15, aims to address social inequity while simultaneously promoting environmentally friendly and creative economic growth.

Table 2: Expenditure-based poverty incidence (in %) by sex and region in 2002, 2004 and 2006

Region	2002			2004			2006		
	M	F	Total	M	F	Total	M	F	Total
Bangkok	2.3	2.2	2.2	1.0	0.6	0.8	0.6	0.4	0.5
Central	8.1	7.2	7.6	4.5	4.4	4.5	3.3	3.3	3.3
Northern	21.7	19.0	20.3	16.4	15.0	15.7	12..5	11.5	12.0
North-eastern	23.7	22.4	23.1	18.8	18.4	18.6	17.3	16.3	16.8
Southern	10.0	9.2	9.6	5.9	6.1	6.0	5.4	5.6	5.5
Whole country	15.7	14.3	14.9	11.4	10.9	11.2	9.8	9.3	9.5
- municipal	5.0	3.8	4.4	3.1	2.9	3.0	4.3	3.6	3.9
- non-municipal	11.4	11.1	11.2	6.8	7.2	7.0	5.7	6.3	6.0

Source: NESDB¹³

2.2 Other major determinants of health

Although Thailand has a very high literacy rate (almost 100%), there are still big differences in the proportions of higher-level education among people in provinces compared to Bangkok. Out of 134 universities and colleges, 65 are located in Bangkok, resulting in disparities of access to higher-level education.

There are also inequities in access to quality health care in different parts of the country. Large gaps exist, for example, between Bangkok and the North-eastern Region in health resource distribution. The Bangkok area has significantly more beds and physicians per population than the North-eastern Region (Table 3). While private hospital beds account for about 25% of total beds, these mostly serve wealthy patients.

Table 3: Number of doctors, nurses and beds and ratios, 2006 and 2008

Category		Region					
		Bangkok	Central	North	Northeast	South	Total
Doctors (2006)	Number	6 411	5 113	3 547	3 721	2 259	21 051
	Ratio	886	2 963	6 020	5 738	3 789	2 975
Nurses (2006)	Number	20 778	26 920	18 342	21 154	13 494	101 143
	Ratio	273	563	648	1 009	614	619
Beds (2008)	Number	18 326	38 584	23 770	27 500	17 686	125 866
	Ratio	312	402	500	779	492	502

Source: Health Resources and Survey Dta, Bureau of Policy and Strategy, MoPH 2008¹⁴

Over the past decades, Thailand's dramatic economic growth has produced new environmental challenges in this once agrarian society. The country now faces problems with air and water pollution, declining wildlife populations, deforestation, soil erosion, water scarcity, and hazardous waste. The open burning of fields in northern Thailand causes major smog every year. Environmental degradation, disruption of the ecosystem and climate change are likely contributory factors in the frequent floods and increasing incidence of vector-borne diseases such as dengue fever in Thailand.

Simultaneous to Thailand's economic growth and urbanization is increasing exposure to international forces and globalization. With this growth and exposure have come advances in health-care technology and improvements in living standards, as well as increasing disparities between social groups and exposure to health risks from other parts of the world. One of the direct effects of these factors in Thailand is unequal access to medical care by different social groups due to the rise in imported sophisticated technologies that increase the cost of medical services.

Economic growth, globalization and urbanization have also brought with them unhealthy lifestyles including physical inactivity; consumption of processed, high-sugar and fat food products; tobacco use; and excessive alcohol consumption. Additionally, there are many public health ethical concerns related to international trade and health, which may have direct and indirect effects on health and social well-being.

Thailand has been affected by emerging infections (e.g. SARS, influenza A/H5N1 and the influenza A/H1N1 pandemic) and the resurgence of old ones. The emergence of Nipah virus outbreaks in Bangladesh, India and Malaysia represents a threat in Thailand as well. Cholera outbreaks are recurring at an increasing frequency while leptospirosis, dengue fever and chikungunya are also re-emerging. Emergence of drug-resistant malaria, TB and HIV are worrying developments. Inappropriate prescribing and use of antimicrobials contribute to the emergence of drug resistance, as does uneven access

to health services, particularly among migrant populations. Irrational use of medicines is also a major driver of rising health-care costs.

2.3 Health status of the population

The life expectancy at birth (LEB) in 2000 was 70 years for males and 75 for females. It is estimated to rise to 72.2 and 76.5 years, respectively, in 2020 (Table 1). Thailand's infant mortality rate (IMR) has dropped from 84.3 per 1000 live births in 1960 to 25 in 2000. Thailand has achieved most of the MDG targets nationally, particularly in areas of reproductive health, maternal and child health, although estimated trends in the maternal mortality rate are affected by a change in estimation methods.¹⁵ The national indicators nevertheless hide the disparities at subnational levels; challenges remain among people living in poverty and among migrant populations, particularly in the border areas. While there has been significant progress in the past two decades on major communicable diseases, morbidity, mortality and disability due to noncommunicable diseases are steadily rising.

(i) Burden of communicable diseases

HIV/AIDS: Successful efforts to control HIV/AIDS in Thailand has focused on affecting behavioural risk factors in sexual transmission resulting in reducing visits to commercial sex workers, increased condom usage, decreased prevalence of sexually transmitted infections (STI) and a substantial decrease in new HIV infections over time. The number of annual new HIV infections decreased from 143 000 in 1991 to 10 853 in 2010.

Since 2002, the government has scaled up antiretroviral treatment (ART) to people living with HIV through more than 900 public hospitals. A fixed-dose combination of antiretroviral drugs produced by the Government Pharmaceutical Organization was a key factor contributing to the expansion of the treatment programme. The production and use of generic drugs contributed to an eight-fold expansion in treatment provision between 2001 and 2003, with only a 40% increase in cost. By the end of 2009, there were 216 118 persons living with HIV receiving ART in Thailand, representing an estimated 76 % of those who need it. ART has been provided freely to all Thais under the National Health Insurance Schemes. The Global Fund to Fight AIDS, TB and Malaria (GFATM) has contributed to the programme by providing funds for treatment of non-Thai residents.

Despite the remarkable achievements in Thailand, more than 1-in-100 adults in Thailand are currently infected with HIV, and AIDS has become a leading cause of death and disability in Thailand. There is also an alarming increase recently in HIV prevalence among men who have sex with men (e.g. from 17.3% in 2003 to 30.7% in 2007 in Bangkok). Increasing risky sexual behaviour among young people is also associated with increasing rates of new STIs and HIV infections among adolescents. These increasing rates, along with an increase in spousal transmission, have led to

concerns that the epidemic is becoming more generalized and feminized in the population and that Thailand could face a resurgence of HIV. Moreover, the HIV prevalence among injecting drug users has always remained high (currently estimated at 52.8%) since the beginning of the epidemic in the late 1980s. The large number of unregistered migrants in Thailand also poses challenges in both prevention and access to treatment for this vulnerable population. Effective prevention measures should therefore be focused among most-at-risk populations (sex workers, men having sex with men, injecting drug users and migrant workers). This would include scaling up effective measures for harm reduction among injecting drug users. Another important challenge will be the emergence of ART drug resistance.

Tuberculosis: Thailand is still classified by WHO as one of the 22 countries in the world with the highest TB burden, with an estimated 130 000 prevalent cases, 93 000 new cases and 12 000 deaths in 2009¹⁶ (WHO Report 2010 Global Tuberculosis Control). In that same year, the case detection rate reached 69% and the treatment success rate improved to 83%. Despite these improvements, the rates are below the global target of 85% due to a high default rate, high mortality rate among TB patients, and incomplete reporting in Bangkok. Integrated TB/HIV services are now becoming widely available in Thailand; in 2008, almost 79% of notified TB cases were screened for HIV. The latest survey of drug resistance found that 1.7% of new cases and 35% of previously treated cases have multidrug resistant TB. Most of these patients are treated by major university hospitals or large private hospitals, which are not linked to the National TB Programme.

Malaria: Malaria is considered a re-emerging disease largely due to a rising incidence in border areas, along with increasing drug resistance. This development is mainly a result of the high mobility of migrants and cross-border populations with limited prevention and access to early diagnosis and appropriate treatment.¹⁷ Overall, the reported number of malaria cases was 51 271, 63 272 and 23 229 in the years 2004, 2006 and 2009, respectively. Approximately 50% of reported malaria cases occur among non-Thai migrants in 2009. There has also been a marked increase in malaria incidence in the four southern-most provinces of Thailand. The border areas of Thailand are now considered the global cradles of emerging artemisinin resistance.

(ii) Burden of noncommunicable diseases, injuries and mental illness

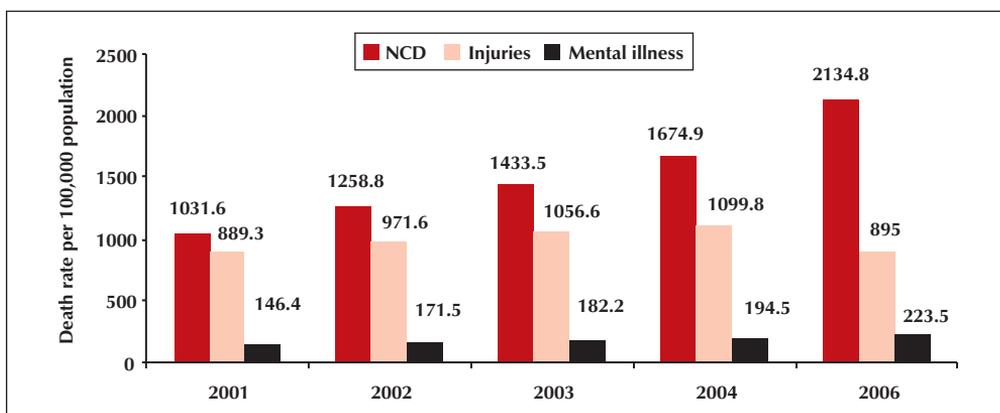
The *2009 Report of Thailand's Burden of Diseases, Injuries and Risk Factors* provides a ranking of the 20 reported conditions according to 'disability-adjusted life years (DALYs) lost (Table 4). Nine of the top ten conditions are due to non-communicable disorders, with traffic injuries in second place.

Table 4: Ranking of 20 causes of disability-adjust life years (DALYs) lost by sex, 2004

Rank	Male			Female		
	Cause	DALYs lost ('000)	%	DALYs lost ('000)	%	Cause
1	HIV/AIDS	652	11.5	316	7.7	Stroke
2	Traffic injuries	592	10.5	295	7.2	HIV/AIDS
3	Stroke	336	6.0	293	7.1	Diabetes
4	Alcohol dependence	333	5.9	191	4.6	Depression
5	Liver cancer	281	5.0	141	3.4	Ischemic heart disease
6	Ischemic heart diseases	184	3.3	131	3.2	Osteoarthritis
7	Chronic obstructive pulmonary disease	183	3.2	126	3.1	Traffic injuries
8	Diabetes	181	3.2	126	3.1	Liver cancer
9	Cirrhosis	145	2.6	111	2.7	Deafness
10	Depression	137	2.4	109	2.6	Chronic obstructive pulmonary disease
11	Bronchus and lung cancer	111	2.0	105	2.5	Anxiety disorders
12	Homicide and violence	108	1.9	94	2.3	Asthma
13	Deafness	108	1.9	94	2.3	Lower respiratory tract infections
14	Suicide	107	1.9	83	2.0	Dementia
15	Lower respiratory tract infections	105	1.9	82	2.0	Cataract
16	Tuberculosis	107	1.5	76	1.8	Cervix uteri cancer
17	Asthma	105	1.5	75	1.8	Nephritis and nephrosis
18	Osteoarthritis	86	1.5	62	1.5	Breast cancer
19	Drowning	79	1.4	56	1.4	Cirrhosis
20	Drug dependence	75	1.3	56	1.4	Low birth weight
	All diseases	5 649	100	4 121	100	

Source: International Health Policy Program, Ministry of Public Health, 2009.¹⁸

Figure 1: Hospitalization rates of selected NCDs, injuries and mental illnesses in Thailand (excluding Bangkok) 2001-2006



Source: Public Health Statistics, MoPH

Findings from the National Health Behavioural Risk Survey in 2007¹⁹ support the above findings. High proportions of Thai people have lifestyles that facilitate the development of NCD's and injuries, for example, unsafe consumption of alcohol, smoking, unhealthy dietary habits, less physical activity, and unsafe road safety behaviour (Table 5).

Table 5: Prevalence (%) of risk behaviours among Thai population, 2007

Risk condition/condition	Prevalence (%)	
	Male	Female
Obesity (BMI \geq 30 kg/m ²)	2.7	4.7
Consumption of high fat diet (1-3 times/day)	31.2	33.1
Consumption of sweet diet (1-3 times/day)	41.5	40.3
Inadequate consumption of fruit & vegetables	79.5	74.5
Inadequate physical activity	57.6	67.3
Consumption of alcohol	64.3	16.1
Currently smoking	41.5	2.4
Not wearing helmet (motorcyclists)	45.5	46.6
Not using seatbelts	30.8	33.7

Source: The survey Report of Behavioural Factors of Non-communicable Diseases and Injuries in Thailand 2007, Centre for NCD, Bureau of NCD, Department of Disease Control, Ministry of Public Health

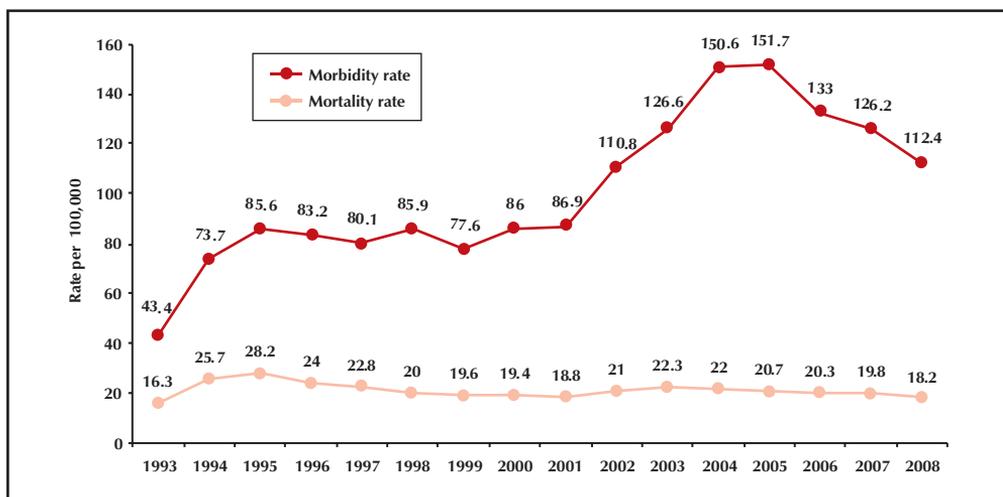
Despite many social mobilization campaigns, the reported mortality rate from road traffic injuries in 2008 remains high at 18.2 per 100 000 population although available

data suggest a decreasing morbidity rate in recent years (Figure 1). Over 70% of fatalities are related to motorized 2 or 3 wheel vehicles (e.g. motorcycles).²⁰ Thailand lacks needed legislation and/or enforcement in the following five internationally recognized, evidence-based, cost-effective areas, which effectively reduce injury, death and disability from road traffic crashes:

- (1) Urban speed limits at <50 km per hour (Thailand has 80 km/hour and self score on enforcement of 2/10)²⁰;
- (2) Blood alcohol concentration < 0.05 g/dl (Thailand has legislation in place, but a self score on enforcement of 5/10)²⁰;
- (3) Motorcycle helmet law and helmet standard (Thailand has a helmet law but only 27% compliance and a self-score on enforcement of 4/10)²⁰;
- (4) Front and rear seat belts (Thailand has a seat belt law for the front seat only, with 56% compliance in the front seat and 2% in back seat; self score on enforcement is 5/10)²⁰; and
- (5) Child restraint (Thailand has no law and therefore no enforcement)²⁰.

The national campaigns to prevent road traffic injuries focus on the weeks of the Songkran celebration (New Year, during mid-April) and during the week of international New Year. Data from the Ministry of Public Health in 2008 shows that the two highest causes of road traffic crashes during the New Year period are drunk driving (23.4%) and speeding (20.9%). About 80-85% of road traffic crash victims during 2008-2010 were motorcyclists, and the remaining were car drivers.

Figure 2: Morbidity and mortality rate of road traffic injuries, 1993-2008



Source: Police Information System Center, Royal Thai Police

(iii) Environmental health

The main responsibility for water supply, sanitation and pollution control services is with the Ministry of Natural Resources and Environment. The Bureau of Environmental Health, MoPH is responsible for providing technical support and capacity building, especially to local organizations. The healthy settings approach is used to promote healthy cities, public latrines, and healthy markets, schools and hospitals. A National Environmental Health Action Plan (NEHAP) 2009-2011 has been developed. The health impact assessment (HIA) is recognized in the Thai Health Act of 2007 as an important healthy public policy tool to minimize the adverse influences of public policy, industrial development and construction projects on health. The National Health Commission Office (NHCO) has an important role in establishing conditions and methods for tracking the health impact assessment. More support is needed to improve national capacity and processes for conducting HIAs.

Future environmental challenges include climate change, increasing urbanization, air and water pollution, and the dangers of hazardous waste and chemicals, including pesticide and heavy metal pollution in the environment. Enforceable standards have yet to be set for permissible levels of hazardous chemicals in food, water and the environment. An effective surveillance system must also be established to monitor compliance with standards and be directly linked to enforcement and punitive action when violations are detected.

Although Thailand has been concerned about occupational health for more than 30 years, injuries and other health conditions related to the workplace are on the rise. Besides injuries, the most common reports of occupational health events are pesticide poisoning, skin diseases, back pain, lead poisoning and silicosis. To date, the government response to these problems has been largely limited to providing medical care or financial compensation to the victims. Effective prevention of occupational hazards is still very limited.

Thailand is currently the world's fourth largest importer of asbestos, which will result in important and expensive public health problems in the near future. Following International Labour Organization (ILO) and WHO recommendations, the Government of Thailand is implementing a national strategy to tackle the asbestos problem by imposing strict controls in the run-up to a complete ban (including chrysotile) by 2013.

The promotion of food safety has been one of the government's priorities under the Healthy Thailand campaign. In 2009, WHO supported an external review of the National Food Safety Programme, which made far-reaching recommendations requiring a coordinated, multisectoral approach among several government sectors and regulatory bodies to achieve a safe food chain "from farm to fork". Thailand is also one of the 177 members of the International Food Safety Authority Network (INFOSAN).

(iv) Health of vulnerable population sub-groups

The aged: In recognition of the rapidly aging population, the government has given stronger attention to the well-being of the “aged”. The Bureau of Empowerment of Older Persons was established in 2002, under the Ministry of Social Development and Human Security. It functions as secretariat and coordinating body of the Elderly Protection Network, which comprises concerned ministries and NGOs. The Second National Plan for Older Persons (2002-2021) was approved by the Cabinet in 2002¹⁶ To guarantee a minimum income for persons over 60 years of age, a universal tax-financed 500 *baht* per month pension was introduced in 2008; however, this amount is about one-third of the average per capita poverty line in Thailand.²¹

The south: Continuous violence in the three southern-most provinces (Pattani, Yala and Narathiwat) since 2004 has killed and injured many innocent people. Health services are also affected. Increasing malaria incidence, comparatively low immunization coverage, a diphtheria outbreak in 2010 and available data on infant mortality and maternal mortality suggest the need for tailored approaches to ensure demand and access to high-quality health services (promotive, preventive and curative). The government has developed a special plan with allocated budgets for improving the health of people in these provinces. WHO has joined the government teams on several visits to the region to advise on how to improve health service quality and accessibility.

Non-Thai mobile and migrant populations: An estimated 2.4 million non-Thai migrants are living in Thailand, mostly from the Mekong countries, but only 1.3 million are registered according to the latest data from the Ministry of Labour (MOL, 2010).²² Studies have confirmed that migrants are needed for the long-term economic development of Thailand, and they account for 5% of the labour force within Thailand. Additionally, it is estimated that migrant workers contribute about 6.2% of the GDP of Thailand.²³ Currently, access to health services of migrants is linked to a process of registration and obtaining a work permit, and then purchase of an insurance package for non-Thai migrants. A large number of migrants working in Thailand do not acquire health insurance, yet migrants and other mobile populations bear a disproportionate share of the health burden in Thailand. The uneven access to health services among migrants is a factor in the emerging drug resistance and the risk of outbreak-prone diseases, which threatens the health security of the entire nation and beyond.

However, data on the health status, health-care seeking behaviour, and access to health services among non-Thai migrants (and their accompanying families) is of poor quality, particularly for unregistered migrants. More so, there is a recognized lack of long-term planning and policy coherence across the Ministries of Interior, Labour and Public Health, making it difficult to plan for migrant health needs and ensure better health security for all in Thailand.

Health services for the estimated 147 900 non-Thai displaced persons in temporary shelters along the border with Myanmar²⁴ have been run by international NGOs in parallel with the Thai health system for more than two decades, Outbreaks occasionally occur within and outside the camps due to the movement of people, their living conditions and their health status. In 2009-2010, WHO collaborated with the MoPH and NGOs in setting up an outbreak early-warning system. The challenges ahead include ensuring the performance of this system, strengthening response actions with clear roles for all actors, establishing standard operating procedures for health services in the camps, and pursuing long-term, coherent, intersectoral policies related to this population.

(v) Emergency and Humanitarian Action and health sector emergency preparedness and response:

Thailand is vulnerable to natural hazards, including floods, tsunamis, storms, droughts, landslides, forest fire, earthquakes and epidemics. Thailand is most frequently affected by floods. Cyclone storms have also caused disasters. Floods in 2010 killed 122 people across Thailand. The tragic Asian tsunami in December 2004 killed 8345 people in Thailand, affected 67 007 others, and resulted in an economic loss of US\$ 1 billion to the country. Droughts have also been a significant hazard. Overall emergency preparedness and response (EPR) activities are coordinated by the Department of Disaster Prevention and Mitigation (DDPM) of the MOI. The Bureau of Health Administration, MoPH, has coordinated health sector EPR actions, although actions are spread across several units of the MoPH. In 2008, the government established the Emergency Medical Institute of Thailand (EMIT) to take a lead role in preparing and responding to natural and man-made disasters in Thailand.

WHO is working closely with the MoPH and other government agencies such as EMIT, the Department of Disaster Prevention and Mitigation (DDPM) of the MOI, the Thai Red Cross Society (TRCS) and several other Inter Agency Standing Committee (IASC) humanitarian partners, including NGOs (national and international), and academic institutions in Thailand. The IASC County Team in consultation with the government assigned WHO and the MoPH as cluster/sector lead agencies for both health and nutrition.

(vi) Other public health challenges and unfinished agendas

Despite Thailand's many remarkable public health achievements, there remain some significant public health challenges or "unfinished public health agendas". These are areas where other middle-income countries have performed better and where moderate investments and political leadership could lead to significant gains in the health status of the population. Such areas include:

- HIV prevention and care, particularly among most at-risk populations (including accelerated efforts on harm reduction among injecting drug users);

- TB control, especially in Bangkok;
- malaria control (including containment of artemisinin-tolerant malaria);
- ensuring adequate iodine intake in the population through universal salt iodization;
- sustaining high-quality universal health care that would also ensure access to health services among migrants and mobile populations;
- reducing teenage pregnancy and preventing unsafe abortion; and
- environmental and occupational health issues in both urban and rural settings.

2.4 National responses to overcoming health challenges

Significant investments over many years have been made by Thailand in the health sector and through health reforms.

In the Constitution of 1997, the provision of health care is defined to the effect that *“A person shall enjoy an equal right to receive standard public health services, and the indigent shall have the right to receive free medical treatment from public health facilities of the state, as provided by laws. The public health services by the state shall be provided thoroughly and efficiently and, for this purpose, participation by local government organizations and the private sector shall be promoted insofar as it is possible. The state shall prevent and eradicate harmful contagious diseases for the public without charge, as provided by law.”*⁶

In order to fulfil these aspirations in a feasible and sustainable way, health reform was inevitable. The Decentralization Act of 1999 devolved a number of public health functions to local elected governments. The universal coverage scheme, launched in 2002, is an effort to extend affordable health services to the entire population (see section 2.5 iv). The various reform processes have also led to the creation of several autonomous agencies in addition to strengthening of the MoPH (see section 2.5 v).

The Tenth Thailand Health Development Plan covers the period 2007-2011. The plan builds on the main concepts from previous plans. However, the emphasis has been put on a holistic development of physical, mental, social and spiritual health and social mobilization for health development. The plan is adopting the sufficiency economy philosophy and the principle of “Good health is the product of Good Society”. Two main tenets of this concept are:

- (1) “From sufficiency economy to sufficient health system” which comprises seven principles: moderation, balance, sufficiency, reasonableness, self-immunity, adjusting to a changing world and ethics and morality.

- (2) “Good health is the product of good society or the society of happy environments”. This is the society of equity, generosity, caring, non-oppression, non-exploitation, equal respect for humanity, and ‘non-harm’ of oneself, other people, and the natural environment.

The plan also led to the adoption of the National Health Act in 2007²⁶ which has the mandate to establish the National Health Assembly:

“A process in which the relevant public and State agencies exchange their knowledge and cordially learn from each other through a participatory and systematically organized forum, leading to recommendations on Healthy Public Policies or Public Healthiness.”

The act specifies three categories of health assemblies: the Area-Based Health Assembly (AHA), the Issue-Based Health Assembly (IHA) and the National Health Assembly (NHA). These health assemblies are to provide an open and participatory forum for all stakeholders, state and non-state, to discuss and build consensus on key issues. The health assemblies are considered a social innovation meant to increase public participation to develop healthy public policy and address social determinants of health. The first formal National Health Assembly was organized in 2008. A National Health Constitution was also developed in 2008 and National Health System Statutes produced in 2009.

The National Health Commission (NHC) has a mandate to prepare and hold the NHA at least once annually. It comprises over 1500 people from 178 constituencies including 76 area-based constituencies (one from each province including Bangkok) with the remainder from civil society, government organizations, health professionals, academia and the private sector. During the NHA, key health issues are discussed and resolutions are produced to guide policy-making. Based on the NHA deliberations, results and resolutions, the NHC will submit recommendations to the National Assembly.

According to the Tenth NESDP’s vision, “Thailand will be a Green and Happy Society” in which people have integrity and knowledge of world standard; families are warm; communities are strong; society is peaceful; the economy is efficient, stable, and equitable; the environment is of high quality and natural resources are sustainable; administration follows good governance under the system of democracy with the king as head of state; and the country is a respected member of the world community.” The Eleventh NESDP (2012-2016) will include the principles of the previous plan and give more importance to equity issues. The main principles include a) sufficiency economy; b) human-centred development; and c) balanced development in all dimensions.

To ensure applicability of these principles, the National Economic and Social Development Board (NESDB) produced the Thailand Vision 2027 paper,²⁵ which stipulates the long-term vision of the country, and the Eleventh Plan is under development to help realize such vision.

2.5 Health systems and services

(i) The health system in Thailand

A mix of public and private providers supplies health services in Thailand. The national network of public health facilities has rapidly expanded since 1961 when Thailand launched the first NESDP. There are also a large number of private hospitals and clinics in urban areas; most of them are owned and run during “off hours” by public-sector physicians. The number of hospitals and beds has increased remarkably in the past four decades (Table 3).

In the public sector, the MoPH is responsible for two-thirds of all hospitals and beds across the country. Other public health services are medical school hospitals and general hospitals under other ministries (such as Ministry of Interior, Ministry of Defence). There are health centres and community hospitals (10-120 beds) in subdistricts (*tambon*), district hospitals (120-500 beds), provincial hospitals (501-1000 beds), a few special centre/ hospitals at provincial level, and large referral hospitals in the capital and major cities. Health centres provide primary care by nurses, midwives and sanitarians. Doctors, full-time or part-time now work at some health centres, called Community Medical Units (CMU). At community-level, primary health care is provided by health volunteers or by self-care. The health-care structure is presented in Table 7. It shows the number of public and private health facilities by administrative level and types of facilities. Currently, MoPH owns 900 hospitals, which cover more than 90% of districts, and 9762 health centres, which in turn cover every subdistrict. Local governments play a very limited role in health services today.²⁶ However, under the decentralization act (1999), the MoPH was to transfer most of its health facilities to local government by 2010; however, the action plan to achieve it was never finalized or implemented.

In consonance with the emphasis on PHC, Thailand has prioritized public health programmes for many years. The achievements have been remarkable and have been largely sustained. For example, antenatal care coverage is impressive and nearly all deliveries are assisted by trained health staff. Good water and sanitation facilities are present virtually throughout the country, and Thailand has a comprehensive nutrition programme. There are, however, gaps in coverage of many public health services, particularly among the poorest segments of the population, and not least among migrants and mobile populations. This gap in coverage results in public health risks borne disproportionately by the most vulnerable, but affecting all of society.

Table 6: Public and private health facilities in Thailand, 2007

Type	Bangkok (urban)	Provinces (urban)	District (rural)	Tambon (rural)	Village (rural)
Medical schools					
- Public	6	5			
- Private	1	0			
Specialized hospital	14	40			
Regional hospital	0	25			
General hospital					
- Public	26	70			
- Private	102	242			
Community hospital	5	0	725		
Private clinic	3 603	12 944			
Health Centre	66/77	0	214	9 762	
PHC Centre	0	3108	0	0	66 223
1 st Class drug store	3 615	5 186	(included in province statistic)		
2 nd Class drug store	479	4 031	(included in province statistic)		
Groceries selling medicine					400 000

Source: Thailand Health Profile 2005-2007; Health Resource Statistics 2007

During 1992-1997 the Royal Thai Government promoted private sector involvement in health services through provision of tax incentives for investment in private hospitals. This led to an increase in the number of private hospitals from 218 hospitals in 1986 to 491 hospitals in 1997. During the economic crisis of 1996-1997, private hospitals faced major financial problems, and by 2004 there were only 298 private hospitals left. Some private hospitals started new marketing strategies and targeted foreign markets. The relatively competitive price, high-quality services and excellent hospitality in Thailand have contributed to a huge increase in the number of foreign patients. In 2004, the cabinet approved a strategic plan 2004-2008 for developing Thailand as a medical hub of Asia. The country recently set a target of 2 million medical tourists by the year 2010; however, concerns remain about some potential negative effects of a major medical hub on Thailand's own health system, in terms of attracting health-care personnel into the private sector and thereby exacerbating the health personnel shortage in Thailand's public sector. This issue was recently discussed at the 2009 National Health Assembly²⁷.

(ii) Human resources for health

Despite an increasing number of health-care personnel graduating every year, their appropriate distribution remains a major problem in Thailand. The ratio of staff/population is the lowest in the North-eastern Region, the poorest in Thailand (Table 3). There have been many initiatives to overcome this inequitable distribution of health staff. Since 1968 it has been compulsory for all medical students to work for the government for three years or pay a major compensation. The provision has since been expanded to other health-care professionals (i.e. dentists, pharmacists, nurses, and other paramedical personnel). There are also financial incentives for rural doctors, which increased by up to 20% after launching of the universal coverage scheme. Since 2005, the government also added more than 10 000 places for medical students, who will be recruited from the rural provinces/districts and trained in provincial hospitals.

In addition to medical personnel, Thailand is also facing a shortage of public health specialists in a number of areas as well as those with a general public health background. Deliberate long-term planning is therefore needed to ensure adequate public health training and experience at all levels of the system. Currently, many public health personnel, both at the central and provincial levels, have more medical background than public health background.

(iii) Primary health care and health system strengthening

Thailand has a long history of primary health care (PHC) development, which started before the Declaration of Alma Ata in 1978. The National PHC programme was implemented nationwide as part of the Fourth National Health Development Plan (1977–1981) focusing on the training of “grassroot” PHC workers, village health communicators (VHCs) and village health volunteers (VHVs). Since then PHC has evolved through many innovative health activities: community organization, community self-financing and multisectoral coordination.

PHC has been successful in Thailand because of community involvement in health, collaboration between government and nongovernmental organizations, integration of PHC into the health sector, decentralization of planning and management, intersectoral collaboration at operational levels, resource allocation in favour of PHC, and the management and continuous supervision of the PHC programme at all levels.

The implementation of PHC in Thailand is based upon a service-oriented approach. In addition to the critical role of linking the community with the local health system, VHVs are assigned to provide health services at community level; however, this approach has resulted in less community self-reliance. Therefore, since 2005 a tool for change management called the Strategic Route Map (SRM) was developed and applied to 48 pilot areas around Thailand. This approach aims to empower the community to proactively address their own needs by taking a more developmental,

holistic, multidisciplinary and participatory approach to health. Preliminary data suggest that the SRM will be effective in achieving its aim, will help link strategies of all relevant agencies, and will promote thinking-and-learning society. Scaling up with this instrument has been ongoing since 2008.

(iv) Social protection in the health system

Health-care financing in Thailand has a long history leading to the mandating of universal coverage for health care in 2002. It started with user fees with exemption, and gradually moved to a pre-payment system. Various forms of pre-payment systems have been tested in Thailand to reduce out-of-pocket payments.

Universal coverage for health care was declared a national policy for Thai nationals in 2001 under the slogan “30 Baht to cure every disease”. To make the Universal Coverage Scheme (UCS) sustainable, health-care reform was introduced as well as a new public management concept, which separated the purchaser and provider and introduced demand-side financing (i.e. money follows the patient) versus the traditional approach of allocating funds on a historical basis. The National Health Security Office (NHSO) was established as the purchaser.

Since the Universal Coverage Policy was introduced in 2002, the social health protection is divided in to three categories: a) a Civil Servant Medical Benefit Scheme (CSMBS) covering 7% of the population; b) schemes for private employees, the Worker Compensation Scheme (WCS) and the Social Security Scheme (SSS) covering 15%; and c) a scheme for all other Thai people, the Universal Coverage Scheme (UCS) which covers 76% of the population. As a result the public health protection schemes now cover almost all Thai citizens, and a migrant health insurance scheme is available for purchase among registered non-Thai migrants who have a work permit.²⁸ Unfortunately, the majority of the 2-4 million non-Thai migrants in the country are not covered by health insurance and do not enjoy the same degree of access to health services.

The total health budget for UCS in 2002 was 51 billion baht (1202 baht per capita). In 2009, the government spent 105.9 billion baht (2002 *baht* per capita) from general taxation²⁹. Different payment mechanisms are used for specific types of services. Capitation is used for most prevention services and ambulatory care. Inpatient services are reimbursed using a “case-mixed system”. Other reimbursed expenditures are based on capital replacement cost in contracted hospitals (e.g. hospital facilities, medical instruments, equipment).

The coverage of all health security systems has increased to 99% of the Thai population in 2009. This achievement is due to expansion of both the SSS and the UCS. Health-care utilization has increased for both outpatient and inpatient services. A series of satisfaction surveys conducted by research institutes show that most of the eligible people are satisfied with the services.³⁰ Surveys conducted by the National

Statistic Office together with academic institutions show that the poorest segment of the population have lower out-of-pocket health expenditures and higher utilization of medical services than the richest, suggesting that the universal coverage scheme is having the desired effect of improving protection and equity in health; however, many challenges remain. The UCS attempts to make close-to-client services available, particularly to the poor. This emphasis requires many more nurses and primary care physicians. Primary care physicians, however, make up only 10% of the physician population. There is an urgent need to produce more nurses and primary care physicians to provide quality care at primary care units. Other challenges include cost containment, efficiency, and ensuring sustained high-quality services. An in-depth evaluation of the first decade of Thai Universal Health Coverage and Health Care Reform is underway (2010).

(v) Key players in health

A unique feature of the health sector in Thailand is that there are several other public health agencies with an autonomous or semi-autonomous status operating side by side with the MoPH. The following section describes these various agencies.

- (1) The Ministry of Public Health (MoPH) has the overall responsibility for developing and implementing the national health policy. The Office of Permanent Secretary is the central administrative authority of the MoPH. There are seven technical departments and one administration unit working under this office. These are: i) Department of Medical Services; ii) Department of Development of Thai Traditional and Alternative Medicine; iii) Department of Mental Health; iv) Department of Disease Control; v) Department of Health; vi) Department of Health Service Support; vii) Department of Medical Science and viii) Food and Drug Administration. The MoPH's total budget in 2007 was 129.7 billion baht or 8.3% of the National Budget³¹.
- (2) The Health Systems Research Institute (HSRI) is a semiautonomous state agency under the MoPH established in 1992 by the Health Systems Research Institute Act, 1992. In accordance with the national social and economic contexts, its objectives are to create and stimulate the generation and synthesis of policy relevant health systems knowledge and encompassing evidence, tools, methods and interventions.
- (3) Thai Health Promotion Foundation (ThaiHealth) was established in 2001, and is considered the first organization of its kind in Asia. Created under the Health Promotion Foundation Act 2001, ThaiHealth is an autonomous state agency outside the formal structure of government. It reports to a Board chaired by the Prime Minister. It is funded by 'sin taxes' collected from producers and importers of alcohol and tobacco. The annual budget in 2006 is 2.5 billion baht. ThaiHealth acts as a catalyst and a change agent. The foundation focuses on its

roles as an assistant and facilitator, rather than being an actor. Its objectives are therefore, “to spark, stimulate, support and develop health promotion process that will lead to good health of the Thai people and Thai society”.

- (4) The National Health Security Act, 2002 approved the National Health Security Office (NHSO) as an autonomous body with the following objectives: a) to collaborate with other health care organizations; and b) to drive Thailand’s health-care system towards equitable and accessible quality health care for all. The 2007 UCS budget is about 91 billion baht, or about 70% of the total MoPH budget. The role of NHSO is to purchase health services for people under the UCS. The office is under the supervision of the Public Health Minister. A National Health Security Board (NHSB) appoints the Secretary-General of NHSO.
- (5) The National Health Commission (NHC) is an autonomous government agency chaired by the Prime Minister in accordance with the National Health Act 2007. NHCO serves the NHC as the secretariat. The NHC establishes policies, direction, development, and solutions for the happiness of all members of society throughout the life course.

The primary tasks of NHCO involve promoting healthy public policy. It facilitates participatory dialogue of all constituencies whether private, public, civil society, academic or technical, from the community to central levels. The NHCO organizes the National Health Assembly, promotes the use of health impact assessments, and performs other duties prescribed under the National Health Act or as entrusted by the council of ministers or NHC.

- (6) Under the Ministry of Public Health, the Emergency Medical Institute of Thailand (EMIT) is an institute that was established by the Medical Emergency Act 2008. Missions of the institute include a) developing a medical emergency system to meet the international standard; b) developing networks with participation of all stakeholders; c) developing an efficient medical emergency management system; d) working as a Medical Emergency Coordinating body during disasters. The Secretary General of the EMIT is the Secretary to the National Emergency Medical Service Committee, Chaired by the Minister of Public Health.
- (7) The International Health Policy Programme (IHPP) was established in 2001 and is a semi-autonomous programme conducting research on national health priorities related to health systems and policy in Thailand. The programme is part of the Bureau of Policy and Strategy of MoPH. It aims to improve the national health care systems and policies through the generation and synthesis of knowledge and evidence. An additional aim of the programme is to strengthen the policy research capacity in Thailand in the areas of health-care finance, economic evaluation and health policy analysis and through

the provision of training grants. The Health Intervention and Technology Assessment Program (HITAP), was established in 2007 under IHPP to appraise a wide range of health technologies and programmes, including pharmaceuticals, medical devices, interventions, individual and community health promotion, and disease prevention.

- (8) In addition to these public health agencies, WHO has officially designated some centres as WHO collaborating centres (CCs). The designation of these CCs is based on Article 2 of the WHO Constitution, which states that WHO is to promote and conduct health research for development through collaboration among national and international institutions. A large network of WHO collaborating centres has evolved over the years and is being constantly updated.

As of 2010, there are 34 designated WHO Collaborating Centres in Thailand. There are also about 35 institutions that are considered of centres of excellence although they have not sought designation as a WHO CC. A network of CCs and of centres of excellence was established in 2004, called the Network for WHO Collaborating Centres and Centres of Expertise in Thailand (NEW-CCET). This network and other key networks such as Thai Public Health Institute Network (THAIPHIN) and South-East Asia Public Health Institute network (SEAPHEIN) could become valuable instruments in strengthening public health capacity in the Region and in South South collaboration. Such initiatives would fit well with Thailand's status as an MIC with a robust health system.

Civil society is also a powerful actor in health development and health protection, including in the control of HIV/AIDS, malaria, tuberculosis, emerging infectious diseases, tobacco and alcohol, as well as the health of migrants and mobile populations.

2.6 Contributions of the country to global health

Thailand has made major contributions to global health development. Among the most notable are:

- (1) **Development and implementation of PHC:** Thailand has been a pioneer in the PHC approach, even before the Alma Ata Declaration in 1978. The initiation of the Basic Minimum Needs (BMN) approach in Thailand was shared and introduced in other WHO Member States. Thailand's experience has been shared with other countries through multiple modalities.
- (2) **Field Epidemiology Training Programme:** In 1980, the MoPH, in collaboration with WHO and the U.S. Centres for Disease Control and Prevention (US-CDC), established the first FETP outside of North America. The goals of the programme are to enhance human capacity for disease surveillance, response, investigation, and control in Thailand and

neighbouring countries. It has since then expanded to veterinarians and to an international training programme.

- (3) ***Establishment of the Thai Health Promotion Foundation:*** Since its establishment in 2001, the foundation has served as an example for other countries of innovative ways to finance health promotion and health in all policies. The foundation also works closely with WHO on NCD issues of global importance.
- (4) ***Universal health care coverage:*** Thailand's experience in extending universal health care coverage to its population has been an example to many countries. Thailand has shared its experience through numerous publications, study tours and workshops.
- (5) ***Exercising TRIPs (Agreement on Trade-Related Aspects of Intellectual Property Rights) flexibilities:*** Thailand has exercised the TRIPs flexibilities to help ensure access to life-saving medicines for its population. More specifically, in 2006 the Thai government issued a compulsory license (CL) for lopinavir/ritonavir and efavirenz to the Government Pharmaceutical Organization of Thailand. The CL was a factor contributing to a dramatic increase in ART to HIV/AIDS cases, from less than 20% in 2005 to 88% in 2008. CLs were later issued for selected heart and cancer drugs. An external review of Thailand's approach to exercising TRIPs flexibilities was conducted by WHO in collaboration with other competent organizations in 2008 at the request of the government. The experience has been shared with other countries and the report of the review put in the public domain.
- (6) ***Vaccine development:*** In 2009 Thailand publicized the results of the largest ever HIV vaccine trial ("Prime-Boost" HIV Vaccine Phase III Clinical Trial), which suggested 31% effectiveness in preventing HIV infections over a period of three years. The study was the first to demonstrate some degree of protection with an HIV vaccine.

Thailand is one of the six developing countries that successfully competed to receive a grant from WHO to establish in-country manufacturing capacity for influenza vaccine. The government also invested a significant amount to construct an industrial-scale influenza vaccine production plant.

A roadmap covering a 10-year period was developed in 2009 which focuses on 5 priority vaccines: dengue vaccine, Japanese encephalitis vaccine using cell-based technology, diphtheria-tetanus-pertussis-hepatitis B combination vaccine, Bacillus Calmette-Guérin (BCG) vaccine and influenza vaccine. The plan involves several centres of excellence in Thailand and focuses on cross-cutting issues such as human resource development.

- (7) **Tobacco control:** Thailand has made considerable progress in tobacco control in accordance with the Framework Convention on Tobacco Control. It is a leader in the Region, and shares its valuable experiences with other countries. Two comprehensive tobacco control laws, the Tobacco Consumption Control Act and the Non-smoker Protection Act, were enacted and implemented starting in 1992, 12 years before the WHO FCTC went into force. Thailand was a strong supporter of the FCTC process and is a signatory to it.
- (8) **The National Health Assembly** is a social innovation of Thailand, established under the National Health Act 2007.²⁷ It aims for participatory and constructive dialogue involving all stakeholders towards consensus on critical health issues. (<http://en.nationalhealth.or.th/nha2010>)

2.7 Summary of Section 2

Key health achievements/opportunities and challenges

Achievements/opportunities

- A middle-income country (MIC)
- Robust health infrastructure and system
- High government priority placed on health security, universal health-care coverage, health promotion, and healthy public policy using participatory approaches
- Strengthening local government in response to the decentralization policy
- Strong civil society on health issues
- Excellence and expertise in academic, governmental and nongovernmental institutions
- Development of a new NESDP, UNPAF and CCS for 2012-16.

Challenges

- Diverse institutional health system
- The “dual burden” of important communicable diseases and NCDs
- High TB burden
- Emerging artemisinin-resistant malaria in border areas
- Widespread iodine deficiency
- Low exclusive breastfeeding rate
- Sustaining universal and quality health care
- Road safety
- Food safety
- High rate of adolescent pregnancy
- Unsafe abortion
- Environmental and occupational health, including exposure to industrial carcinogens such as asbestos
- Migrant and border health issues
- Policy coherence across sectors; multisectoral and intrasectoral coordination/collaboration.

3 — Development cooperation and partnerships

3.1 The aid environment in the country

Partnership in health is a key strategy for health development in Thailand. The country receives support to strengthen national capacity in specific areas from a few development partners. Thailand is also becoming a development partner, like other MICs, by assisting developing countries, both within and outside the Region, through its “Forward Engagement” foreign policy. It has established the Thai International Technical Cooperation Agency (TICA) for technical cooperation with other countries. Thailand became a signatory to the Paris Declaration on Aid Effectiveness³² in 2005, aiming to improve the way aid is delivered, used and managed.

3.2 A stakeholder analysis

There are 23 agencies and 2 development bank offices with programmes in Thailand, which comprise the United Nations Country Team (UNCT), namely, Asian Development Bank (ADB), Food and Agriculture Organization (FAO), International Civil Aviation Organization (ICAO), International Finance Cooperation (IFC), International Labour Organization (ILO), International Organization for Migration (IOM), United Nations Convention to Combat Desertification (UNCCD), United Nations. International Strategy for Disaster Reduction (UNISDR), United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Environment Programme (UNEP), United Nations Educational, Social and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), United Nations Human Settlement Programme (UN-HABITAT), United High Commissioner for Refugees (UNHCR), United Nations Children’s Fund (UNICEF), United Nations Industrial Development Organization (UNIDO), United Development Fund for Women (UNIFEM), United Nations Office on Drugs and Crime (UNODC), United Nations Office of the High Commissioner for Human Rights (UNOHCHR), United Nations for Project Services (UNOPS), United Nations Volunteers (UNV), World Health Organization (WHO), World Bank (WB). In addition to UN country offices, the country hosts eight UN regional offices based in Bangkok, which provide services to neighbouring countries.

The key health partners for Thailand include: GFATM, the Bill and Melinda Gates Foundation, Bloomberg Initiative, Rockefeller Foundation, UN agencies, development banks and a few bilateral donors (e.g. Australia, the EU, Japan and the United States). International NGOs provide services for migrants and displaced persons in temporary shelters along the Thai Myanmar border.

The health-related UN agencies that are currently working in Thailand, such as UNFPA, address the integration of reproductive and maternal health as well as strategies for aging within overall health strategies.³³ UNICEF's work in Thailand is to ensure the well-being and rights of all children living in Thailand.³⁴ WHO and UNICEF work closely on issues of breastfeeding, immunization and control of iodine deficiency. UNDP's health-related work addresses the MDGs and decentralization issues.³⁵ ILO, UNEP and WHO are working together on eliminating asbestos-related diseases, while IOM, WHO and other partners are addressing issues of migrant health.

The Inter-Agency Standing Committee (IASC) country team consists of UN and non-UN agencies such as NGOs (national and international), IOM, ICRC, and academia. The IASC assigned WHO to take the lead on Health and Nutrition in Thailand.

Thailand is an active member of ASEAN and there are several priority issues that are addressed by the ASEAN member states related to communicable diseases (including HIV/AIDS), food safety, tobacco control, emergency preparedness and response, and pharmaceutical development. Some new areas under discussion are improving maternal and child health, addressing the health of migrants, promoting healthy lifestyles, and containing artemisinin-tolerant malaria.

In addition to its involvement with ASEAN, Thailand has been active in a number of other regional and subregional cooperation initiatives through the Asia-Pacific Economic Cooperation (APEC) and the Ayeyawaddy-Chao Phraya-Mekong Economic Cooperation (ACMEC). The Greater Mekong Sub-region, which comprises six countries along the Mekong basin (Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam), also builds strong partnerships in social and economic cooperation. Thailand is active in a number of health-specific initiatives such as the Mekong Basin Disease Surveillance Initiative (MBDS), the Mekong Malaria Programme, the South-East Asia Tobacco Control Alliance, and the Global Partnership on Road Safety.

The MoPH and US-CDC have also established the Thailand MoPH-US CDC Collaboration Centre to strengthen national capacity in the prevention and control of emerging infections, HIV and TB.

Thailand has ratified a range of UN conventions and treaties, for instance, on human rights, Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against women (CEDAW), the Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR).

Civil society is a very strong force in Thailand and many civil society organizations (both national and international) are actively engaged in a number of public health issues.

3.3 Thailand as a development partner country

Thailand has established the International Partnership for Development Programme³⁶ which works in five areas: (1) Supporting new initiatives to enhance “South South” cooperation within the Region and beyond, such as the Thailand Africa Partnership for Development; (2) strengthening the effectiveness and coordination of Thailand’s Official Development Assistance, in line with global efforts to increase aid effectiveness and Thailand’s commitment to the Paris Declaration; (3) analysis, documentation and dissemination of Thailand’s development experience, particularly in HIV/AIDS, sustainable agriculture and microfinance; (4) promoting Thai nationals serving abroad as volunteers; and (5) promoting partnerships between the UN system and the Thai private sector. TICA, Ministry of Foreign Affairs has taken the ownership for coordination of aid from Thailand, but many government agencies work bilaterally with other countries.

The aid system of Thailand requires further development in terms of policies, procedures, rules, and guidelines for planning, formulation and implementation, as well as monitoring and evaluation. Policies and procedures need to include core principles of aid effectiveness as set down in the Paris Declaration.

3.4 UN reform status and the UNPAF process

Under the UN reform process, Thailand is committed to “Delivering as One”, and the United Nations Development Assistance Framework (UNDAF), referred to as the United Nations Partnership Framework (UNPAF) in Thailand, has been developed jointly with the government.³⁶ In line with the UN alignment and harmonization agenda, it provides a framework to jointly plan and support national plans and strategies in areas where the UN has expertise and comparative advantages. As a specialized agency, WHO is one of the signatories to this framework, which outlines the following five areas of cooperation: (i) Access to quality social services and protection; (ii) decentralization and provincial/local governance; (iii) access to comprehensive HIV prevention, treatment, care and support; (iv) environment and natural resources management; (v) Global partnership for development. The United Nations estimates that a total of about US\$ 110 million in technical cooperation is needed to deliver the expected outputs under this UNPAF over 5 years.

Under the UNPAF, several thematic working groups (TWG) were established. WHO is actively represented in addressing health-related issues. The TWG on health was led by WHO and co-chaired by the MoPH. WHO is also actively involved in the Joint UN Programme-Mae Hong Son chaired by FAO, which addresses social sector needs including health issues and nutrition among school-aged children in underserved communities.

The Royal Thai Government and the UNCT have developed a new UNPAF for the years 2012–2016 which is closely aligned with the six development strategies of the 11th NESDP and focuses particularly three. These are: (i) managing natural resources and the environment towards sustainability; (ii) promoting a just society; and (iii) strengthening economic and security cooperation in the Region. Based on considerable consultations with the government, three key areas were identified as priority areas where the United Nations can add value to the government plan. These are: (i) climate change; (ii) social reform for equities and empowerment; and (iii) global partnerships. WHO is actively involved in the planning for all three areas.

3.5 Key issues, challenges and opportunities

Thailand, as an emerging development partner, would benefit from stronger engagement with the United Nations (including WHO) to facilitate greater South South cooperation and/or linkage of Thai expertise to address needs outside of Thailand.

As for health development within Thailand, the country no longer needs significant financial support, but it could capitalize more fully on WHO's normative functions including knowledge management, links with international expertise from all levels of WHO, and its international networks. It could also benefit more from direct technical collaboration in carefully prioritized areas of health for maximum impact. Thailand should also capitalize on WHO's convening power and social credit to get relevant actors and sectors within Thailand to work together towards specific health objectives in accordance with national needs and priorities.

The new UNPAF opens up opportunities for policy coherence and intersectoral action in many areas such as those related to social determinants of health, road safety, climate change, environmental health, chemical safety, occupational health, urbanization and health, and social protection of particularly vulnerable populations such as non-Thai migrants and mobile populations.

4 — Review of WHO cooperation over the past CCS cycle

The Royal Thai Government has collaborated with WHO since its inception and has had a WHO country office since 1949. The collaboration has consisted of technical support, capacity-building (through workshops and fellowships), normative guidance, supporting small projects research and pilot activities, and facilitating horizontal collaboration with other countries. Yet, over the past decade, the international public health landscape has changed, with many new partnerships and stakeholders working in international health. There are therefore great opportunities in Thailand to more fully optimize the convening power, social credit, and technical expertise of WHO and its related networks, while recognizing the critical role of other key international health partners.

Similarly, the national health landscape has changed in recent years with health sector reform/decentralization, and the establishment of new public health bodies in addition to the MoPH. Each agency has varying degrees of social, policy, political, technical and financial power to make a difference in Thailand and beyond. There are also an increasing number of opportunities to further leverage the expertise and experience of Thailand within the Region and beyond due to the expanded engagement in global and regional health.

Through documentation review and consultations with stakeholders, cooperation between WHO and Thailand over the past CCS cycle was assessed. Meetings and discussions with a number of stakeholders were held. These included meetings with senior officials from MoPH, ThaiHealth, NHSO, NHCO, Faculty of Public Health, Mahidol University, and UN consultants involved in the development of the next UNPAF 2012-16. From these meetings, a consensus emerged that the WHO country office must drastically reform the way it works in Thailand by changing the overall modalities for programme planning in order to increase the impact and effectiveness of WHO collaboration in Thailand. This will require adapting staff composition as well as competences of the office staff.

4.1 The consistency between the CCS priorities over the cycle

The current CCS addresses seven broad strategic areas: 1) communicable disease; 2) noncommunicable diseases, injuries and mental illnesses; 3) health promotion and

healthy public policy; 4) monitoring and evaluation of health systems development; 5) health services to the poor and at-risk populations; 6) environmental health; and 7) human resource development.

The CCS priorities are consistent with the priorities of the Tenth National Health Strategy/Plan (2007-2011) and the country office structure and workplans of 2008-2009 and 2010-2011 bienniums. The CCS priorities cover most of the Strategic Objectives (SOs) of the MTSP. Table 6 shows the linkage between the seven priorities in the CCS and the MTSP.

Table 7: Linkages between CCS strategic priorities and SOs

2008-2009 CCS priorities	Strategic Objectives (SOs)
Communicable diseases	SO 1, SO 2
Noncommunicable diseases, injuries and mental health	SO 3, SO 6
Environmental health and food safety	SO 8, 9
Health for vulnerable and cross-border population	SO 5
Health promotion	SO 6
Health systems	SO 10
Human resource for health	SO 10

The 2010–2011 workplan covers a vast range of products and activities spanning all WHO SOs. There are more than 200 major results planned for the biennium, thinly spread across all 13 SOs– of which 11 have at least ten major results planned. The budget for activities is approximately US\$ 6.1 million. This situation reflects the disconnection between the CCS and the actual activities funded through the WHO country programme.

4.2 Resources for WHO collaborative programmes

WHO Country Office in Thailand is relatively small in terms of the number of professional staff. Currently there are only 3 international professional staff, 7 national professional officers and 15 national support staff in the office.

During the 2008-2009 biennium US\$ 5.774 million was allocated from assessed contributions (AC), whereas for the 2010-2011 biennium the AC was reduced to US\$ 5.63 million while unit costs for staff increased. In addition to AC, the Country Office received about US\$ 4.7 million through voluntary contributions (VC). The budget allocations by SO are shown in Table 8.

Table 8: Budget allocation by SO in 2010-11

Strategic Objectives	Budget for staff (US\$ in thousands)		Budget for activities (US\$ in thousands)	
	Assessed Contributions (AC)	Voluntary Contributions (VC)*	Assessed Contributions	Voluntary Contributions*
1. Communicable Diseases	182	82	366	508
2. HIV/AIDS, tuberculosis and malaria	268	425	110	619
3. Noncommunicable Diseases, violence and injuries, and mental health	174	0	155	0
4. Maternal, Neonatal and child health, and reproductive health	0	0	0	270
5. Emergencies Disasters	0	1 172	220	397
6. Risk factors (health promotion)	0	628	149	771
7. Social and economic determinants	0	0	0	130
8. Environmental and occupational health	0	0	170	0
9. Nutrition, food safety and food security	0	0	0	144
10. Health systems	772	350	556	592
11. Medical products and technologies	0	82	100	220
12. Leadership, governance and partnership	822	460	75	10
13. WRO Management	1 024	0	487	143
Total	3 242	3 199	2 388	3 803

* Not all VC funds shown in this table are secured
Source: Thailand-WHO Collaboration 2010-11, 2010.

The MoPH has provided free office space for the WCO. It is connected with the WHO Global Private Network, enabling fast connections with the SEA Regional Office in New Delhi and WHO Headquarters in Geneva. It is equipped with tele- and videoconference facilities. Since the beginning of 2010, the Country Office has switched from Activity Management System to Global Management System as the main administrative platform.

4.3 Implementation of each strategic priority, identifying key achievements

(i) Enhancing primary prevention, surveillance and control of communicable diseases and epidemics

Many activities undertaken in 2008-2009 contributed to the preparedness and response to the H1N1 pandemic in compliance with the IHR (2005), including seven joint reviews of the pandemic response in Thailand. A publication was prepared on lesson learned in responding to the pandemic.

WHO provided support to HIV/IDS, tuberculosis and malaria control programmes in normative areas as well as direct technical support. Included were development of operational guidelines, establishment of mechanisms to increase access to anti-tuberculosis drugs and diagnostics, and capacity building in areas of surveillance and epidemiology. WHO was also involved in assessing and strengthening pesticide management in Thailand.

WHO supported the external review of the Food Safety System in Thailand (from “farm to fork”) in collaboration with FAO and strengthening of INFOSAN within Thailand.

(ii) Integrating measures to reduce risks of noncommunicable diseases, injuries and mental illness

WHO supported NCD control and advocacy for policy makers and other key activities such as the development of the National Master Plan for prevention and control of NCDs, strengthening of the NCD control network and improvement of NCD risk factor surveillance.

Drowning is a major cause of deaths in young children. WHO supported the development of a model for child drowning prevention at the provincial level.

(iii) Building capacity and partnerships for health promotion and healthy public policy.

Most activities implemented addressed tobacco control and alcohol harm reduction, as well as support to strengthen multisectoral approaches to address risk factors of NCDs under the National Health Promotion programme. WHO has been actively involved in the National Health Assembly and collaborated in preparing a publication on the NHA approach to healthy public policy dialogue and intersectoral action.

(iv) Strengthening capacity for monitoring and evaluation of health system development

WHO supported the review of the health research system performance and the development of the Provincial Health Account system.

(v) Multisectoral approach to address health services for the poor and at-risk populations, including those in border and conflict areas

WHO has been providing technical support by working with MoPH and other sectors on addressing the health needs of non-Thai migrants in Thailand. WHO also supported the pilot development of a health information system on migrants and the establishment of a prioritized research agenda on migrant health.

WHO served as an advisor to the MoPH team on strengthening health service delivery, particularly for maternal and child health in the three southern provinces. Three site visits and meetings with the team and local staff were made and the findings shared with other concerned agencies (UNFPA and UNICEF) to facilitate joint planning with the MoPH to address the health needs in the southern provinces.

(vi) Promoting environmental health and surveillance of environmental hazards

WHO provided support to environmental surveillance, strengthening the use of health impact assessments (HIA), and implementation of a National Environmental Health Action Plan (NEHAP). WHO also supported an important study on the health of the population in the industrial estate, Mab Ta Phut. It also facilitated the establishment of the first regional chemical safety help desk.

(vii) Strengthening human resources for health through existing networks within and outside the country

WHO has been involved in strengthening human resources for health in Thailand through a number of mechanisms. For example, WHO has provided long-term fellowships in close consultation with the MoPH/IHPP to support high level study (doctoral and master's degrees) in various fields deemed essential to support evidence-based national health policy and health system development as well as specific public health programmes. For example, in the 2010-2011 biennium alone, WHO supported high level study in the following areas: medical anthropology; social determinants of health; international public health; health economics; epidemiology; and intellectual property and public health. WHO supported short-term fellowships as well to facilitate participation in international workshops or meetings on key public health issues. WHO also supported capacity-building workshops within the country and recruited international expertise to review or collaborate technically on specific issues in

Thailand (e.g. food safety, national regulatory functions, vaccine development, pesticide management, water-sanitation issues, HIV, TB, and malaria prevention and control, as well as IHR functions). WHO has also supported some domestic and regional networks such as NEW-CCET, THAIPHEIN, SEAPHEIN, and SEARAME to strengthen institutions and staff and to enhance horizontal collaboration to meet public health challenges at national and regional levels.”

(viii) Support of WHO Country Office in Thailand to the South-East Asia Region during 2008-2009

WHO Country office has provided support to the activities carried out by the Regional Office and various supporting networks. The support included:

- Assisting in arranging 150 international meetings/workshops;
- arranging 415 fellowships in Thailand from countries in the Asia-Pacific; and
- supporting networks such as NEW-CCET, SEAPHEIN, and SEARAME.

(ix) Strengthening the IDD Elimination Programme

The UN Country team (particularly UNICEF and WHO) have advocated at a high level and collaborated technically with the MoPH and other partners to address iodine deficiency in the country. This problem may explain (at least in part) the results of recent studies on low average IQ in the country and particularly in the most affected regions. The MoPH jointly organized with the UN Country Team a multisectoral, multistakeholder Development Cooperation Seminar (DCS) entitled “Iodine Deficiency Disorders: A Development Challenge for Thailand” to enable needed policy dialogue and understanding of the issues and to further galvanize needed action.

4.4 Facilitating factors, constraints and lessons learned

Major facilitating factors:

- Good collaboration with stakeholders at country level, particularly during the CCS and workplan development;
- close contacts with government counterparts throughout planning and implementation of activities;
- common understanding of limitations for implementation and the funding mechanisms of VC-funded programmes across all levels of WHO;
- excellent working relationship with the health-sector government agencies, UN and non-UN agencies as well as other ministries, particularly during emergency situations; and
- increased technical and financial support to the MoPH through targeted programmes such as H1N1 pandemic preparedness and response.

Constraints:

- The current CCS strategic agenda does not appear to have influenced the workplans of the 2008-2009 or 2010-2011 bienniums. Substantial budgets were allocated to all SOs, though many of them were not in the strategic agenda;
- considerable fragmentation and lack of a clear process for strategic planning and prioritization of government-WHO collaboration according to the priorities in the country and comparative advantages of each collaborating agency;
- difficulties in getting real-time verification of funding availability through AMS;
- insufficient analysis or use of available evidence and knowledge management by the WCO in its collaboration with the government;
- language barriers and technical writing skills are sometimes an impediment to effectively communicating and publishing important experiences and achievements in Thailand.

Lessons Learned:

- The workplan of WHO in Thailand should be more directly linked to the priorities described in the CCS.
- High-level engagement of the government is necessary to prioritize the government-WHO collaboration.
- A manageable approach of joint planning, monitoring and evaluation is needed between WHO and the health sector government agencies.
- The considerable fragmentation within the public health sector of Thailand creates difficulties in coherently articulating overall strategic health priorities and plans of the government with partners.
- WHO's work in Thailand needs to be prioritized into fewer areas. It should move away from a donor-recipient relationship scattered across many small projects with little tangible outcome. In line with Thailand's status as a middle-income country, WHO should instead pursue a more knowledge-based partnership with the government in a few selected areas of work and use its technical assets, neutrality and convening power to enhance capacity, synergies and collaboration of many health stakeholders.
- WHO in Thailand needs to utilize more effectively the entire organization and its specialized networks to link international expertise with Thailand when and where it is needed and to provide better and more timely knowledge management of the latest recommendations and best practices.
- Many health challenges in Thailand require intersectoral action, but establishing effective intersectoral mechanisms and policy coherence across sectors is

difficult. WHO and the United Nations as a whole could help more, using convening power, to bring various sectors together and provide a neutral space for needed dialogue. This is proving to be a service much in demand by the government, of the UN system in the form of “Development Cooperation Seminars”.

- The experience and lessons learned in Thailand should be shared more fully with other countries. WHO should promote and assist Thailand in publishing its experiences and achievements.
- WHO should more selectively and strategically engage with UN working groups, joint programmes and joint teams.

5 — The strategic agenda for WHO cooperation

5.1 The prioritization process to define the strategic agenda

An elaborate process has been implemented over 2010 with all key government public health agencies (17 organizations) to identify and define the priorities for collaboration between WHO and the government as the basis for the future CCS. Using agreed-upon criteria and a deliberative process, 21 proposed areas of collaboration were prioritized to five. The criteria applied for the selection were: 1) Each priority area should be of common interest to all stakeholders; 2) should have a good potential for success; 3) should be challenging and include intersectoral issues; 4) should fill gaps in knowledge and interventions; and 5) should be areas that provide benefit to others both regionally and globally. Also implicit in this priority setting process is the public health importance in Thailand of the areas selected and alignment of these with the National Health Development Plan.

The selected priorities are:

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

Concept papers relating to these priority areas were reviewed and endorsed during a high-level meeting in August 2010, as were modalities of future collaboration. The 1st Steering Committee meeting was held on 2 December 2010.

It is important to emphasize that each priority area will be addressed through a coordinated programme of work that will seek to harness the potential strengths of various agencies and stakeholders in Thailand.

In addition to these five priority areas, WHO will continue with its normative functions as directed by its governing bodies. There are other important public health challenges in Thailand that do not fall within the priority areas, but which will

continue to be part of WHO's collaboration with Thailand. The work in these areas will be planned in a biennium-to-biennium mode through negotiation between WHO, national authorities and relevant stakeholders. In summary, the major change in WHO's approach in the next CCS will be to strategically focus WHO's collaboration with the government on a limited number of public health challenges (primarily the five areas listed above).

5.2 The strategic agenda

The strategic agenda of WHO comprises four different clusters of activities: 1) Five priority areas (detailed below); 2) normative functions; 3) major public health challenges and unfinished agendas; and 4) support to Thailand's role in health beyond its borders.

The five priority areas will receive a minimum of 50% of the financial (AC) and human resources available from WHO.

(1) The five priority areas are:

i. Community health system	
Objective:	Empower and strengthen the subdistrict health system so that the community health system will be more effective and responsive to the health needs of the population.
Main focus area:	Building up and strengthening the community health system
Approach:	<ol style="list-style-type: none"> 1. Develop and advocate for national policies on strengthening community health systems; 2. Support the decentralization policy; 3. Strengthen primary care; 4. Support social movements to gain support and public recognition for community health systems; and 5. Support development of new tools and social innovations.
Lead agencies:	NHSO, HSRI
ii. Multisectoral networking for NCD control (NCD network)	
Objectives:	<ol style="list-style-type: none"> 1. Promote collaboration, partnership and integration among various sectors to tackle NCDs, including health-related and non-health-related sectors in Thailand. 2. Strengthen national policies, plans and interventions for prevention and control of five main NCDs: cardiovascular diseases, diabetes, cancers, chronic respiratory diseases and hypertension.
Main focus area:	Building up networks for implementing integrated NCD control

Approach:	<ol style="list-style-type: none"> 1. Promote collaboration and partnership among agencies; 2. Networking integration and cooperation through established mechanisms to strengthen policy, social communication and capacity building; and 3. Establish the linkage and collaboration with regional and global levels of NCD networks.
Lead agency:	ThaiHealth
iii. Disaster preparedness and response	
Objective:	<ol style="list-style-type: none"> 1. Establish coordination and collaboration mechanisms in the Disaster Health Emergency Management System among various national and international agencies; 2. Further support the development of the Disaster Health Emergency Management System to be effectively and efficiently integrated and linked with relevant agencies at all levels in institutional, legislative frameworks, policies, SOPs, contingency plans and capacity building; 3. Engage various sectors systematically to establish mechanisms for disaster prevention, preparedness, response, recovery and rehabilitation.
Main focus area:	Strengthening national capacity and coordination in disaster management, particularly in the health area.
Approach:	<ol style="list-style-type: none"> 1. Establish a well-functioning agency network for maximum coordination, cooperation, and collaboration in disaster health emergency management; 2. Strengthen human resource capacity and resource planning; 3. Establish a management structure and disaster response plan.
Lead agencies:	EMIT, WHO
iv. International trade and health	
Objectives:	Build individual and institutional capacities and generate evidence to support coherent policy decisions on international trade and health for positive health outcomes of the population.
Main focus area:	Building national capacity in trade and health negotiation
Approach:	<ol style="list-style-type: none"> 1. Knowledge generation, management and sharing; 2. Capacity building; 3. Network strengthening.
Lead agencies:	IHPP
v. Road safety	
Objectives:	<ol style="list-style-type: none"> 1. Establish international coordination and knowledge sharing on strengthening of Thailand's road safety network, particularly in relation to motorcycle safety; 2. Substantially reduce the rate of motorcycle-related injuries and death.

Main focus area:	Improve national road safety programme effectiveness through multisectoral and international collaboration.
Approach:	<ol style="list-style-type: none"> 1. Identify a lead agency in government to guide the national road traffic safety effort and a mechanism for intersectoral action; 2. Undertake an assessment of the problem in terms of its magnitude, policy, and institutional settings; 3. Strengthen the national master plan on road safety on aspects of behavioural and legislative strategies and actions and; allocate the needed human and financial resources; 4. Implement specific actions to prevent road traffic crashes, minimize injuries and their consequences, and evaluate the impact of these actions as they relate to motorcyclists; 5. Maintain high-quality, real-time information on road traffic accidents in order to accurately monitor levels and trends; and 6. Support the development of national capacity and international cooperation.
Lead agency:	ThaiHealth

The detailed plans for each of these programmes can be accessed on the WHO Thailand website.³⁷

(2) The normative functions

WHO will continue to provide the normative functions as a core area of support. Norms, standards and guidelines will be shared in a timely way with key stakeholders. Expertise will be provided to support application of standards and guidelines. Their use will be promoted and the implementation monitored. Programme reviews (involving international experts) of specific areas of work will be supported. Programme areas related to vaccine development, emerging infectious diseases (EID) and application of the IHR, laboratory capacity, and food safety will remain a high priority.

Knowledge management is a related area that will be strengthened in the country office with support from SEARO. The purpose is to provide timely, reliable and comprehensive information and knowledge services to health institutions and individuals in Thailand and WHO staff members in order to strengthen the national health systems. This will be achieved through:

- Strengthening the Health Literature, Library and Information Services (HELLIS) Network and other partners with a view to build sustainable national capacity in providing information services to the health sector;
- supporting the transfer of knowledge and technology in identification and management of national information and knowledge assets;

- promoting information and knowledge-sharing practices among HELLIS Network members and other partners through the established HELLIS infrastructure; and
- creating an environment for the sharing and effective use of knowledge.

(3) Major public health challenges and the unfinished agenda

There are a number of public health challenges that need to be addressed more vigorously in order to achieve a better impact on the health status of the population of Thailand. Some of these are considered “unfinished agendas” where Thailand is lagging behind other countries and where opportunities for major gains are evident. WHO will focus its technical support on these challenges, which include but are not limited to:

- TB control
- HIV prevention and care (including harm reduction)
- Malaria control (including containment of artemisinin-resistant malaria)
- Reducing teenage pregnancy
- Preventing unsafe abortion
- Ensuring adequate iodine intake in the population through universal salt iodization
- Ensuring equitable access to health services among migrants and mobile populations
- Environmental and occupational health

Malaria is a special challenge in Thailand, where border areas are cradles for drug resistance. The uneven access to health services among non-Thai migrants and mobile populations is considered an important factor in emerging drug resistance for HIV, TB and malaria.

(4) Thailand’s role in health beyond the borders

Thailand, as an MIC, is increasingly seeking to become an active player in global health and to contribute expertise and knowledge from its experience in health systems development to other countries and international agencies. It is developing significant capacity on health issues of international importance. It is active in the governing bodies of WHO and in global health partnerships. WHO will continue to support and enhance Thailand’s involvement in international health activities.

WHO will assist Thailand in fulfilling its aspirations as a bilateral and multilateral partner in health with active participation in technical panels and as technical experts to

other countries. Such assistance will draw on the expertise in the WHO Collaborating Centres and centres of excellence in Thailand. The capacity of these centres will be enhanced through training, information and network-building.

Thailand, as an emerging partner in health development beyond its borders, can benefit from facilitation by WHO to foster more South South collaboration and “triangular: approaches to development assistance. Thailand will also support specific programmes in WHO. For example, a memorandum of understanding was recently signed by ThaiHealth and WHO to support the global NCD strategy.

Partnerships with MICs are under review within the UN family in general and in WHO in particular. Experience from Thailand may be used as a potential model for WHO’s work with other countries, and WHO will seek to enhance collaboration among MIC countries.

Thailand could become a more prominent global partner by greater documentation and publishing of its achievements and experiences internationally. This will require capacity building, technical support, encouragement, and facilitation to produce such outputs in the international public domain.

Multicountry activities (MCAs) are programmes where two or more WHO Country Offices in the Region collaborate. Past examples of Thailand’s involvement in MCAs include a multi-country workshop on injury surveillance and prevention, developing a nursing curriculum in DPR Korea and Timor-Leste; building influenza diagnostic capacity in Myanmar; sharing knowledge and experience of case management of severe H1N1 with Maldives, Nepal and Sri Lanka; and training in case management of dengue hemorrhagic fever and shock syndrome in several countries. Thailand will continue to play a key role in MCAs with countries in the Region as needed.

WHO Thailand, in partnership with the government, houses a number of programmes that serve multiple countries both inside and outside the Region. The country office provides operational and administrative support to these programmes, and the WHO Representative for Thailand supervises some of the staff.

- The WHO Mekong Malaria Programme has facilitated the coordination of malaria control activities among the Greater Mekong Subregion countries to enhance malaria control and contain the emergence of drug-resistant malaria.
- Vaccine Supply and Quality unit in SEAR. The work includes National Regulatory Authority capacity-building for vaccines, support to strengthen vaccine management and vaccine safety including monitoring of AEFI, and hospital sharps waste management.
- Stockpile management and operations: A regional stockpile of essential drugs, commodities, and emergency kits has been established since early 2007 to

assist Member States to prepare and respond to public health emergencies in line with the IHR (2005).

- A biregional water and sanitation programme provides technical support to several countries in both SEAR and WPR.

5.3 WHO's contributions to UNPAF

A new United Nations Partnership Framework (UNPAF) for 2012-2016 has been developed. In preparation for its development, a two-phased study was conducted during 2009-2010 on the role of the United Nations in Thailand as a middle-income country. Extensive and intensive consultation, planning and prioritization with national authorities, civil society, technical bodies, and stakeholders led to finalization of the new UNPAF 2012-16. It describes a partnership that is closely aligned with the new National Economic and Social Development Plan (NESDP) 2012-2016 and intends to exert the UN's comparative advantages in Thailand as a middle-income country. The UNPAF 2012-2016 will include three joint teams on issues of: 1. Climate change; 2. enhancing the role and capacity of Thailand as a global partner; and 3. social reform for equity and empowerment.

The planning of the new CCS has been timed and implemented in such a way as to maximize the "convergence" of the Thailand-WHO collaboration and the new UNPAF, while fulfilling WHO's obligations as per its own governing bodies. WHO will engage in all three joint teams. The CCS priority area of disaster preparedness and response is a key adaptation measure for climate change. The CCS strategic agenda to facilitate Thailand's work beyond its borders aligns closely with enhancing the role and capacity of Thailand as a global partner. The CCS priority area on strengthening community health systems may find some common ground in the future with the work on social reform for equity and empowerment.

5.4 The modalities of implementation

Modalities for planning, implementing and governing the five priority programmes were agreed upon at the high-level meeting by the main public health agencies of the Royal Thai Government. The governing structure applies the principles of financial and programmatic accountability; inclusiveness, involvement, ownership and participation by all stakeholders. The modalities also seek as much as possible simplified programme management and oversight which would include:

- **A Steering Committee** for oversight and to monitor achievement and progress in all five programmes
- **Subcommittees for** closer oversight in each of the five areas
- **Internal and external peer review of plans**

- **Annual programme/financial audits**
- **A mid-term and final review**

The Country Steering Committee (CSC) is the overall oversight body for the five programmes. It will be chaired by the Permanent Secretary, MoPH and co-chaired by the WHO Representative to Thailand. Details of the governance structure are included in Annex 4. The CSC will approve of a subcommittee for each of the five priority programmes. WHO will be represented in each committee and participate in funding specified deliverables within the context of the overall plans and proposals.

For the remaining areas of work, WHO will continue the working modalities that are established in collaboration with MoPH. The WHO country office will continue to draw on expertise and material from SEARO and WHO headquarters as well as its associated networks of expertise, and will execute WHO normative functions when needed.

Some funding from assessed contributions or extrabudgetary funding (if mobilized) will be available to address the public health challenges and unfinished agendas. This work will be planned, implemented and monitored on a biennial basis in accordance with WHO programme management procedures.

5.5 Validation of the CCS strategic agenda with NHP priorities

The National Economic and Social Development Plan for 2012–2016 is under development and the National Health Plan (NHP) will be prepared as a part of this plan. The process that has been adopted to identify the priority programmes is similar to that applied to develop the NHP. The processes have been running in parallel, engaging the same stakeholders, so presumably reflect similar priorities. WHO is facilitating the work and will be an important strategic and technical partner but will not play an active role in implementation.

The public health challenges listed in section 5.2 are fully recognized by the key government public health bodies, including the MoPH. As WHO is not a funding agency, its main contribution will be to exert its technical power, its “social credit” and its neutral convening power. It will, however, use its modest financial support in a catalytic way and to leverage bigger funds (when needed) from donors to fully support selected areas of work.

5.6 Validation of the CCS strategic agenda with UNPAF

The action plan for the new UNPAF 2012-2016 is currently under development, so validation of the new CCS with the new UNPAF is not yet possible.

5.7 Validation of the CCS strategic agenda with the MTSP

The five priority programmes fall under the strategic objectives of WHO's MTSP in the following way:

- Community health and primary health care (SO 1, SO 4 and SO 10)
- NCD network (SO 3, SO 6 and SO 10)
- Disaster preparedness and response (SO 1, SO 5 and SO 8)
- International trade and health (SO 2, SO 3, SO 10 and SO 11)
- Road safety (SO 3, SO 6 and SO 10)

The public health challenges listed in section 5.2.3 are all included in the MSTP. They encompass SO 2 (malaria, TB and HIV control, as well as harm reduction), SO 4 (adolescent pregnancy, unsafe abortion and breastfeeding), SO 8 (environmental and occupational health), SO 9 (adequate iodine intake through universal salt iodization) and SO 10 (universal coverage including for migrants).

6 — Implementing the strategic agenda

6.1 The role of WHO

The proposed shift in the strategic agenda has implications for the staff functions in the WHO country office and the support needed from other levels of the organization. To ensure maximum support to the priority areas, the secretariat function and the implementation of the priority programmes will be supported by a minimum of 50% of technical staff time available in WCO.

The structure, composition and competencies of the WCO will be subject to a review that will aim to reorganize the office so that it will be better optimized and equipped to undertake new responsibilities as a consequence of the new CCS.

The normative functions will be strengthened and efforts will be made to mobilize additional funding for a full-time senior professional staff member with a broad knowledge of public health to coordinate this area and assist in promoting Thailand's role beyond its borders. The staff will also provide technical assistance to help document and publicize Thailand's achievements and experience in health development.

The strategic priorities in this CCS cover a range of technical expertise available at SEARO and WHO Headquarters. A close working relationship between the country office and relevant technical units at the Regional Office and Headquarters will add value to the work of WHO in Thailand.

6.2 Using the CCS

The Country Office will:

- Widely disseminate the CCS document to the government and other partners working in and with the country;
- use CCS priorities to revise existing workplans and guide future ones;
- map the CCS priorities to the MTSP SOs as a basis for the next WHO operational plans;
- use, with the requested support and backstopping, the content of the CCS to

define and shape the health component of the UNPAF and other partnership platforms, keeping in mind partner contributions and

- use the CCS for advocacy and resource mobilization for health.

The Regional Office and Headquarters will:

- Widely disseminate the CCS document and the brief to all WHO departments and divisions, and to other relevant partners and stakeholders, including through the use of innovative approaches such as “country days”, the “official launch” of the CCS, lunch-time seminars and the use of intranet and Internet sites;
- ensure that technical interactions with the Country Office and government are consistent and based on the CCS priorities;
- ensure that CCS priorities are used as the basis for the preparation of strategic and operational plans, including budgets and resource allocation; and
- use the CCS for advocacy and resource mobilization for WHO’s work in countries.

6.3 Monitoring and evaluation of the CCS

WHO will monitor programme implementation using established procedures. Efforts will be made to align the monitoring of the priority programmes with the agreed upon processes for their oversight, monitoring and accountability.

These procedures will include a mid-term review and an end-of programme review. The mid-term review may consider curtailing or phasing out some programmes and identifying and initiating activities in new priority areas, in which case, WHO will adjust its activities accordingly.

WHO will undertake a mid-term review of the entire CCS, separate from the above exercise, in order to ensure that workplans and activities are in line with the strategic directions.

Annex - 1: WHO core functions Core functions of WHO applied at country level

The Eleventh General Programme of Work (GPW) defines six core functions based on WHO's mandate and an analysis of its areas of comparative advantage. Their application in each country is determined by the Country Cooperation Strategy. The six core functions are:

- ***Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.*** At country level, WHO acts as a broker on high-level policy issues and leads or harmonizes the efforts of all development partners, helping to align their work with national priorities.
- ***Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.*** WHO builds Member States' capacity in generating and disseminating knowledge, as well as in applying the knowledge gained from appropriate health research that will bring improvements in health.
- ***Setting norms and standards, and promoting and monitoring their implementation.*** WHO supports Member States in the application of global/ regional norms and standards to different contexts and settings, and also brings country realities and perspectives into the setting of norms and standards.
- ***Articulating ethical and evidence-based policy options.*** WHO provides Member States with reviews of policy options to consider in different settings. WHO gathers global evidence and facilitates its adaptation for country work, and suggests to government and civil society what is feasible in different socio-economic contexts.
- ***Providing technical support, catalysing change and building sustainable institutional capacity.*** WHO provides high-quality strategically sustainable policy advice and technical support in response to national needs; catalyses change with clear direction; and supports building of institutional capacity, focusing on strengthening key institutions for implementing health policy.
- ***Monitoring the health situation and assessing health needs.*** WHO helps ministries of health link with other national statistical institutions for collection, analysis and dissemination of health information; supports monitoring of the health situation; and helps build national capacity for surveillance and response and mapping of public health risks.

Annex - 2: Strategic Objectives (SO) under the MTSP 2008-2013

SO 1	To reduce the health, social and economic burden of communicable diseases
SO 2	To combat HIV/AIDS, tuberculosis and malaria
SO 3	Prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment
SO 4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals
SO 5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact
SO 6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex
SO 7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches
SO 8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
SO 9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development
SO 10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research
SO 11	To ensure improved access, quality and use of medical products and technologies

SO 12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work
SO 13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively

Annex - 3: National Health Development Data

Indicator	Unit	Source
Finance		
General government expenditure on health as % of total expenditure on health (2007)	73.2	World Health Statistics 2010
General government expenditure on health as % of total general government expenditure (2007)	13.1	
Per capita total expenditure on health at average exchange rate (US\$, 2007)	136	
Per capita total expenditure on health in international dollars (2007)	286	
Per capita GDP at average exchange rate (US\$ 2008)	4,043	WDI 2009
Per capita GDP in international dollars	8 239	IMF 2009
Per capita government expenditure on health at average exchange rate (US\$ 2007)	100	World Health Statistics 2010
Per capita government expenditure on health in international dollars (2007)	209	
Prepaid plans as % of private expenditure on health (2007)	19.5	
Private expenditure on health as % of total expenditure on health (2007)	26.8	
Out-of-pocket expenditure as % of private expenditure on health (2007)	71.7	
Social security on health as % of general government expenditure on health (2007)	9.7	
Total expenditure on health as % of GDP (2007)	3.7	

Human resources		
Health workers (rate per 1000 population)		
• physicians	22 435 (0.37)	WHR 2006
• nurses	171 605(2.82)	
• midwives	872 (0.01)	
• public & environmental health	2 151 (0.04)	
Service delivery		
In-patient beds per 1000 population	1.99	The Report of Health Resource 2006
Physicians: hospital beds	1:6	

Annex - 4: Government-WHO collaboration: proposed governance for the five priority areas for direct technical collaboration

The High-Level Meeting on 19 August 2010 agreed on the new modality for the Thailand-WHO collaboration during the period 2011-2015, which aims to be streamlined, efficient, and flexible but also ensure quality, inclusiveness and accountability. The following describes in more detail the governance structure to promote a multisectoral approach and support the agreed upon modality of collaboration.

1. Formation of “Steering Committee”

1.1 Terms of Reference

- 1.1.1 Provide general oversight and guidance, both financially and programmatically
- 1.1.2 Monitor overall achievements and progress in each of the five priority areas of work
- 1.1.3 Approve the plan/budget in each of the five priority areas of work
- 1.1.4 Decide on new priority areas of work when the objectives of existing ones are achieved
- 1.1.5 Convene the mid-term review and use such results for re-programming where necessary and advance the agenda
- 1.1.6 Appoint a subcommittee for each of the five priority areas, based on nominations by the lead agency coordinators
- 1.1.7 Other responsibilities as assigned by the MoPH

1.2 Composition

- 1.2.1 CEOs (NHCO, NHSO, ThaiHealth, HSRI, EMIT, HAI)
Permanent Secretary of the Ministry of Public Health (MoPH)
Deputy PS of the MoPH
MoPH/Senior Advisor on Disease Control
MoPH/Senior Advisor on Health Economics
MoPH/DGs of DDC, DOH, HSS, FDA

Chairpersons of the five subcommittees
Representatives from other sectors (MoI, MoE, MoC)
WHO representative to Thailand

1.2.2 Chair: Permanent Secretary; Co-chair: WHO Representative

1.3 Secretariat: *Programme leader, HITAP*

1.4 Meetings: *semi-annual starting in Dec 2010*

2. Subcommittees for the five priority areas

2.1 Terms of Reference

- 2.1.1 Provide oversight and guidance on plan operation and implementation
- 2.1.2 Monitor the achievements and progress in each plan
- 2.1.3 Provide guidance to improve the performance and facilitate the achievements in each plan
- 2.1.4 Other responsibilities as assigned by the Steering Committee

2.2 Composition

- 2.2.1 Members: to be assigned by the Steering Committee for each of the five priority areas. They may include high-level focal point(s) of the relevant department(s) of the MoPH, high-level focal point(s) of the relevant autonomous agency, WHO focal point, high-level focal point(s) of other key government sector(s) competent in specific areas of concern, professional(s) from relevant centre(s) of excellence and relevant civil society representative(s).
- 2.2.2 Chairpersons:
 - International trade and health: Dr Siriwat Tiptaradol
 - Road safety: Dr Udomsilp Srisaengnam
 - NCD network: Dr Prakit Vateesatokit
 - Community health systems: Dr.Mongkol Na Songkla
 - Disaster preparedness: Dr Pichit Rattakul
- 2.2.3 Co-chair: Government organization (either MOPH or other government sector to promote intersectoral action)

2.3 Secretariat: Lead focal point agency

2.4 Meetings: Quarterly basis or more frequent as deemed necessary by the subcommittee

3. Structure of plan

Each plan/proposal should contain the minimum elements enumerated in 3.1 (below). This will still allow for flexibility of the plans/proposals, but a minimum of standardization to facilitate preparation, review, comparison, and approval by the Steering Committee. Note that preferably the proposal should aim a five year programme. The minimum elements are as follows:

- 3.1 Goals
- 3.2 Objectives
- 3.3 Strategies
- 3.4 Expected outcomes and impacts
- 3.5 Products/activities/outputs (i.e. deliverables)
- 3.6 Assumptions
- 3.7 Timeline
- 3.8 Indicators of process and outcome
- 3.9 Overall budget disaggregated by major products, including unmet needs and possible sources to cover unmet needs
- 3.10 Potential implementing partners
- 3.11 Stakeholders and their potential role (e.g. in specific working groups; stakeholders would include centres of excellence (e.g. university centres), civil society, government organizations, United Nations, etc. The stakeholders should represent national as well as sub-national perspectives.

4. Annual stakeholder meetings

These will be conducted in December, starting in 2011. The host of the annual stakeholder meeting would rotate among the different agencies. The objectives of this meeting are to report the progress, achievement and challenges of each of the five programmes, create public awareness, and foster further collaborations and trust-building with stakeholders in the wider society.

5. Review of proposals and implementation

Peer review: A peer review will be conducted for the programmatic and financial aspects of each of the five proposals. The review processes will be managed by ThaiHealth through ThaiHealth's existing mechanisms. The reviewers of each proposal will be Thai experts as suggested by the lead agency coordinator of each area of work. If necessary,

some of them may be drawn from ThaiHealth’s pool of experts. WHO will invite international experts for review of each proposal.

Mid-term review: A mid-term review will be conducted 2.5 years after implementation begins to assess progress, process, output and impact.

Final review: A final review will be conducted at the end of 5 years of implementation to assess the overall output and impact.

6. Reporting and auditing

Reporting and auditing would be undertaken annually, in two aspects: programmatic and financial. The audit is limited to the programmatic activities and pooled budget from multiple agencies and its expenditures for each priority area (i.e. not an audit of WHO). It also does not include related-activities operated outside of the agreed upon activities for each priority area of work. The HSRI will manage the auditing process for each of the five areas. Differences in requirements for reporting and auditing mechanisms among organizations are anticipated (as each agency has its own rules), but should be minimized and streamlined as much as possible. The lead agency coordinator of each area of work should ensure that implementers are aware of and accommodate these requirements and rules.

7. Rules and spirit of engagement

Lead agency coordinators of each area should ensure a consultative process with stakeholders in developing plans and proposals.

Programme strategies and activities should be carefully devised to synergize with existing programmes in similar and related areas.

Repetition and competition should be avoided. Instead, efforts to “add-value” to ongoing or new efforts should be emphasized.

A situation analysis including a mapping exercise is required for each area of work, in order to understand fully the ongoing programmes and related resources already available.

New programmes under the Thailand-WHO collaboration should aim to fill gaps, not only by injecting additional resources, but also by more effectively mobilizing and managing the already available resources.

There is no need to “pool” all financial resources for programmes, as separate management of resources (e.g. at peripheral levels) may be more appropriate or expedient in some cases. Thorough communication with identified stakeholders on the details and modalities of future collaboration and commitments are therefore, encouraged at this step of proposal development.

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The WHO Country Cooperation Strategy (CCS) is a medium-term vision for its technical cooperation with a Member State, in support of national health policy, strategy or plan. It is the main instrument for harmonizing WHO cooperation in countries with that of other UN agencies and development partners.

This CCS for Thailand has a five-year horizon in order to align the strategic plan with the country's next national health plan (2012-2016) and with the new United Nations Partnership Assistance Framework (UNPAF). It focuses on a few strategic priorities that will be implemented collaboratively. This signifies a new way of working in health and the modalities identified for the partnership operations focus on a multisectoral approach involving a number of national health agencies, with WHO in a key facilitating role.

It identifies five priority programmes of work, namely: (a) community health system; (b) multisectoral networking for NCD control (NCD network); (c) disaster preparedness and response; (d) international trade and health and (e) road safety.

These five priorities constitute the main focus for WHO's direct technical collaboration in Thailand. In addition, the CCS describes 3 other important collaborative areas which include fulfilling WHO's normative functions, addressing public health challenges and unfinished agendas in Thailand and facilitating Thailand's role in health beyond its borders.

This CCS is an innovative and dynamic strategic tool for future collaboration between Thailand and WHO. This model may inspire future collaboration between WHO and other Middle-Income Countries in the spirit of aligned and harmonized country-led partnership.



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Cover: scene from a traditional mural painting at Wat Suthat, a 200-year-old temple in Bangkok, depicting an aspect of contemporary life at that time.