

Thailand: A World Leader in Health Promotion

Major Risk Factor Control
Programs funded by
ThaiHealth: Achievements
and Challenges

Promoting Health in Communities and Organizations

Methods and
Approaches
to Achieve
Health in
all Policies

How ThaiHealth Facilitates Capacity Building, Evaluation and Innovation

Strengthening
Governance
and Operations

TheWayForward



10

Ten-Year Review of Thai Health Promotion Foundation NOV 2001-NOV 2011

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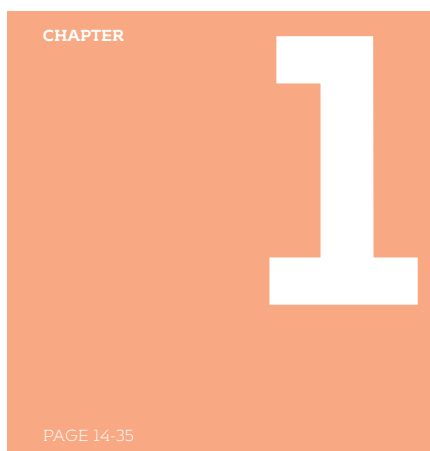
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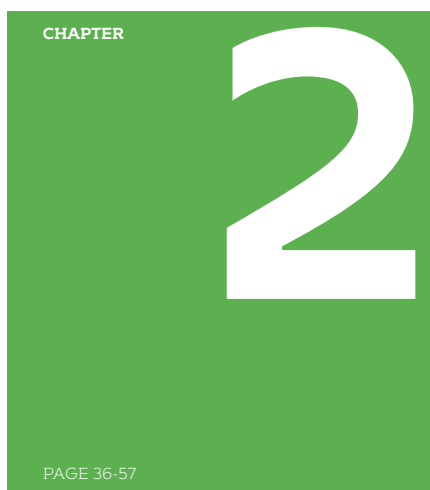
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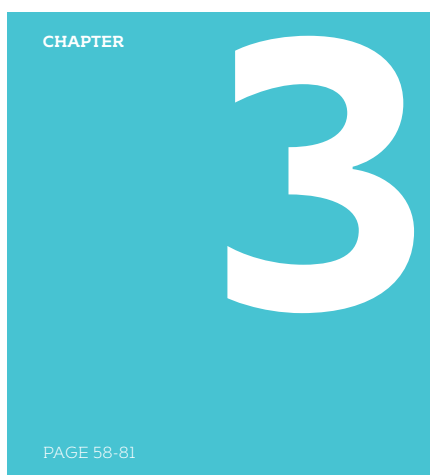
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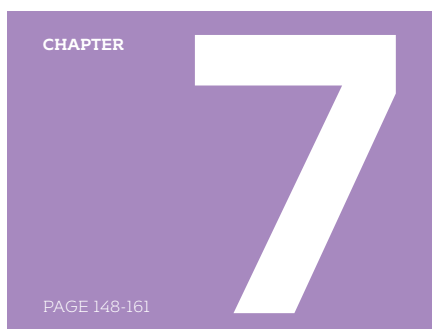
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PREFACE

The Evaluation Board of the Thai Health Promotion Foundation (ThaiHealth) appointed by the Cabinet according to section 37 of the Health Promotion Foundation Act B.E. 2544 (2001), comprises of members with eminent knowledge, abilities, and experience in the areas of finance, health promotion, and evaluation. The Evaluation Board has the authority and duty to evaluate the results of policies, activities, and operations conducted by ThaiHealth, in order to provide directive guidance and recommendations on strategies and operational development to ThaiHealth so that the foundation could be more efficient and effective in performance for achieving its goals and missions. The Evaluation Board has monthly meeting for monitoring and evaluation of programs of ThaiHealth and also issues an annual report of ThaiHealth performance evaluation.

On the special occasion of the 10th anniversary of ThaiHealth's establishment on November, 2011, the Evaluation Board decided to evaluate the performance of the 1st Decade of ThaiHealth. The evaluation process began in July, 2010. The board had been quite honored that leading international organizations such as the World Health Organization, World Bank, and Rockefeller Foundation agreed to send their representational experts with knowledge and experience in health promotion to participate as evaluators, in addition to providing partial financial support for the evaluation.

The Evaluation Board of ThaiHealth would like to express sincere gratitude to all six members of the International Evaluation Team. These distinguished evaluators are Dr. Rhonda Galbally – founding CEO of the VicHealth, Australia; Dr. Armin Fidler – Lead Adviser for Health Policy and Strategy, World Bank, Washington D.C., U.S.A.; Dr. Mushtaque Chowdhury – Associated Director, Rockefeller Foundation, Asia Office, Thailand; Dr. KC Tang – Coordinator for Health Promotion, WHO, Geneva, Switzerland; Dr. Suvajee Good – Program Coordinator for Health Promotion, WHO-SEARO, New Delhi, India; and Dr. Sripen Tantivess – Senior Researcher, Health Intervention and Technology Assessment Program, Thailand.

The Evaluation Board would like to thank Dr. Samlee Plianbangchang, the WHO Regional Director for South-East Asia, for providing financial support for the evaluation and

sending a representative from the WHO-SEARO to work as an evaluator. The Evaluation Board would also like to thank Dr. Suwit Wibulpolprasert, for his role as the Chairperson of the Supporting Committee for Evaluation of the 1st Decade of ThaiHealth, for his advice, as well as his assistance in facilitation to contact the WHO, World Bank, and Rockefeller Foundation in sending their representatives to participate as evaluators.

The Evaluation Board is also highly appreciative of the cooperation and support from Dr. Vichai Chokevivat – the 2nd Vice-President of the ThaiHealth Executive Board; Dr. Krissada Ruengareerat – Chief Executive Officer (CEO) of ThaiHealth; Assistant Prof. Dr. Supreda Adulyanon – Deputy CEO; Ms. Waranya Teokul – Director of the Policy and Strategy Section as well as all ThaiHealth staff throughout the evaluation process which included the preparing essential documents for the evaluation, coordinating work with interviewees, and facilitating field visits. The Evaluation Board would also like to thank Dr. Manit Prapansilp and Mrs. Lalana Rojanapaibulya, in their roles as the secretaries of the Evaluation Board, for coordinating and facilitating evaluation work. The Evaluation Board’s sincere thanks also extend to everyone who provided information for the evaluation and all interviewees.

Finally, the Evaluation Board would especially like to thank Dr. Rhonda Galbally for her commitment and her tireless effort to fulfill the exceptional work as the Chair of the International Evaluation Team.

The Evaluation Board is highly confident that this evaluation report will be greatly beneficial to ThaiHealth and providing valuable information for further strengthening the performance and development of the foundation so that it can achieve its mission more efficiently and effectively, in order to allow **“everyone in Thailand to have sustainable wellbeing.”** Furthermore, individuals and the health promotion organizations in various nations as well as health professionals and academia may also use this report as a case study to advance their own work.

The Evaluation Board of ThaiHealth

May 2012

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EXECUTIVE SUMMARY

Following a ten-year campaign during the 1990s, the Thai Health Promotion Foundation (ThaiHealth) was established in 2001. The campaign's roots lay in the highly successful Thai tobacco control movement. Hence the model used to establish ThaiHealth's funding base was a dedicated levy on tobacco, a so-called sin tax that not only provided the funding base for ThaiHealth, but also raised the price of cigarettes, an efficient and effective mechanism for lowering smoking rates. Further funding for ThaiHealth came from a levy on alcohol, another sin tax used to reduce the volumetric rate of alcohol consumption. Therefore, the funding mechanism for ThaiHealth was itself a powerful health promotion intervention.

The aim of ThaiHealth over its first ten years was to create a health promotion culture across Thailand. With its emphasis on multisectorality, communities and settings, as well as major risk factor reduction programs, ThaiHealth has established a broad reach, geographically, among diverse population groups, and across the lifespan from birth to old age.

Important gains in the major risk factor areas have been achieved and the impacts have been significant in smoking, alcohol and road injury reduction. An enormous amount of activity has led to major social health outcomes in areas such as education, public broadcasting and consumer protection. ThaiHealth has also made a seminal contribution to the development of major infrastructure, such as the National Health Assembly, enabling civil society across Thailand to participate in health promotion.

ThaiHealth has become a beacon in the network of health promotion foundations: it is increasingly called on to transfer its knowledge and experience to a growing number of countries looking to establish similar mechanisms to ensure that health is promoted with sustainable resources on a multisectoral platform.

Having successfully completed its tenth year, ThaiHealth is now entering a new decade as a mature organization. In order for it to continue in its leadership role, both in Thailand and internationally, ThaiHealth now needs to sharpen its focus. While it is understandable that the first decade was one of establishing relevance across the country, the second decade must be characterized by increased rigour and more emphasis on strategy.

In particular, new stringency must be brought to ThaiHealth's evaluation practices. In its efforts to spread the health promotion word, ThaiHealth has left itself vulnerable by not yet establishing a sufficiently strategic approach to evaluation. This is a major risk for ThaiHealth because, without a highly strategic evaluation plan, ThaiHealth may well find it increasingly difficult to prove its value for money in the current shifting environments, domestically and internationally, due to the global financial crisis.

ThaiHealth's Second Decade: The Era of Evaluation

The 5-Year Review was entitled *Many Things to Many People*. This has generated lively discussion about whether or not ThaiHealth has been too many things for too many people.

Part of the answer to that question lies in the fact that, for its first ten years, ThaiHealth's primary aim was to establish the relevance of health promotion across the country. ThaiHealth could therefore never reach too many people, because its task was to develop a health promotion culture where prevention is part of the life of all Thais, including the most disadvantaged communities and population groups. In fact, ThaiHealth still has some significant way to go to make health promotion a top priority in Thailand. While its reach is broad and has led to many valuable outcomes, the work to maintain and extend relevance, especially in a strategic way, is never ending and this must remain a top goal for ThaiHealth for the next ten years.

The second question prompted by the 5-Year Review is: are ThaiHealth's programs addressing too many issues? The answer is that if strategic knowledge is not extracted and transferred from every intervention, if impact evaluation and cost-benefit analysis are not robust for all relevant plans and programs, or if the value of an approach cannot be proven then there may well be too many issues on ThaiHealth's agenda.

Over the next decade, decisions about which issues to add and which to delete must include the capacity to assess possible outcomes and their impacts. This means that ThaiHealth must tackle evaluation full on. Applying knowledge from evaluation to the strategic selection of priorities would mean that disadvantaged population groups would become a much stronger focus for ThaiHealth, especially in areas where risk factors are greatest. An organizational development approach to evaluation with clear indicators and outcome and impact data would enable a sharper focus on one or two settings. Communities and local government organizations would remain a priority, but with evaluation and the transfer of knowledge gained built in from the outset. Early childhood would be emphasized, especially to reduce non-communicable diseases across Thailand.

ThaiHealth's Second Decade: The Era of Capacity Building

In order to ensure that ThaiHealth continues addressing frontier issues and approaches for the next decade, a significant upgrading in capacity for strategic thinking is required, both for ThaiHealth as an organization, and for its stakeholders, including partners and potential partners.

However, capacity can only be built when there is a common understanding about what works, what does not and why. This requires ThaiHealth to link its need to build capacity with a much more stringent approach to evaluation. Learning and ultimately knowledge must be extracted from evaluation so that the most important issues that require capacity building can be identified. A virtuous circle needs to be developed, connecting evaluation to learning and knowledge, and then connecting knowledge to capacity building.

This capacity should not only be based on knowledge gained from evaluation, it should also be delivered using a decentralized model. A decentralized approach to capacity building would mean that ThaiHealth could usefully reach every corner and every community of Thailand, and potentially, using cost recovery approaches, the international community. ThaiHealth should carefully plan its capacity building strategy as a ten-year vision. New skills and knowledge are needed, in areas such as social epidemiology, action research, impact evaluation, health promotion economics and strategic thinking. An approach needs to be developed to ensure that these areas are identified in a systematic plan to build capacity, to be implemented over a realistic time frame.

ThaiHealth's Second Decade: The Era of Strategic Thinking, Learning and Innovation

ThaiHealth's future depends on its capacity to remain at the forefront of innovation. ThaiHealth must be able to systematically apply knowledge gained, both from its own program experiences, and from new research, when developing new approaches to health promotion.

Strategic thinking must be built in as an expectation for ThaiHealth, but this should not be seen as ThaiHealth's job alone. Maintaining a permeable organizational boundary is imperative. This involves welcoming new coalitions, new wisdom and new expertise, from whatever source. ThaiHealth must remain open and alert, striving constantly to develop high quality relationships with all stakeholders. Quality relationships are also necessary to ensure scale-up from ThaiHealth trials. This means that relevant scale-up partners, including government departments, must be actively involved as partners from the very beginning of the development of innovative programs and approaches.

Some of ThaiHealth's most successful innovative programs have resulted in spin-off organizations. The ongoing connections and interdependencies with these spin-offs should be emphasized: strong systematic engagement will enable these valuable programs and organizations to add to ThaiHealth's capacity for ongoing innovation.

ThaiHealth's Second Decade: The Era of Transparent, Efficient and Assured Processes and Relationships

In order to maintain its credibility, ThaiHealth must continue its strong work to ensure that all processes and procedures regarding grant awards, partner selection and governance decision-making are all scrupulously fair, clear and transparent. It is now time to introduce a system for attestation of these processes. The role of the Evaluation Board could valuably be expanded to include the task of ensuring that all ThaiHealth processes that have any potential for conflict of interest are properly monitored and dealt with, and those procedures documented and published, to ensure continuous improvement.

The next decade will be challenging. ThaiHealth must achieve the transition to become a mature but still constantly dynamic organization. Its second ten years must be an era of strong strategic thinking, generating new research, approaches and knowledge. Evaluation and capacity building must drive ThaiHealth's momentum within transparent and fully accountable processes. Then the invaluable role that ThaiHealth has played so far will be not only equalled but surpassed by its contribution to new health promotion knowledge, in order to benefit both Thailand and the rest of the world.

Chapter

1

**THAILAND:
A WORLD LEADER IN
HEALTH PROMOTION**

Chapter 1

THAILAND: A WORLD LEADER IN HEALTH PROMOTION

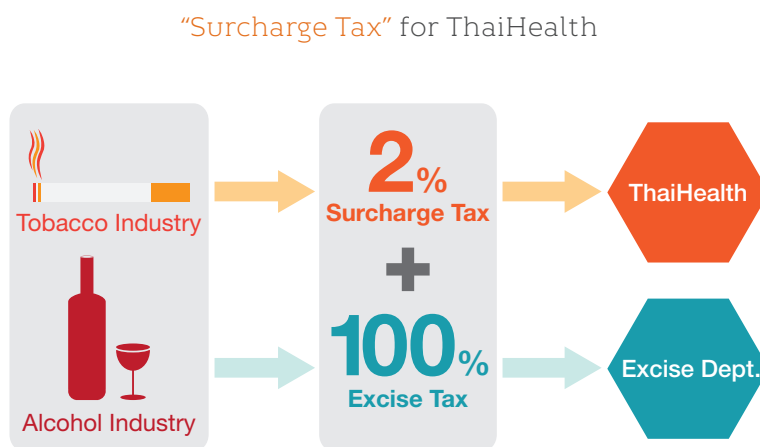
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Introduction

Thailand is a world leader in health promotion and disease prevention, adopting policies and implementing programs years ahead of other countries. In 2001, when the country was still in the early stages of recovery from the 1997 Asian financial crisis and when gross national income was only US\$1,900 per capita, the Government pushed through two major health reforms. One was the tax-financed Universal Coverage Scheme, guaranteeing all Thais access to health services regardless of their ability to pay. The second reform was to create the Thai Health Promotion Foundation (ThaiHealth) to be funded entirely from a dedicated 2% additional tax on the sale of tobacco and alcohol (see Figure 1.1).

ThaiHealth was established under the Health Promotion Foundation Act 2001 to stimulate, support and develop a systematic approach to health promotion in Thailand. Its governing board is chaired by the Prime Minister and half its members are from independent social organizations. Working with a wide range of multisectoral implementation partners, each year ThaiHealth spends around US\$100 million funding over 1,000 health promoting projects and activities. ThaiHealth emphasizes health-promoting public policies, issue-based programs and holistic approaches; its activities target the social determinants of health. ThaiHealth acts as a catalyst for projects that attempt to make positive changes in health status by changing values, lifestyles and social environments.

Figure 1.1 Mechanisms to finance ThaiHealth



Source: ThaiHealth, 2011

This report presents the results of an independent evaluation of ThaiHealth’s first 10 years, 2001 to 2011, highlighting its achievements and challenges, assessing the transition from the establishment phase (the first five years) to organizational maturity, and making recommendations to help ThaiHealth become a more mature and secure organization.

This first chapter provides background information about health promotion, globally and in Thailand, and also describes how the 10-Year Review was undertaken. Chapter 2 highlights the achievements made and challenges faced in the major risk factor control programs funded by ThaiHealth,

including tobacco and alcohol control, road safety, physical activity and nutrition. How the Foundation promotes health in communities, organizations and health systems is covered in Chapter 3. Chapters 4 and 5 address the methods and approaches behind all of ThaiHealth’s work to achieve “health in all policies”. Chapter 6 assesses governance and operations. The 10-Year Review team’s assessment led to a number of specific and actionable recommendations in each targeted area, and these are summarized at the end of their respective chapters. The final chapter of the report focuses on three priorities and sets out a vision for the second decade of ThaiHealth.

The global health promotion movement: A brief history

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The architects of ThaiHealth drew on the evolving global health promotion movement. Health promotion was established as a policy imperative in 1986 at the first Global Conference on Health Promotion, held in Ottawa, Canada. The Ottawa Charter¹ defined health promotion as the process of enabling people to increase control over their health and its determinants. It specified five areas of action: (1) the development of health-promoting public policies; (2) the creation of supportive environments; (3) the development of personal skills; (4) the strengthening of community actions; and (5) the reorientation of health services.

During the late 1980s and 1990s health promotion emerged as a response to the recognition that, unlike medicine and the treatment of illness, prevention requires action in all sectors and in every part of the community. The most important sectors for health promotion are not primarily focused on the health sector itself. Effective health promotion is not only multisectoral, it also draws on many different disciplines and knowledge bases. This can pose challenges for ministries of health because their legitimate remit is within the health sector. Health ministries, like most vertically oriented government departments, also find it difficult to mobilize, lead and facilitate other sectors

within government. In addition, like government departments in general, many health ministries also find it difficult to engage with agencies outside government. Furthermore, health ministries tend towards a heavy focus on medicine and treatment, and escalating demand for treatment leaves little funding to invest in health promotion.

In 1988 in Australia a new model of health promotion financing and infrastructure was developed to address these challenges and constraints: the Health Promotion Foundation (HPF). Any HPF should ideally be part of government, and must at least be at proper arm's length so as to act freely in pursuit of its goals. As an independent statutory authority or agency, the HPF must have a separate budget stream, which should ideally derive from a mechanism for health promotion (for example, a tax on tobacco and alcohol). The eight features of the HPF model are described in Box 1.1.

The World Health Organization (WHO) has played a strong leading role in promulgating the HPF model as a means for countries to acquire dedicated funds for health promotion without having to reduce the budgets of health ministries. WHO has also supported the development of HPFs in countries to enable them to generate new knowledge, to consolidate and analyse such data and information, and then to catalyse investments in health promotion programs and action.

Box 1.1

The health promotion
foundation model:
Eight features

Funding mechanism

Ideally, an HPF uses funding that promotes health and at the same time insulates the funds from any competition for health ministries' resources. The ideal source of funds is a percentage increase in tobacco and alcohol taxes, as these taxes are themselves health promotion strategies. Raising the price of cigarettes and alcohol is the most effective strategy to reduce consumption².

Governance structure

The HPF governing structure is ideally multisectoral, consisting of all sectors relevant to the promotion of health. Representatives of the health sector may well be in a minority, as both board members and staff would have backgrounds in many disciplines to reflect the necessary expertise from many sectors and disciplines, such as education, industry, local community development, marketing, knowledge management, evaluation, economics, law and regulation.

Focus on the determinants of health

The HPF ideally embraces all sectors and settings that have an impact on health status. This approach is reinforced by a focus on the social determinants of health³, with new research adding to decades of knowledge that reducing inequalities leads to improvement in health status. In addition to access to health services, the social determinants of health include income level, education, work, housing, transport, justice, early childhood programs and recreation—all these sectors being outside the health sector.

Focus on health inequalities

Acknowledging the regressive nature of the tax (or dedicated levy) on tobacco and alcohol and the unequal distribution of ill health, the HPF focuses on disadvantaged populations and communities.

Health in all policies

The HPF focuses on establishing innovative health-in-all-policies strategies, whose twin goals of improved population health outcomes and a narrower health gap are shared across all government ministries. This requires addressing complex health challenges through an integrated policy response that spans traditional portfolio boundaries⁴.

Community ownership for sustainability

The HPF also takes into account social epidemiological evidence showing that for sustainability at local levels, the community must own and lead health promotion efforts⁵. The HPF should provide a platform for strong engagement with local governance structures and communities.

A multipronged social marketing approach

The HPF ensures that social marketing is aimed not only at behavioural change but also at developing community support for strong health-promoting policies and at developing community-owned social marketing messages. In addition, the HPF supports the development of capacity in the media to accurately report on health promotion.

Stimulating innovation and measuring outcomes

A major task for the HPF is to be at the forefront with the latest knowledge about interventions and evaluation and to use this to guide further investment into new areas for program development. Ideally the HPF supports the pioneering of evaluation and intervention research to ensure that all health promotion efforts are effectively and efficiently evaluated, based on value-for-money outcomes, and the HPF uses evaluation to promote continuous improvement, learning and the building of capacity.

An evolving model of health promotion

Health promotion has evolved since the Ottawa Charter in 1986. In the past decade, the “health in all policies” approach has been gathering momentum and replacing the healthy public policy approach initially outlined in the Ottawa Charter⁶. Health in all policies is a horizontal, complementary policy-related strategy that examines determinants of health that are controlled by sectors outside of health. While continuing to recognize that health promotion requires a collaborative effort by all government sectors at all levels, the new approach does not assume that other sectors will take health and health equity into account, but considers that priorities other than health may override the policy-making process⁷. In this regard it is the task of an HPF to ensure that health is a sufficient priority for all relevant ministries and sectors, including the private sector, to achieve the development of healthy environments and conditions so that health status can improve.

A great majority of the determinants of health lie outside the health sector, and therefore decisions made outside the healthcare system often have a major bearing on elements that influence the risk factors for disease⁸. Health gains can be achieved by influencing policies in domains such as trade, food and pharmaceutical production, agriculture, urban development, pricing, advertising, information and communications technology and taxation, rather than by changes in health policy alone.

New patterns of consumption and communication, urbanization and environmental change have resulted in rapid changes in

the factors that contribute to health. While globalization has accelerated social, demographic and economic change, and created opportunities for a greater level of collaboration and engagement of all sectors of society across the world, it has also had some detrimental effects on health and well being and has led to an increase in some health risk factors (for example, the marketing of cigarettes and alcohol, and the spread of HIV).

Health promotion efforts are invested in a comprehensive approach to addressing the risk factors of disease. Many risk factors contribute to more than one disease. Tobacco use, for example, which accounts for 9% of global deaths, is linked to multiple non-communicable diseases such as cancer and chronic respiratory disease. Hazardous and harmful use of alcohol amounts to 3.8% of global deaths, more than half of which are non-communicable diseases such as cancer and cardiovascular disease, and relates strongly to escalating rates of mental illness and accidents.

Exposure to the risk factors of disease is largely determined by social position; this in turn results from a combination of other conditions—the social determinants of health⁹. Modern health promotion works

to ensure social inclusion and values the role of community. Strengthening community action and engaging communities in the implementation and control of programs have always been important elements of ensuring the sustainability of health promotion policies and programs¹⁰. Integrating community mobilization into health promotion and empowering communities to address their health concerns requires networks, participation, local leadership, shared vision and interests, norms, and mutual support and trust.

Community mobilization is likely to be initiated through actions by non-government organizations (NGOs), civil society, and community and public health advocates. However, control of the initiative often rests with “experts”. Social epidemiology shows that to achieve sustainable health changes through community action, control of community-based initiatives must rest with the community, in order to foster a society in which all people feel valued and have the opportunity to participate fully in the life of a society. Further, it is now understood that well organized and empowered communities can become highly effective in determining their own health by making public and private sectors accountable for the impact of their policies and practices.

Health promotion in Thailand prior to 2001

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Even before the establishment of ThaiHealth in 2001, Thailand had a strong track record in health promotion. The tobacco control movement and its organization, the Action on Smoking and Health Foundation (ASH) had become a world leader in advocacy to establish policies, legislation and regulation to reduce and ultimately prevent the consumption of cigarettes. This included: ridding sports of sponsorship by tobacco companies; raising the price of cigarettes; influencing trade policies to prevent the dumping of international cigarette brands in Thailand; and developing smoking cessation programs.

In 1986 the Thai Anti-Smoking Campaign Project was established in the Moh-Chao-Ban Foundation. This small project led by Professor Prakrit Vathesatogkit and Ms Bungon Ritthiphakdee coordinated networks of organizations with similar interests to undertake a wide range of activities¹¹. Among its activities was a campaign in 1993 for increases in the excise tax on cigarettes and earmarking the surplus to the Ministry of Public Health (MoPH) with the aim of enhancing its tobacco control program. However, although cigarette taxes increased, the efforts to attract funding for tobacco control were unsuccessful.

During 1995-1996 the idea of diverting the earmarked cigarette and alcohol tax to finance health promotion in Thailand gained traction¹². In parallel, the global pool of research evidence on tobacco as a major health risk

factor was growing, as was the knowledge base related to effective policy options. The Health Systems Research Institute (HSRI) commissioned researchers in the MoPH, universities and legislative institutes to search for an innovative financing model for health promotion, including reviewing experiences in different countries. Dr Supakorn Buasai, Deputy Director of the HSRI, and other Thai officials, visited Australia to assess the Victorian Health Promotion Foundation (VicHealth), the world's first HPF. VicHealth, a comprehensive HPF based on the most progressive principles of health promotion as exemplified in the Ottawa Charter, was initially established and funded with a dedicated levy on tobacco. Not only did the levy provide a funding source for investment in innovative health promotion, it was also inherently health promoting in raising the price of cigarettes.

The campaign to establish ThaiHealth supported by the HSRI began in earnest and the vision for ThaiHealth started to evolve. Lessons learned from VicHealth informed much of the early vision for ThaiHealth. The experience of Healthway (established in Western Australia in 1993) as well as the New Zealand Health Sponsorship Council (set up in 1994 as a sponsorship-based health promotion foundation) provided further examples of what worked and also about what could have been done differently.

Introducing ThaiHealth

The approach ultimately adopted and then elaborated by ThaiHealth included increasing tobacco and alcohol taxes, promoting healthy sponsorship of sports and culture, developing healthy environments, developing multisectoral support for health promotion, taking a social determinants approach to health promotion, and promoting innovation and new knowledge (see Box 1.2 for details).

ThaiHealth adopted the comprehensive WHO paradigm of health: “Health as a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief or economic and social conditions”¹³. ThaiHealth has explicitly pursued a social rather than biomedical model of health. Hence the relationship between behavioural risks and social determinants informs ThaiHealth’s strategies, rather than an approach based solely on the burden of disease, although the burden of disease still plays an important role in the setting of ThaiHealth’s priorities.

Box 1.2

The ThaiHealth approach

Increase tobacco and alcohol taxes

- This is one of the most efficacious methods for driving down demand for cigarettes and alcohol.

Promote healthy sponsorship of sports and culture

- Tobacco sponsorship of sport and cultural events was banned before ThaiHealth was established; ThaiHealth added the alcohol dimension by lobbying for a similar ban on alcohol sponsorship and by sponsoring national, youth and university sporting events.

Develop healthy environments

- Pursuing public policies in all relevant sectors at national, provincial and local levels as well as organizational and system-wide policies that make environments more conducive to and supportive of health.

Develop multisectoral support for health promotion

- Engaging in a partnership approach with government departments, NGOs, communities and settings in which people live, work, socialize and are educated, and taking an organizational, community development approach.

Take a social determinants approach

- Developing co-morbidity models that attempt to avoid a narrow focus on specific risk factors by addressing risk based on inequality and disadvantage, including underlying social determinants.

Promote innovation and new knowledge

- Taking a strong knowledge-based approach, contributing to and keeping up to date with the latest research and understanding to innovate, develop and evaluate programs.

Figure 1.2 The triangle that moves mountains



Source: ThaiHealth, 2011

Based on the context in which ThaiHealth operates, a high premium is placed on the need to strengthen civil society, as well as taking account of socio-economic conditions, gender-related risk, occupational status and educational attainment, culture and belief systems, and the importance of social and community networks.

ThaiHealth's health promotion philosophy and practice is based on Professor Prawase Wasi's "triangle that moves the mountain" with its three powers of knowledge, social participation and policy advocacy¹⁴ (Figure 1.2).

The first side of the triangle refers to the power of knowledge, meaning the generation

of knowledge on which to base the development of strategies and programs. Evaluation of programs is critical to knowledge generation. Just as important is to share knowledge publicly within Thailand and with the rest of the world so it can be used to inform health promotion practices, to build capacity and to improve ThaiHealth's strategies and programs.

The power of social participation, the second side of the triangle, means that as far as possible ThaiHealth's strategies are based on the desire for communities themselves to identify priorities and design solutions that they believe will work, based on the best available information and evidence.

The National Health Assembly represents the pinnacle of the social participation side of the triangle, along with local community decision-making. Social epidemiological evidence now backs this as a vital approach to ensure the sustainability of health promotion effort¹⁵.

Social participation can also be seen as an aspect of mass marketing, where social marketing is used to change behaviour as well as to create supportive environments conducive to policy change. ThaiHealth’s approach recognizes that without community ownership, any behavioural gains from the more mainstream social marketing approaches will be unsustainable for future generations.

The third side of the triangle refers to the power of policy. ThaiHealth puts great effort into achieving policy change to foster healthy and supportive environments. Policy is developed at the national, provincial, district and sub-district (Tambon) levels. ThaiHealth’s policy efforts extend to organizations and networks of organizations advocating them to move towards developing healthy, safe and supportive environments in their local communities.

The interaction of the three sides of the triangle — knowledge, social participation and policy advocacy — is the inspiration for ThaiHealth’s comprehensive approach to health promotion. The three sides of the triangle in combination, plus funding, make up all of the necessary elements for achieving sustainable improvement in health status for a nation.

Without policy and its regulation, health will not be promoted. The policy side of the triangle takes account of the shift described above from the Ottawa Charter’s call for “healthy public policies” to the contemporary WHO approach of “health in all policies”. Health in all policies can only be achieved with social participation, including domestic and global mobilization and advocacy, for the development of health promotion, and most importantly for its regulation and oversight. In addition, the social participation side of the triangle includes the need for communities to own health promotion to ensure its sustainability. Health in all policies is not possible without knowledge, including searching for and discovering what works and what doesn’t, finding out how to utilize this knowledge to develop policies, and transferring all knowledge gained within Thailand and internationally.



ThaiHealth's development: 2001-2011

Organizations do not exist in a vacuum. They are not only guided by their Executive Board, CEO and active stakeholders, but also influenced by surrounding context and social structure. During the 10 years since its creation, ThaiHealth has been affected by the country's socio-economic environment, including national policies and politics. Factors such as political change and unrest, decentralization policies, demographic shift, globalization, and the digital revolution have had a major impact on ThaiHealth's development. In some instances, contextual factors induced substantial changes in ThaiHealth's governance and management. Meanwhile, shifts in particular components of the health systems could either accelerate or impede the introduction of the health promotion programs and activities supported by ThaiHealth. A background paper providing a detailed assessment of how key contextual factors have impacted on ThaiHealth, which was produced as part of the 10-Year Review, is available at <http://info.thaihealth.or.th/library>.

The first five years: The establishment phase

As was the experience of VicHealth and other HPFs, during its initial five-year start-up period, ThaiHealth tended to lean towards defensiveness in the face of what was perceived as a threatening external world. Among its numerous perceived enemies were the major multinational tobacco and alcohol corporations. One of ThaiHealth's first major challenges was to tackle the alcohol industry's deeply entrenched stranglehold over the sponsorship of sports in Thailand, which attracted significant aggression. On the domestic front, ThaiHealth had to navigate an often volatile political environment and hostility from some government departments that resented its large budget of new funds to invest in innovation, compared with their budgets that were mostly spent on recurrent programs.

In addition, ThaiHealth faced a mixed response from some of its partners who, while enjoying the new funding, were somewhat resistant to the new demands made on them for greater accountability and demonstrated outcomes. A different set of criticisms came from failed grant applicants and from organizations that had not been selected as partners. As illustrated in Figure 1.3, ThaiHealth responded by building

a high boundary wall to resist external attacks from natural enemies (tobacco and alcohol industries) and potential friends (partners, media, parliament and the MoPH).

In 2006, after five years of development, ThaiHealth commissioned an evaluation of its operations and approach. *Many Things to Many People: A Review of ThaiHealth*¹⁶, published in 2007, concluded that despite significant political volatility, ThaiHealth achieved a great deal in its first five years in terms of the breadth, quantity and quality of its health promotion activities. During those years from 2001 to 2006, ThaiHealth played an active role in supporting and accelerating the commitment to health promotion espoused in national policies and frameworks and exemplified elements of the comprehensive best practice approach to health promotion as articulated in the Ottawa, Jakarta and Bangkok Charters.

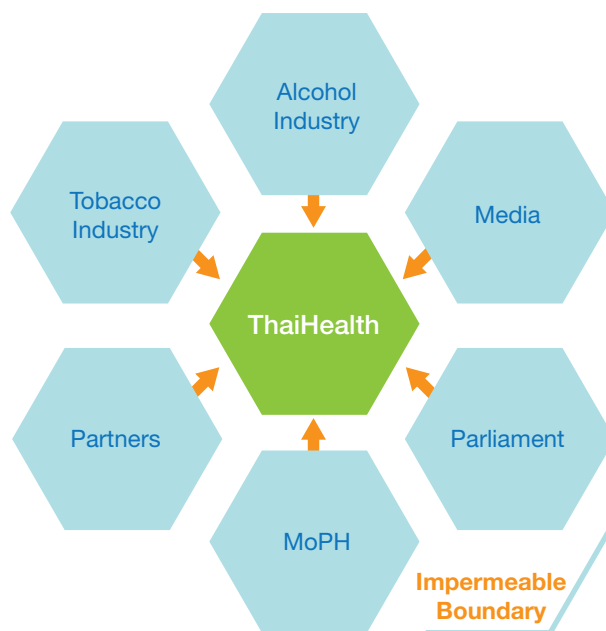
The 5-Year Review noted that ThaiHealth had driven strong, world-leading policy in areas such as tobacco control, alcohol control and road injury, which had clearly contributed to notable downward trends in the numbers of injuries and deaths related to these risk factors. The Review highlighted the early establishment of models of community control

and design for sustainable health promotion at local levels and the launch of cutting edge social marketing campaigns that went beyond addressing behaviour change and focused on developing a cultural environment to enable national, provincial and local policy. Importantly, ThaiHealth had established workable governance, organizational and operational structures and systems capable of surviving political change and difficult political crises.

The 5-Year Review also identified opportunities to strengthen or adjust focus in some areas.

It raised questions about the sustainability of some projects and programs and asked whether continuing to expand the breadth and volume of activities would spread ThaiHealth too thinly. The reviewers felt more should be done: to address health inequalities and the social determinants of health; to maintain freedom from political interference; to work more closely with local government; to improve the monitoring and evaluation system; and to share approaches, experiences and lessons learnt with other organizations within Thailand and globally.

Figure 1.3 ThaiHealth’s first five years



Source: adapted from Harold Bridger Tavistock Institute 1992

The second five years: Becoming a mature and secure organization

ThaiHealth’s establishment phase bears similarities to all new organizations; however, a hallmark of its success as a mature organization is its ability to remain resilient in the face of external pressures. By its very nature, an effective HPF (well beyond the established phase) must continue to push numerous boundaries and challenge powerful industries and, on occasion, political interests, to achieve its aim of promoting the health and well-being of the population.

One of the aims of the second five years for any HPF is to become secure in its existence, with systems that are sufficiently flexible to adapt to new circumstances. Most importantly, ThaiHealth during this period should have become sufficiently robust to allow for a permeable boundary and relationship with its external environment (Figure 1.4). In fact, the quality and management of relationships with a range of stakeholders — existing and potential — is an important indicator of a robust organization able to withstand challenges and adapt to new circumstances.

Figure 1.4 ThaiHealth’s second five years



Source: adapted from Harold Bridger Tavistock Institute 1992

It is also important that, as a mature organization, ThaiHealth should have added to its work in mobilizing a health promotion movement and bedded down its role by ensuring evidence is obtained through high-quality evaluation. During its second five-year phase ThaiHealth should have ensured that the organization itself is healthy, with appropriate staff policies for work-life balance and modern management including telecommuting. It should have ensured that its control functions and external oversight systems are robust and continuously improving.

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ThaiHealth on the world stage

As the development of ThaiHealth's plans and programs progressed over its first 10 years, so too did its contribution to the development of health promotion globally and in individual countries. Its emphasis on decentralization and capacity building has influenced present day health promotion practice. Other countries have much to learn from the social model ThaiHealth has used to successfully include the social determinants of health within health promotion. Despite this aim being high on the global health agenda, few countries have been as effective in achieving it as Thailand. The HPF with its intrinsically intersectoral mode of governance and operations is in a primary position to move this agenda forward, and ThaiHealth is at the forefront of this possibility.

WHO invited ThaiHealth to advise and provide technical support to Southeast Asian nations in the establishment of similar health promotion organizations¹⁷. In 2005, the WHO Regional Office for the Western Pacific requested



ThaiHealth to provide technical support for the establishment of similar HPFs in Member States under the Prolead 1 Project (comprised of Fiji, Malaysia, Mongolia, the People's Republic of China, the Philippines and Tonga) and under the Prolead 2 Project (comprised of India, Japan, Lebanon, Oman, South Korea and Vietnam).

Malaysia, Mongolia and South Korea have formally set up HPFs based on the experience of ThaiHealth and other health promotion organizations, including VicHealth, Healthway and SwissHealth, among others.

ThaiHealth's contribution to the development of other HPFs as well as to health promotion in concept and practice has been a priority. This international work provides high value for ThaiHealth and is discussed in more detail in Chapter 7 in terms of practical ways to systematize and fund ThaiHealth's international work.

How the 10-Year Review was undertaken

The 10-Year Review was conducted between July 2010 and December 2011 by a group of international and Thai experts, whose names are listed on the contributor's page (see Annex III). To ensure an impartial evaluation, the Review received technical assistance from WHO, including the WHO Regional Office for South-East Asia, the World Bank and the Rockefeller Foundation.

The framework for the 10-Year Review was based on ThaiHealth's philosophy and aims as stated in its plans and annual reports. The terms of reference were generally designed to assess the degree to which ThaiHealth has reached a level of maturity that enables it to withstand external contextual factors, while at the same time remaining open and relevant in the face of changing needs and expectations.

Details about the seven terms of reference are provided in Annex I. All the people who were interviewed by the experts are named in Annex II.

The 10-Year Review adopted a risk approach. The value of such an approach is that it builds in a realistic assessment of present and future threats, as well as opportunities suitable for a more mature ThaiHealth. A risk approach tests for complacency and rigidity and looks for the necessary elements of flexibility and speed of adjustment and adaptation as and when change is required. Some of the specific risks considered in the 10-Year Review are described in Box 1.3. One part of the review involved assessing ThaiHealth's performance in implementing the recommendations from the 5-Year Review, the results of which are available at <http://en.thaihealth.or.th/resource-center/manythings>.



Box 1.3

Risks considered in the 10-Year Review

National government: The degree to which the national government fully understands ThaiHealth's approach and value. In addition to demonstrating sound fiduciary management and accountability, does ThaiHealth adequately prove value for money using robust evaluation? Does the ThaiHealth portfolio of plans and programs include sufficient emphasis on major national priorities, including new initiatives? Are there realistic plans for communication and relationship improvement with all relevant ministries, especially the MoPH, and when there is a change of government?

Provincial authorities: With its emphasis on decentralization it is important for ThaiHealth to engage provincial level governments. While some provinces will be keener than others, a strategy must be devised to convince even the most disengaged provinces to subscribe to the health promotion agenda. This includes consideration of the strength of engagement with ThaiHealth, the health promotion agenda and the plan to build capacity.

Local government: Decentralization emphasizes local and district levels of government, and research shows the value of this level of community control of health promotion¹⁸. The challenge for ThaiHealth is to deliver sufficient capacity building so that even disengaged local governments will participate in developing and financing health promotion. Clearly some local governments are more attuned to health promotion than others and the temptation may be to work with them as the easiest option. The risk is that this would alienate and exclude those local governments who are less amenable, who might then express criticism of ThaiHealth. Strategies to bring disengaged local governments into ThaiHealth's agenda need to be assessed.

Economic downturn: The review needs to assess ThaiHealth's cognizance of the global financial crisis, particularly its potential impact on health status in relationship to inequalities and hardship among disadvantaged communities and population groups. The impact of the global financial crisis on risk behaviour, including mental health pressures relating to alcohol use, might also be expected to be considered by ThaiHealth. In addition, it would be valuable for ThaiHealth to assess its contribution to improving the economic resilience of households in the face of economic crisis. Further, ThaiHealth's contribution should be assessed in terms of improving social safety nets and/or reducing household out-of-pocket expenditure, either for health services or by generating savings as a result of health policy that reduces smoking and alcohol consumption, thus reducing health expenditure by encouraging healthier lifestyles.

Reputation: Damage to its reputation is one of the most important risks, and should be constantly monitored by ThaiHealth. This is especially important in times of political and/or economic storms. Robust tools, systems and strategies must be employed by ThaiHealth to assess and mitigate any risk to reputation from issues such as perceived conflict of interest, lack of transparency, poor financial management and inadequate communication. This is true particularly with respect to failed grant applicants, partners whose funds are declining, or potential partners who may feel excluded.

Efficiency: The risk of ThaiHealth moving towards a bureaucratic model of operations has implications for efficiency as well as reputation. Although retention of staff is an important aim, this must be balanced against the risk of overstressed and overstretched staff and the need to bring in new

ideas and enthusiasm. Roles, accountabilities and responsibilities, and especially interdependencies, must be clear so that ThaiHealth does not become a number of separate vertical programs, which would lead to both inefficiency and reputational risk.

Effectiveness: The capacity of ThaiHealth to set priorities based on high-quality evidence needs to be tested. The risk in this area concerns not only efforts being spread too thinly, but also inability to acquire or respond to new knowledge. ThaiHealth must remain at the forefront of innovation: this is vital for the role of ThaiHealth as an HPF. In addition the risk to reputation should be assessed from investing in many programs and projects without ensuring appropriate models of evaluation such as social epidemiological research for local community development projects. Effectiveness also includes assessing weaknesses in evaluation models, systems and even purpose. If evaluation becomes primarily de facto monitoring, it loses its value as a generator of high-quality new knowledge on which to base new developments.

Innovation and development: One of ThaiHealth's greatest values is the expectation that it has the resources and the freedom to become and maintain its position as a leading innovator in health promotion. This means that where new developments prove their worth and scale-up might be warranted, ThaiHealth's role may change from developer to advocate for nationwide programs funded from other government sources. Therefore, systems and culture need to highlight innovation to avoid the risk of losing or diluting the innovative edge that is recognized as a core strength of ThaiHealth. An important risk to assess is the robustness of the systems for keeping up with new knowledge and global developments so that ThaiHealth can remain innovative.

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Annex III

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Rhonda is currently Chair of the Royal Women's Hospital (Australia's largest and leading women's hospital), Chair of the National People with Disability and Carers Advisory Council, Deputy Chair of the Government's Advisory Committee for the establishment of the National Disability Insurance Scheme and a member of the Ministerial Reference Group advising re the Gonski Review of School Funding.

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In 2008 Dr. Fidler became Advisor for Health Policy and Strategy in the Bank's Human Development Network, responsible for global health policy, international health partnerships, Health Reform in Middle Income Countries and cross-cutting "Health in All Policies", such as in the areas of Climate Change, Water and Sanitation or Road Traffic Injuries.

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Dr. Chowdhury was a coordinator of the UN Millennium Task Force on Child Health and Maternal Health and of the Joint Learning Initiative on Human Resources for Health working group on Priority Diseases. He was also the coordinator for two civil society initiatives in Bangladesh called the Education Watch and the Health Watch. He is the co-recipient of the 'Innovator of the Year 2006' award from the Marriott Business School of Brigham Young University in USA and in 2008 he received the PESON oration medal from the Perinatal Society of Nepal. Dr. Chowdhury has published in the areas of public health, primary education, poverty alleviation and environment. He was the founding Dean of the BRAC University James P. Grant School of Public Health and is Professor of Population and Family Health at the Mailman School of Public Health of Columbia University in New York. Dr. Chowdhury holds a PhD from the London School of Hygiene and Tropical Medicine, an MSc in demography from the London School of Economics and a BA from the University of Dhaka in Bangladesh.

He is on the board and committees of several organizations and initiatives. Some of these include: International Advisory Board of the newly established Centre for Sustainable International Development at the University of Aberdeen, Independent Monitoring Board (IMB) of Global Polio Eradication Initiative of WHO, and International Advisory Committee of the International Field Epidemiology Training Programme (IFETP) in Thailand.



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Dr. Tang joined WHO in 2002 as a scientist. In his earlier years, he was active in building institutional capacity to promote health and in promoting the evidence-based health promotion approach particularly in low and middle income countries. In the mid 2000s, he played a lead role in renewing the focus of health promotion on promoting multisectoral action and tackling social and economic causes of poor health, including through the 6th Global Conference on Health Promotion held in Bangkok, Thailand and his work as a member of a core group responsible for developing the Strategic Objectives of WHO on addressing social determinants of health.

More recently he took the lead technical role in the 2009 United Nations Economic and Social Commission (ECOSOC)/WHO Annual Ministerial Review Regional Preparatory Meeting on Promoting Health Literacy that resulted in a recommendation in the 2009 ECOSOC Ministerial Declaration to countries to develop appropriate action plans to promote health literacy. The abbreviated version of the background paper of the Regional Preparatory Meeting was also published in an academic journal.

His role in the lead up to the UN HLM on NCDs included the coordination of the drafting of the Global Status Report on NCD 2010, and of the input from UN organizations to the preparation of the UN Secretary General's Report on Prevention and Control of NCDs.

He is an editorial adviser to the WHO Bulletin and was a member of the Ethics Review Committee of WHO from 2008-2011. Dr. Tang has published more than 50 articles and commissioned reports.

Prior to Dr. Tang's appointment with WHO, he taught at the School of Public Health at the University of Sydney from 1997 to 2001 where he co-founded the Masters of International Public Health Programme and played a leading role in building capacity to promote health in several countries, including the 3 year World Bank - AusAID funded Health Promotion Capacity Building Project in China (Health VII).

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Chapter

2

**MAJOR RISK FACTOR
CONTROL PROGRAMS
FUNDED BY THAIHEALTH:
ACHIEVEMENTS &
CHALLENGES**

Chapter 2

MAJOR RISK FACTOR CONTROL PROGRAMS FUNDED BY THAIHEALTH: ACHIEVEMENTS & CHALLENGES

38

What does ThaiHealth fund?

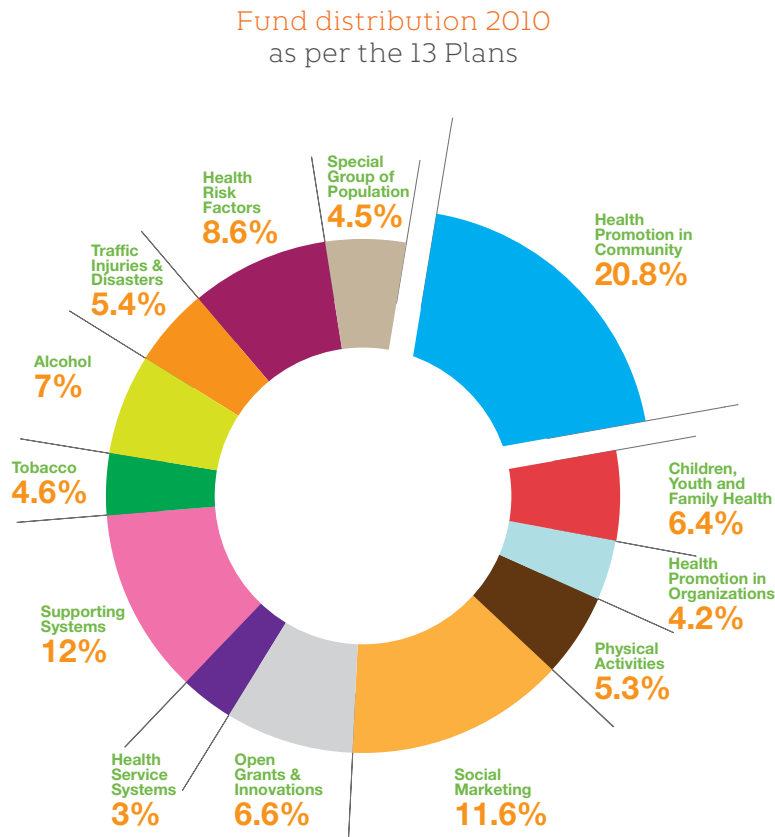
The money ThaiHealth receives from a 2% excise tax on the sale of alcohol and tobacco is distributed among 13 plans, ranging from tobacco and alcohol control to health promotion in communities, social marketing and system support (see Figure 2.1). The wide ranging and numerous programs that are funded under each plan represent the explicitly social model of health promotion that ThaiHealth adopted when it was set up in 2001.

When the Thai Health Foundation was established in late 2001 (fiscal year 2002) there were only seven plans, namely: tobacco, alcohol, traffic injuries, health risk factors, health promotion in community, physical

activity and supporting systems. Later, in 2003, another five plans were added, namely: child, youth and family health, healthy organizations, social marketing, open grants and health service system. The plan for specific population groups was added in 2009. Ninety-five percent of funding is spent on these 13 plans and 5% is spent on administration. In 2009, ThaiHealth invested a budget to promote health of 0.75% (3,489 million baht) of total national health expenditure, which is 434,974 million baht¹.

This chapter highlights some of ThaiHealth's achievements in modifying major health risk factors (tobacco and alcohol consumption, unsafe driving, physical inactivity and junk food)

Figure 2.1 Fund distribution, 2010



Source: ThaiHealth, 2011

and makes a number of recommendations to overcome specific challenges identified in the 10 -Year Review.

But first it is important to note the challenges related to attribution. It is evident that credit for achievements realized cannot be given to ThaiHealth alone: recognition is also due to the partners and other organizations working on the key program areas. Responsibility for the

success or failure of programs is also difficult to attribute because of the large number of partners involved, and because many community development interventions are small in scale. While ThaiHealth plays a catalytic developmental and investment role, it does not deliver programs, so there will always be multiple contributors to success (or failure) in any area of endeavour, be it major or minor. It is also difficult to attribute without

Tobacco consumption control

selective impact evaluation, including analysing complex interventions using quasi experimental evaluation design. This requires an analysis of counterfactual confounding factors.

It is important to note that ThaiHealth has never claimed sole credit for program outcomes and impacts. On the other hand, the Foundation is responsible for its approaches and funded outputs, processes and systems and so must share that credit.

It is also clear that there is considerable overlap between many of the 13 plans, and this makes program-specific attribution difficult. For example, tobacco and alcohol consumption are often linked, and alcohol is often involved in road traffic injuries. Some population groups have a higher prevalence of the major risk factors than others. Health promotion in communities and organizations cuts across all the risk factors, as does social marketing.

Smoking is the second most significant cause of death in the world and, without effective anti-smoking campaigns, it is predicted that by 2020 about 650 million people will die from smoking, mainly adults between 25 and 65 years of age². According to the latest global survey in 2007, 1.8 billion youths aged 10-24 years old had become smokers, and more than 85% of these were in developing countries.

When ThaiHealth was founded in 2001, tobacco use was killing 42,000 Thai people per year (115 persons per day or 6 persons per hour). In total, 29,502 million cigarettes, an average of 71 cigarette packs per person, were being smoked annually, and young adults (15-24 years old) and women were increasingly picking up the habit³. The estimated economic losses from smoking-related diseases in Thailand were about US\$ 414-1,200 million in 1995-96.

Between 2005 and 2006 tobacco expenditure decreased by 4,039 million baht (US\$ 128.79 million) and the level of tobacco taxation decreased by 394 million packs (18%). In 2009, 10.9 million or 20.7% of the population aged over 15 years smoked: 10.4 million men and 540,000 women⁴. This represents a 12.26 million drop in the number of smokers since 1991.

Measures to achieve results catalysed and funded by ThaiHealth

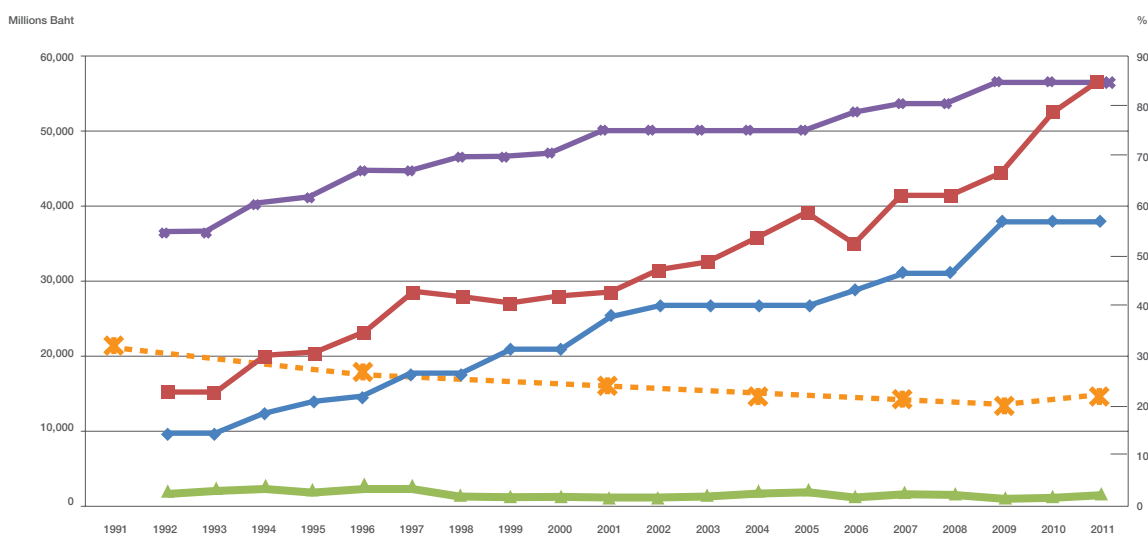
As discussed in Chapter 1, one of the key measures countries use to reduce tobacco consumption is to raise taxes on cigarettes. Since 2001 ThaiHealth has strongly advocated using taxation measures to reduce tobacco consumption: ThaiHealth advocates raising taxes from 80% to 90% (import price and factory price), that is 10-13 baht per pack for domestic tobacco and 15-17 baht per

pack for imported cigarettes, to maintain high tobacco prices. In 2008, a 20,000 million baht government revenue increase provided a boost to the national budget and at the same time potentially improved health status. Figure 2.2 shows the reduction in smoking rates in relation to the increase in the excise rate on tobacco.

Tobacco control measures in Thailand have been developed in line with international standards, particularly the Framework Convention on Tobacco Control (FCTC). ThaiHealth has advocated, funded and supported a number of policies

Figure 2.2 Excise tax rate, revenue and smoking prevalence, Thailand, 1991-2011

Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
■ Tobacco Excise Revenue (Millions Baht)	-	15,438	15,345	20,002	20,736	24,092	29,755	28,691	26,708	28,110	29,627	31,247	33,582	36,326	39,690	35,651	41,823	41,823	44,167	53,367	57,196
▲ Sales of Cigarettes Packs (Millions)	-	2,035	2,125	2,328	2,171	2,463	2,415	1,951	1,810	1,826	1,727	1,716	1,904	2,110	2,187	1,793	2,028	1,916	1,790	1,800	2,038
◆ Tobacco Excise Rate (%)	-	55	55	60	62	68	68	70	70	71.5	75	75	75	75	75	79	80	80	85	85	85
◆ Price per Cigarette Pack (Baht)	-	15	15	18	21	24	28	28	32	32	36	38	38	38	38	42	45	45	58	58	58
✕ Current Smoking Rate (% of the population aged over 15 years)	32.00						28.81				25.47			22.98			21.22		20.70		21.36



Source: Tobacco Control Research and Knowledge Management Center, Mahidol University

and programs aimed at achieving four objectives: reducing the number of people who smoke; reducing tobacco consumption per capita per year; controlling the use of other types of tobacco products; and minimizing exposure to second-hand smoke.

A few examples demonstrate the different types of policies that ThaiHealth has influenced. Since 2005, cigarette pack pictorial warnings have been required by the MoPH⁵ and cigarette and tobacco advertisements have been banned at the point of sale. Thailand was the third country in the world to take this measure⁶. In 1992 the Tobacco Control Act stipulated, among other actions, a ban on smoking in government buildings. By 2008 support services for giving up smoking (and alcohol consumption) were available across Thailand, offering telephone consultations and therapy organized by government, the private sector and the community. ThaiHealth has also supported a ban on smoking throughout hospitals in Thailand and in 2011 80% of hospitals were smoke-free.

More recently, ThaiHealth collaborated with the MoPH on a declaration to strengthen regulations about warning messages and signs on cigarette packs⁷. The 2010 declaration led to several compulsory changes to cigarette packaging. The number of pictorial warnings on cigarette packs was increased from nine to ten, tobacco ingredients (including the substances that cause cancer) had to be listed, the pictorial size was increased from 50% to 55% of cigarette pack surface, and messages about “low-tar” or “light” were banned. In addition, tobacco companies are now required

by law to print the name and number of the National Quitline (1600) on all cigarette packs. The declaration also extended the ban on smoking in public places.

In addition to advocacy efforts to change government policy, throughout its first 10 years ThaiHealth was actively involved in developing media and social anti-smoking campaigns together with the Action on Smoking and Health Foundation Thailand and other partners. For example, in 2008, supported by ThaiHealth, the anti-tobacco network drafted a handbook to establish a movie rating about tobacco smoking content.

While the strategies used by ThaiHealth to catalyse, advocate for and support tobacco control are comprehensive, there does not seem to be a specific focus on disadvantaged population groups, including people with disabilities, Muslims in the south of Thailand, stateless refugees and unregistered workers. However, there are a variety of activities applying art and using local/ethnic culture to empower ethnic and disadvantaged groups on the issues of health risks. This strategy has worked well because its content was created and communicated by groups within communities sharing the same dialects and beliefs.

Disadvantaged groups need to be included as partners in designing and co-developing strategies and programs because research has shown that community-based participation is ideally suited to healthy community projects⁸. These groups should be funded to work in partnership with the Action on Smoking and Health Foundation.

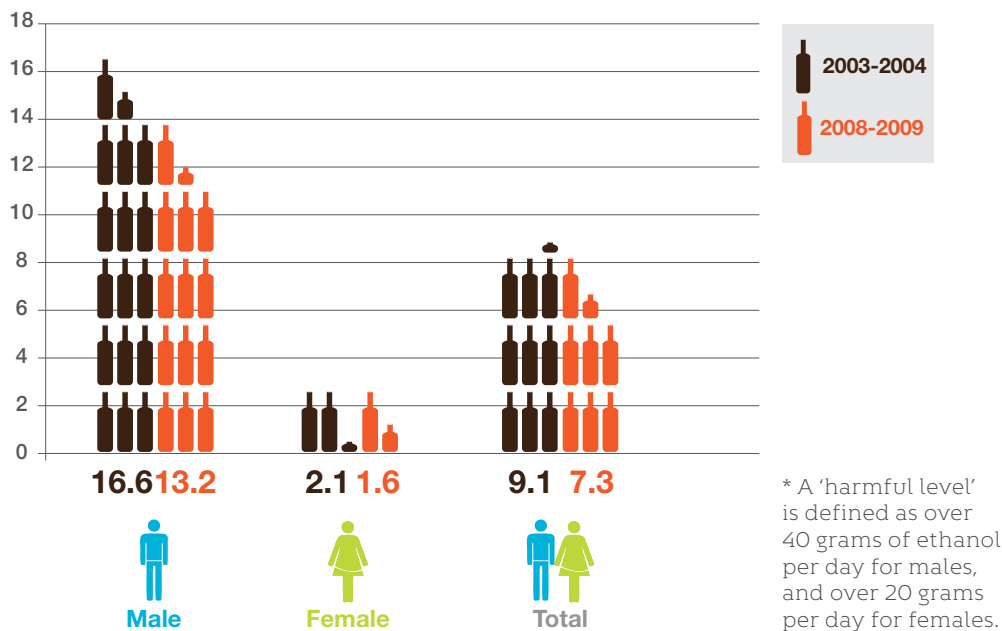
Alcohol consumption control

From 1989 to 1997 alcohol consumption among Thais nearly doubled, from 721.8 to 1,604.3 million litres. By 2001 the figure had risen to more than 1,926.1 million litres, but since then the number of Thais who drink alcohol has been on the decline. The number of alcohol drinkers decreased from 16.2 million in 2004 to 14.9

million in 2007. The rate of new female drinkers fell from 5.6% in 2003 to 1.8% in 2009, and the rate of new male drinkers decreased from 33.5% in 2003 to 23.3% in 2007⁹. Data also show a declining trend in the number of Thais who consume dangerous amounts of alcohol (see Figure 2.3).

Expenditure on alcohol consumption fell by 4,000 million baht (US\$ 127.55) in 2006, and revenue from alcohol taxes fell by 2% or 1,389 million baht in 2005-2006.

Figure 2.3 Percentage of Thai people aged over 15 consuming alcohol at a harmful level* per day, 2003-2004 and 2008-2009



Source: Health Systems Research Institute: Report of Health Examination Survey.

Between 2008 and 2011, the alcohol control program led to a 16,000 million baht (US \$510.20) reduction in expenditure on alcohol in real terms. Between 2008 and 2009, sales of beer and whisky dropped by 178 million litres, reducing domestic expenditure by almost 8%, which is projected to equate to a drop in overall consumption of alcohol of about 2,600 million litres.

This decreasing trend was confirmed by a report from the National Accounts Office, the Office of the National Economic and Social Development Board showing that after many years of increases, household expenditure on alcohol began to decline in 2008, decreasing from 154,998 million baht (US\$ 4,942.53 million) in 2008 to 139,337 million baht (US\$ 4,443.14 million) in 2010 (see Figure 2.4). National survey data show that household

consumption of alcohol fell from 32.7% of total household expenditure in 2004 to 29.3% in 2007. Meanwhile excise tax on four types of alcoholic beverages increased in 2009. Tax on white spirits increased from 110 to 120 baht per litre of pure alcohol; tax on blended spirits and special mixed spirits increased from 280 to 300 baht; tax on beer increased from 55% to 60% of price, and on brandy from 45% to 48%.

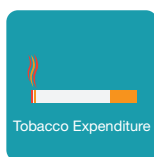
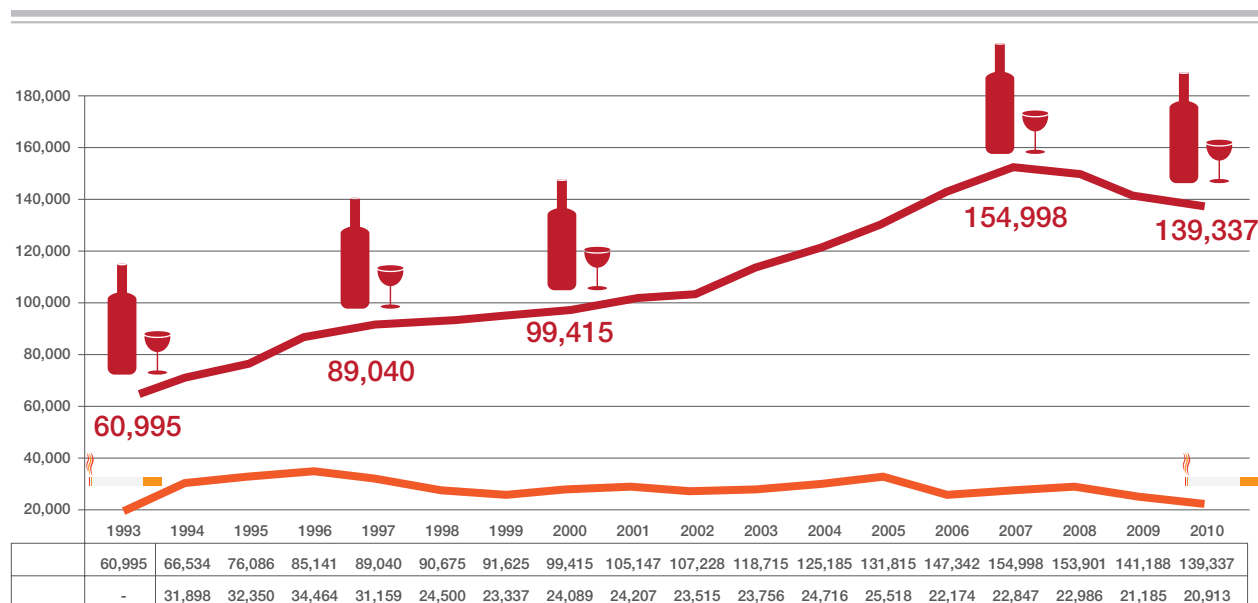
Because of the recent research evidence on the increased risk of cancer from moderate but regular drinking (see Box 2.1), the whole issue of what is a safe limit has come into question. While this makes the goal of reducing the population-wide volumetric consumption of alcohol important, reducing alcohol consumption in disadvantaged groups and population groups who work in high-stress settings should still remain as priorities.

Box 2.1

Studies show even moderate alcohol intake can be harmful

It is well established that any consumption of alcohol by young people is harmful because their brains are still developing¹⁰. However, evidence about safe consumption of alcohol is changing. A recent study suggests moderate consumption of alcohol by women increases the risk of breast cancer: women who consumed three to six drinks per week had a 15% higher risk of invasive breast cancer compared with non-drinkers. In addition, women who consumed at least 30 grams of alcohol daily on average (at least two drinks per day) had a 51% increased risk of breast cancer compared with women who never consumed alcohol¹¹. Another study found that moderate consumption of alcohol increases the risk of cancer in both women and men, by approximately 3% and 10% respectively, and negates the protective impact of alcohol on lowering the risk of stroke and heart disease¹².

Figure 2.4 Household expenditure on alcohol and tobacco, 1988 as reference price (unit: million baht)



Source: National Accounts Office, Office of the National Economics and Social Development Board.

Measures to achieve results catalysed and funded by ThaiHealth

Thailand's achievements in implementing alcohol control policies are world leading. As Figure 2.5 shows, there has been a dramatic rise in alcohol-related policies since ThaiHealth was established in 2001. Health promotion advocates in many countries find it difficult to generate government traction for tackling alcohol because of the size and influence of this industry. While tobacco control is now well established, governments continue to support the alcohol industry's entrenched sponsorship

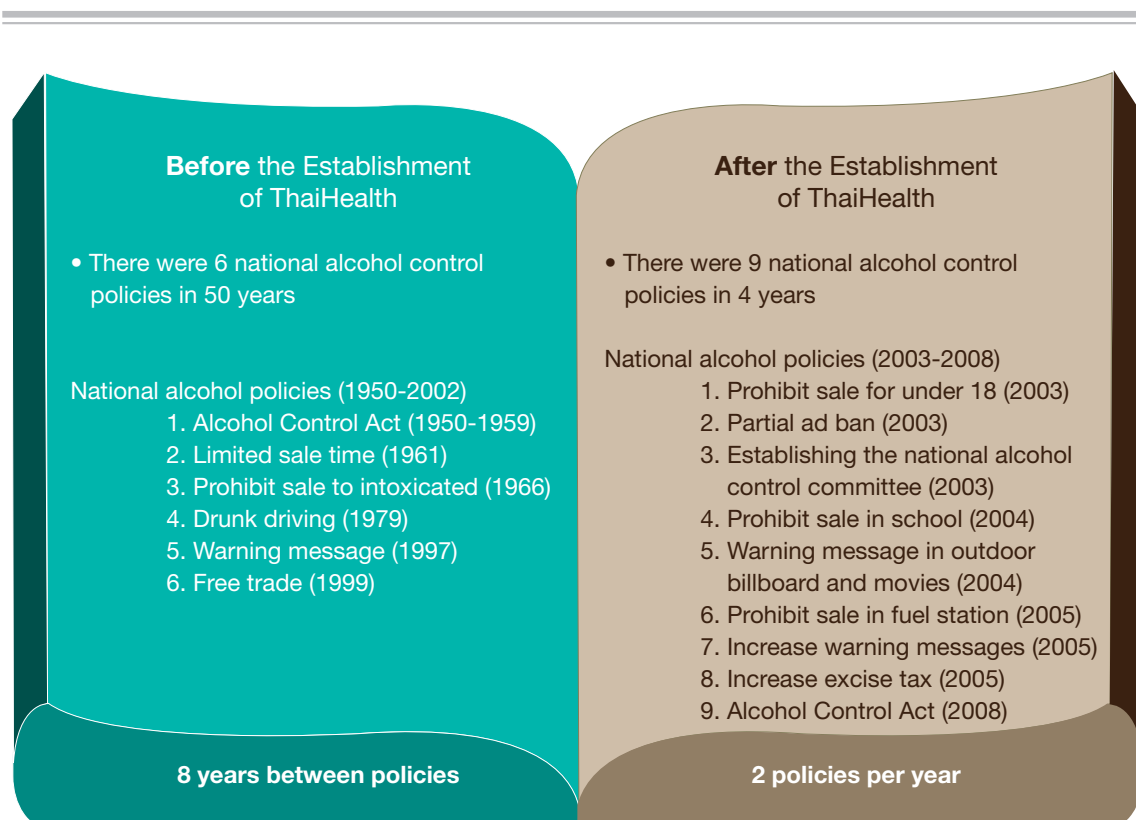
of sport, which generates enormous value in advertising to the industry. Similarly, governments are wary of using price increases as a lever to reduce consumption, even though, as with tobacco pricing, the efficacy of this approach is well established. Despite these challenges, ThaiHealth has successfully advocated using taxation measures to reduce alcohol consumption and potentially control the number of new drinkers. Taxing alcohol has also generated considerable revenue (as much

as 70,000 million baht, or US\$ 2,332 million, per year) which the government has been able to use to boost the national social welfare budget.

A few examples show the broad range of alcohol control policies pursued by ThaiHealth between 2001 and 2011. In 2003 ThaiHealth successfully persuaded the Thai Cabinet to ban alcohol advertising before 10 p.m. on radio and television, and on billboards close to educational institutions. That same year also saw the launch of the annual “No alcohol during Buddhist Lent” campaign, during which

more than 40.4% of drinkers abstained from alcohol. In 2009, an AC Nielsen poll revealed that 61% of the population aged 15-55 stated that they were aware of the campaign and intended to stop drinking at this time. AC Nielsen estimated that between 61% and 75% of the population who were aware of the campaign actually changed their behaviour and stopped drinking, and 40% of both drinkers and non-drinkers stopped giving alcohol as gifts.

Figure 2.5 Changes in alcohol policies after the establishment of ThaiHealth (2001 - 2008)



Source: Centre for Alcohol Study, Thailand.

In 2007 the Minister of Public Health and all strategic partners in alcohol control, catalyzed by ThaiHealth, launched a major advocacy campaign to build support for the draft Alcohol Control Act. The campaign led 13 million people to sign a petition in favour of the draft, which was comprehensive and covered all crucial aspects. The parliament passed the Alcohol Control Act in 2008 and, since then, it has become the dominant mechanism influencing rules and regulations related to alcohol control in Thailand. In 2009 the National Alcohol Control Committee banned sales of alcohol during significant Buddhist days and the Thai New Year and since 2009 ThaiHealth has run a joint campaign with the MoPH and the Ministry of the Interior banning the inclusion of bottles of alcohol in New Year gift baskets¹³ or as gifts, particularly to policemen.

Since 2009 drinking alcohol in or on vehicles (for example, in the back of pickup trucks and on motorbikes) has also been banned since intoxicated passengers can cause accidents.

ThaiHealth has campaigned hard for alcohol-free zones (no drinking, advertising or selling). In 2007 ThaiHealth supported the Ministry of Education when it made educational institutions across Thailand “free from alcohol consumption and sales” and also the Sangha Supreme Council in 2008 when it declared that all temple events and festivals would be alcohol free. A memorandum of understanding between the Control of Diseases Department, the MoPH and governors in 75 provinces signed in 2010 further increased the number of alcohol-free zones in public areas.

In the future, in line with the approach that shows the efficacy of working with population groups themselves to devise strategies¹⁴, ThaiHealth could expand its work with

young people’s organizations to devise and implement their own strategies for alcohol control, which could be funded from the alcohol plan budget.

ThaiHealth’s alcohol control efforts might also benefit from being systematically extended to local communities and could be raised in the community plan. This could be achieved by asking the Community Plan Administrative Committee (PAC) to address the question of alcohol control at community level via a community process. What would local government organizations (LGOs) including those at Tambon level recommend to control alcohol consumption in their communities? Based on the answers, trials could be developed and evaluated carefully. Joint oversight by alcohol and community PACs would also drive a focused process that would promote integration within ThaiHealth.

The relationship between alcohol and teenage pregnancy, domestic violence and other non-road injuries should be explored and included in plans and programs. There are a few best practices at Tambon level that have integrated interventions on the health risk impacts of alcohol drinking among teenagers with sexual violence and teenage pregnancy. Some practices have been adopted by other Tambons to tackle these inter-related problems.

It is most important to evaluate the impact of alcohol control programs, especially social marketing campaigns, to ensure they are having an impact on the target group. For example, if an alcohol control campaign is supposed to target young people and heavy drinkers, but instead only changes behaviour in moderate drinkers, then it would need to be realigned to ensure that it meets its stated aims.

Road safety and accident prevention

As with tobacco and alcohol consumption, the annual number of road accidents and related deaths have been in decline since 2004 (see Figure 2.6). Between 2005 and 2008, the number of road accidents decreased from 122,040 to 88,713. In contrast, between 1998 and 2004 the number of road accidents had increased from 73,737 to 124,530. Furthermore, the number of deaths from vehicle accidents declined from 22.9 per 100,000 in 2003 to 16.82 per 100,000 in 2010, and half of those fatalities were 15–35 years old¹⁵. The key factors were driving under the influence of alcohol and not wearing seat belts and helmets. In 1996–97, 26% of traffic accidents were related to drink driving. Moreover, a Thai Road Foundation study¹⁶ found that during 2003–2009, the proportion of drivers wearing seat belts increased from 22% to 34%, but was still low among passengers (8% to 13%). In addition, the number of people wearing helmets decreased slightly, from 17% to 15%.

In terms of economic benefit, the loss due to injuries and deaths was reduced by 9,200 million baht (US\$ 293.36 million) between 2006 and 2008. In the same period ThaiHealth spent only 665 million baht (US\$ 21.2) on road safety and accident prevention.

In 2009, AC Nielsen reported that 92% of the population aged between 15 and 55 were aware of the road safety campaign, so the message had reached at least 10 million people across the country. AC Nielsen also reported that 84.5% of them intended to change their behaviour as a result.

Unfortunately, the cross section survey by AC Nielsen did not include a question as to whether respondents actually changed their behaviour. ThaiHealth implemented several measures on road safety, while a media campaign during the major festivals has been used to raise public awareness of the seriousness of road accidents.

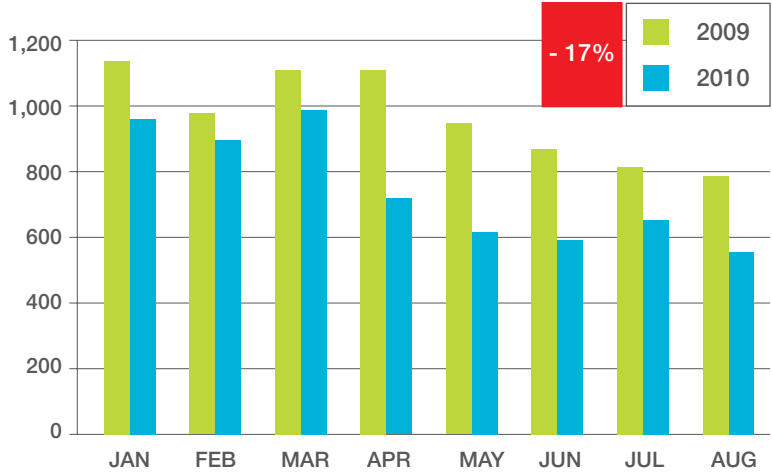
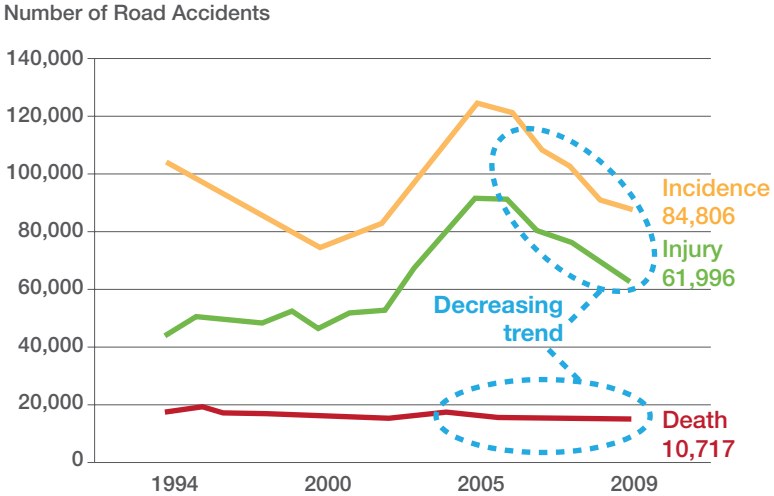
Measures to achieve results: catalysed and funded by ThaiHealth

ThaiHealth has supported the development of and funded partners to deliver a successful comprehensive road injury reduction strategy. Part of the strategy is ThaiHealth's own advocacy for progressive steps towards road safety based on worldwide evidence.

For example, ThaiHealth jointly advocated (with the Ministry of Transport) the establishment of the Road Safety Centre in 2003 and among other things supported the Centre to assist 69 provincial offices to make plans for and work on improving road safety. In 2009, with the help of ThaiHealth, an integrated plan for a more systematic approach was developed and the Centre's status was strengthened by the Prime Minister's Office's regulation on road safety and accident prevention¹⁷. The Road Safety Master Plan 2009–2012 aims to reduce deaths from vehicle accidents from 19.8 per 100,000 in 2009 to 14 per 100,000 in 2012.

The Road Safety Research Centre was set up in 2007 in order to support policy advocacy and social movements with research evidence and knowledge about how to make the campaigns more effective.

Figure 2.6 Traffic accident trends in Thailand



Year	Death rate		Injury rate	
	Per 100,000 people	Per 100,000 vehicle	Per 100,000 people	Per 100,000 vehicle
2003	22.40	5.48	128.52	30.73
2004	22.21	6.67	151.94	45.65
2005	20.60	5.69	151.18	41.81
2006	20.21	5.12	132.61	33.57
2007	19.82	4.87	125.37	30.85
2008	18.24	4.38	112.10	26.90
2009	16.87	3.94	97.59	22.81

Source: Royal Thai Police, 2011; National Road Safety Centre, 2011.

In December 2007, in cooperation with the Ministry of Justice, ThaiHealth successfully advocated for an increase in penalties for drunk driving from a fine-only to a fine plus probation. In 2009, ThaiHealth's work with the Ministry of Interior led to regulations on the safe upper limit level of alcohol in blood while driving and to increased penalties.

In 2003-04 ThaiHealth developed a pilot project with rescue teams at the district level in five provinces. Their tasks were to develop road safety campaigns and to assist with injuries from road accidents. Based on evidence from the pilot provinces that the number of road accidents had been reduced by 2.8-5.2 times compared with those provinces that were not in the project, the pilot projects were extended in 2008 with the cooperation of 2,806 local governments to cover the whole country.

ThaiHealth also worked with Highway Police to launch the Road Safety Campaign during annual festivals such New Year (January 1) and Thai Traditional New Year (April 13). The accident prevention task forces were set up at central and provincial levels, with collaboration from various agencies both public and private, coupled with social media campaigns, such as "Drink Don't Drive" and "Think Before Starting (your vehicle)".

A strategy could now be developed with Tambon Administration Organizations and the Bangkok Metropolitan Administration to make

road injury a priority at LGO level. Local data, such as accident rates and trends, would need to be collected as a core tool for planning interventions, which will be different for different sized communities.

It would also be valuable to compare data with other countries. In addition, it is important to ensure that all measurement of intention to change behaviour as a result of social marketing campaigns is made in relation to data on the numbers of people who actually changed their behaviour.

Road safety data is full of confounders and in many countries reductions in deaths and injuries per motor vehicle are partly due to improved vehicle safety. ThaiHealth acknowledges that this is also part of health promotion in the area of road injury reduction. Safety issues such as better vehicle design, advocacy to ensure use of child seats, seat belts, helmets for motor bikes, and so on, are important aspects of the overall strategy used by ThaiHealth.

Gaining some understanding of the contributions of different aspects of the road injury reduction program would require ThaiHealth to control for factors in a quasi-experimental design impact evaluation, to understand the impact of ThaiHealth's work on safety policy in comparison to efforts in areas such as social marketing, education and community development.

Sports and physical activity

Although the link between physical activity, health and well-being is well documented, less than one third of the Thai population exercises on a regular basis (three to five times per week). In 1997, the exercise rate was 30.7%, and by 2001 the rate had decreased to 24.2% before increasing to 29.1% in 2004 and 29.7% in 2009. Children aged 11 to 14 years exercised the most, while people of working age (25-59 years old) had the lowest exercise rate¹⁸. Male exercisers in all occupation groups had slightly higher exercise rates compared with female exercisers, except for males from 15 to 24 years of age who had 20% higher exercise rates than females.

Measures to achieve results catalysed and funded by ThaiHealth

The main strategies of the Physical Activities Plan are to promote physical activity and create conducive environments. There is some focus on important structural reform in the area of sports sponsorship by alcohol companies and a systematic approach to drowning and diving injuries. ThaiHealth has collaborated with various stakeholders such as public transportation agencies, local government agencies and city planners to create healthy spaces to encourage more people to take daily exercise and many settings are engaged to provide exercise opportunities. Some examples are highlighted in the following paragraphs.

National level sporting events in all categories have been declared “Alcohol Free Sports Events” and 14 sport associations have chosen to refuse sponsorship from alcoholic beverage companies¹⁹.

With ThaiHealth’s support, in 2006 the Ministry of Education announced a policy increasing the length of the physical education curriculum from one to two hours a week²⁰. In addition, physical education instructors were trained at 60 pilot site schools nationwide²¹, and two after-school programs were developed: the After School Exercise Program in cooperation with five large industrial estates, and the After School Sports Program in cooperation with the Office of the Basic Education Commission, the Ministry of Education and LGOs²².

With drowning the number one cause of death among Thai children younger than 15 years of age, ThaiHealth worked to create the Learning to Swim to Strengthen Thai Children Program, an innovative approach to reduce drowning fatalities among Thai children²³.

At the urging of ThaiHealth and the Ministry of Tourism and Sports, 19 provinces established exercise programs and developed mechanisms to promote exercise²⁴ and LGOs nationwide supported the use of public venues as exercise locations. ThaiHealth also established the Exercise in Gardens Program, in cooperation with the city of Bangkok, to organize activities at 10 public parks in Bangkok and adjoining areas²⁵.

A number of specific campaigns based on exercise were also established. For example, cooperation with sports media saw the development of the “Exercise is Magic Medicine” Program, which aimed to create



health trends through entertainment businesses with celebrities and model families acting as presenters for the program. More than 20,000 people participated in this program²⁶.

Finally, the “Thai People without Pot Bellies” Network used exercise as one of its strategies to control weight and stimulate knowledge to improve policies and environments that are conducive to weight reduction. Participants in the program numbered 2.9 million people, and 80% were able to reduce their weight beyond set limits and to control their weight using three principles involving food, mood and exercise²⁷.

Included in the mix of programs and actions are some short-term social marketing campaigns, focusing on behaviour change only, which may not yield any sustainable changes. There is a need for measurement after a campaign concludes to assess this. Moreover, the lack of robust evaluation design means that it is difficult to ascertain which parts of the exercise program have had an impact on increasing rates of exercise.

The issue of participation in sport, as well as exercise for disadvantaged populations and communities, needs to be considered as

this brings in a focus on social determinants. Research showing the health status improvement from belonging to a social network makes the development of strategies to promote participation in sport among disadvantaged populations an area for future focus²⁸. In this regard, ThaiHealth has allocated approximately 15% of the budget of the Physical Activities Plan to supporting exercise and sport for disabled persons and disadvantaged groups, as well as improving accessibility for disabled persons to public sport venues.

Acknowledging the co-morbidity relationship between exercise and mental health and the increasing prevalence of eating disorders among young women, ThaiHealth should consider developing programs with mental health networks and women’s groups to promote exercise and sports participation. ThaiHealth might also wish to consider the efficacy of relating exercise to food and nutrition and integrating the two areas in relation to healthy weight.

Other health risk factor control efforts

In addition to the major risk factors — smoking, drinking alcohol, dangerous driving and physical inactivity — there are several other important issues that ThaiHealth invests in as part of its mission to promote the health and well-being of all Thai people. This section describes three program areas: reducing children’s sugar intake, protecting consumers and promoting digital safety for children.

Reducing children’s sugar intake

A 2006 survey of sugar consumption behaviour among primary school children in grades 5 to 6 (11-12 year olds) found that each child consumed on average 20 teaspoons of sugar per day, mostly from soft drinks: this is three times higher than the dietary requirement. ThaiHealth has supported a number of initiatives to address this health risk. For example, plans for a campaign to reduce children’s sugar intake, developed in cooperation with the Office of the Basic Education Commission, provided information to participating schools that abstaining from one bottle of carbonated beverage a day for one month would reduce a child’s weight by one kilogram. Other evidence showed that schools that did not sell carbonated beverages reduced consumption of carbonated beverages per child by seven-fold compared with schools that sold carbonated beverages²⁹. The campaign was effective and in 2008 schools became

carbonated-beverage free³⁰. This followed legislation in 2005 banning companies from adding sugar to formula and supplement foods for infants and young children³¹.

The achievement of carbonated-beverage free schools is a good example of issue-specific advocacy leading to systematic change. ThaiHealth was eventually able to build on this single issue and develop a comprehensive food and nutrition policy that covers: (1) junk food advertising and marketing, (2) pricing and taxation for healthy locally grown food compared with imported junk food and franchised fast food chains, (3) food labelling, (4) provision of and access to healthy food options in schools, workplaces and other settings, and (5) social marketing.

Consumer protection

Consumer protection is an often forgotten but nonetheless important area of health promotion, particularly in relation to standards for products and food. Among the related initiatives that ThaiHealth has facilitated are:

- promoting an enactment of the Article 61 of the 2007 Constitution by advocating the establishment of an independent organization to protect consumers³²;
- advocating that citizens, in their role as consumers, should be effectively protected under laws governing liability for unsafe products³³; and
- advocating for the Office of the Consumer Protection Board to announce measures governing water cooler machines soldered with lead, and to forbid schools from using water cooler machines containing lead, following the discovery that up to 10% of schools used water cooler machines that contained lead³⁴.

ThaiHealth may now wish actively to encourage the independent consumer organization and the government to focus on legislation and regulation of standards.

A safe digital world for children

The safety of children using the Internet and online tools has been identified as a relatively new and growing problem. In 2009, 9% of children at primary and lower secondary schools were found to be addicted to games, a two-fold increase from 2006. ThaiHealth activities in this area illustrate its ability to work effectively across multiple sectors. For example, in cooperation with the Ministry of Social Development and Human Security, ThaiHealth participated in developing private data protection for children in the online world. Some related activities undertaken with the Ministry of Culture include advocating for the systematic regulation of websites and games with inappropriate content, organizing a Good Game Exhibition to create healthy digital online venues for children and youths, and facilitating the opening of an Internet Café and Game Shop Hotline to receive reports of inappropriate behaviour and complaints from game shop operators³⁵.

ThaiHealth cooperated with Ministry of Education in establishing the Communications and Creative Digital Contests for HRH Princess Sirindhorn Trophy, which rewards healthy digital online venues, and contributing to the creation of a safe information technology environment through the Net Knowledge Manual and the Cyber Age Parents' Manual. Work with the Department of Mental Health resulted in the Teenage Mental Health Institution introducing a course called Parental Care for Children in the Cyber Age. A survey

of parents participating in the course showed that 79% were able to reduce their child's gaming addiction. More importantly, where a child's gaming addiction was reduced, the reduction was due entirely to a shift in parents' behaviour. For example, being more open to their child's opinions and establishing good communication with their child resulted in a 91% improvement³⁶.

Digital safety is one example among others of a strong social determinant that many countries have not yet recognized as a health promotion issue. While ThaiHealth is showing leadership in identifying these less obvious issues and developing practical activities to deal with them, the choice of actions appears to be opportunistic and random. This raises the question of how many such issues ThaiHealth can effectively tackle. One possibility is for ThaiHealth to initiate action and then pass it over to others to carry forward. With the development of the Quality Learning Foundation (see Chapter 3) issues such as digital safety may become an area for such a spin-off organization to encompass into its programs.

Recommendations

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All major risk factor programs

- Include a specific section on disadvantaged population groups in all existing and future risk factor plans, including tobacco, alcohol, road injury and exercise.
- Fund and include as partners organizations representing the disadvantaged and other population groups, and make them leaders in design and implementation.
- Develop and roll out capacity building for non-government and government partners

about how to work with organizations representing disadvantaged groups.

Alcohol and integration with community and other risk factors

- Systematically include local communities as part of alcohol and community plans.
- Design a process for developing an alcohol control strategy, led by the alcohol and community PACs together with LGOs and Tambons.
- Implement and evaluate trials using action research and aggregated models with joint oversight by alcohol and community PACs
- Develop programs across ThaiHealth plans to measure co-morbidities between teenage pregnancy and alcohol, domestic violence and alcohol, and other injuries apart from road accidents and alcohol.

Road injury prevention

- Jointly develop (between community and road injury plans) a systematic strategy aimed at making road injury a priority at LGO level including Tambons and the Bangkok Metropolitan Administration.
- Improve the collection of local information and data as these are essential tools for planning local interventions, as well as for action research and designing aggregated evaluation models.

Physical activities, sports, food and nutrition

- Develop an integrated exercise, food and nutrition approach to focus on healthy weight, ensuring that unintended harm is not done by increasing rates of eating disorders.
- Consider establishing a healthy weight research centre focusing on exercise, food and nutrition data, policy, evaluation and intervention research. Include social

epidemiology and studies that assess the health status improvement from belonging to social networks such as sporting and exercise groups.

- Develop strategies with disadvantaged populations and communities to ensure that these groups are included in all ThaiHealth supported exercise and sports programs.
- Make mental health promotion a new focus for exercise and sports inclusion programs based on the co-morbidities between exercise, food and nutrition and mental health (and eating disorders).
- Build on the work focused on sugar/soda as a single issue and develop a comprehensive food and nutrition policy/strategy including issues such as:
 - junk food advertising and marketing, especially to children;
 - pricing and taxation of healthy locally grown food compared with imported junk food and franchised fast food chains;
 - improving food standards, regulation and labelling;
 - provision of and access to healthy food options in a number of settings including schools and workplaces; and
 - social marketing.

Consumer protection

- Continue to work with consumer organizations and the government to develop a consumer protection strategy that includes issues such as product standards to prevent home and community-based injuries.

Digital safety

- Consider transferring responsibility for digital safety among young people to the Quality Learning Foundation.

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Chapter

3

**PROMOTING HEALTH
IN COMMUNITIES AND
ORGANIZATIONS**

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PROMOTING HEALTH IN COMMUNITIES AND ORGANIZATIONS

Health promotion in communities

60

Promoting health at the community level has been at the core of ThaiHealth's work since its inception. The objectives of ThaiHealth's community plan are to drive local communities to establish well-being systems managed by communities, to develop measures to solve problems, and to create strong leaders and processes to drive dynamic well-being development work. Another important objective is to transfer good practices in health promotion, whether within Thailand or by adopting overseas experience.

One example of a ThaiHealth funded project is the Pak Poon model of local administration in the town of Nakorn Si Thammarat, which

includes a comprehensive plan for promoting health in the community. The Pak Poon model comprises early childhood development programs, support units for disabled children, alternative learning programs for drop-out students, programs oriented to reducing obesity among children and ageing people, and programs to encourage people to live self-sufficiently by having their own gardens. Nakorn Si Thammarat's health service centre has played a very active role in health promotion. Under the Pak Poon model, among other things, staff capacity to care for elderly people with chronic diseases has been strengthened and the emergency unit improved. ThaiHealth has supported Pak Poon since 2008 in order

to facilitate adoption of the model by other towns; and it has established another learning centre in Khun Talay District where local administrations from across Thailand can go to compare and exchange ideas and practices.

Holistic health learning centres have been established in more than 200 villages, fostering capacity building and local ownership. Such learning centres supported by ThaiHealth must agree to engage with a network of at least 20 local administrative authorities. This process should lead to more local authorities themselves becoming learning centres. While developing infrastructure of this kind can be a sustainable facilitator of good quality community development, these centres need to be rigorously evaluated. As the health learning centre model unfolds, action research evaluation should be used to capture exactly what is being done, what outcomes are being achieved and what could be improved. The number of health learning centres presents an opportunity for benchmarking the performance of the centres against each other, and using this process to transfer what has been learned. This approach would also

satisfy what will necessarily become an escalating demand for evaluation by applying a useful method that will support continuous learning and improvement.

Box 3.1 briefly describes a number of other examples of community-based programs supported by ThaiHealth. Given its importance, all aspects of community development must be evaluated appropriately, and knowledge transfer across the whole community program needs to be strengthened and systemized. This is the only way for a community-based approach to be fully accepted as a legitimate value-for-money health promotion method. These issues are expanded on in Chapter 4, which focuses on methods and approaches.

The rest of this chapter elaborates on various programs supported by ThaiHealth that are geared towards specific communities of population groups, such as Thai Muslims and the disabled, the community of women, communities of workplaces, and places of worship. The chapter concludes with a review of health promotion programs within the health system.



Box 3.1

Examples of community-based programs supported by ThaiHealth

Local Well-Being Funds, Sustainable Agriculture Systems, and Reformed Local Planning Processes (in 2007)

An important part of ownership, prioritization and sustainability of health promotion by local communities is ensuring local financial contributions.

The **Pleasant Tambon Program** has been initiated in 336 Tambons and covers 1.7 million people¹. This is a complex program where each Tambon defines the steps to take towards community strengthening and including often marginalized groups such as people with disabilities, impoverished families, refugees and immigrants. The program needs to be evaluated using social epidemiology to pick up any beneficial effects addressing common health risk factors that are not specifically included in the Tambon's interventions.

Senior Citizen Volunteer Caregivers provide care to 6,000 senior citizens across 204 Tambon Administrative Organizations. This initiative is a realistic approach to an ageing population. Programs need to be aggregated (within provinces or regions) and evaluated in terms of impact on health and well-being of senior citizens. It would be particularly valuable to assess the health benefit to older people where volunteers are facilitating and assisting them to participate in their local communities^{2,3}.

The Community Radio Network was launched in 2001, and ThaiHealth started to support the network in 2005. By 2009 there were 303 stations providing information and offering possible solutions to problems posed by local citizens. The development of local communication networks is an important contribution to addressing the social determinants of health. Many of the community broadcasting stations now broadcast health information.

The **Five Self Sufficient Villages** project was launched in 2011 by ThaiHealth and local partners. Its objectives are: (1) to develop systems at the local level that allow communities to manage their own well-being; (2) to set up 30 learning centres per year that focus on the four well-being dimensions; (3) to transfer knowledge to 700 other local government organizations per year.

Many village communities identify the issues of economic sustainability and environmentally safe farming methods as priorities. ThaiHealth has rightly supported these Tambon-developed initiatives, not only because they were identified by local communities, which is core to the community development method, but also because environmental issues including the direct health consequences of chemical use in farming are important.

Paying attention to the special needs of disadvantaged groups

Working with different disadvantaged population groups is a vital area for ThaiHealth as part of its mandate to address the social determinants of health. The prevalence of smoking, alcohol consumption and road injuries, among others, is higher in disadvantaged groups than in the general population. The regressive nature of ThaiHealth's funding base lends impetus to the active direction of funds to disadvantaged groups to reduce behavioural risks.

The current approach is to apply the same empowerment principles that ThaiHealth applies to communities: that is, ensuring that groups themselves decide on their own priorities, with ThaiHealth facilitating the process and outcomes. This approach stands in contrast to that which treats these groups as passive recipients of the wisdom of the experts. In countries such as Australia, for example, health promotion work with indigenous communities is now led by indigenous health leaders, but for other disadvantaged population groups such as people with disabilities, people with a mental illness, refugees and impoverished communities, risk factor programs are more usually imposed top down. Not only does this top down approach fail, it has a negative impact in further disempowering these groups.

In Thailand, disadvantaged population groups include cultural minority groups, the poor and marginalized, the disabled, informal workers, stateless people, and people affected by conflict and violence, among others. This section focuses on Thai Muslims, the disabled and stateless people to illustrate ThaiHealth's involvement in this area.

Thai Muslims

ThaiHealth has a long-term interest in the health and well-being of culturally diverse communities, having supported several now well-established initiatives in the early stages of their development. Among these is the Health Promotion for the Muslim Community program, focusing on promoting healthy lifestyles and providing a better understanding and management of public healthcare services. This program seeks to remedy the gap in healthcare services for the more than 5 million Thai Muslims who are concentrated in the southern border provinces.

ThaiHealth initiated the creation and promotion of specialized health programs in Muslim communities through cooperation with the Thai Muslim Network led by local Muslim leaders to promote health through an improved understanding of the religious belief system and different health lifestyle and cultural behaviour. This effectively extends the work of the MoPH by providing services to a wider population in a culturally sensitive manner. This has been so successful that a Muslim leader has become a board member of ThaiHealth.

ThaiHealth has addressed some of the inequalities experienced by Muslim groups by promoting the inclusion of circumcision for Thai males as part of the benefit package of the Universal Coverage Scheme (in 2005) and the drafting of the Za kat Fund Act to improve managerial efficiency and to ensure that the fund will be equally distributed to all eight beneficiary groups, especially the disadvantaged and poorest of the poor in the Muslim community, as articulated in the Qur'an.⁴

ThaiHealth's decision to focus on the southern border provinces followed a direct request from the government. Due to the violence and conflict in the region a different working approach was required, outside the formal health structures. ThaiHealth established the Health Research Centre at the Prince of Songkla University to develop and implement strategies guaranteeing access to basic health services even in areas of unrest. ThaiHealth also funded youth programs run by music, sports and art organizations in 44 Tambons in these provinces, with the objective of promoting peace and unity in the area. It also supported networks for civil servants and their families who were affected by the unrest.

ThaiHealth's approach addresses social determinants of health by including highly disadvantaged areas and communities, with carefully thought through programs that address cultural change and support. It is notable that ThaiHealth undertook all of this work with the communities themselves as partners. This approach should be replicated with all disadvantaged communities. The recently established Health Research Centre at Prince Songkla University will hopefully be able to support realistic and helpful models of evaluation of these programs.



Disabled people

ThaiHealth's program on the health of disabled people developed a training program and taught visually impaired people how to use white canes, as a pilot project. A white cane costs less than 450 baht, but the cost of training is about 20 times higher as there should be at least 120 hours training over a period of 20 days. Later, the pilot project was scaled up and adopted by the MoPH with the support of 770 million baht from the National Health Security Office (NHSO) for the six years from 2010 to 2015. The aim is to train all 80,000 blind people.

ThaiHealth participated in promoting the rights of disabled people under Article 30 and Article 54 of the 2007 Constitution, unveiling a tourism map for differently disabled people and senior citizens in the country's five regions with the cooperation of the Tourism Authority of Thailand⁵.



Stateless people

ThaiHealth has advocated for a systematic resolution to the problem of stateless people's lack of access to health-care services. On 20 March 2010, the Cabinet allocated 472 million baht (through the Office of the Permanent Secretary of the MoPH) to hospitals along border areas in 15 provinces to provide health-care services to 457,409 stateless people. This is to ensure the right to health and universal coverage to all people living in Thailand, regardless of their citizenship. This is another important achievement as access to health care is an important social determinant of health for stateless people in border communities.

As one aspect of a whole plethora of access issues for disabled people, access to tourism might be considered a lower priority than other access issues that also relate to social determinants of health. Examples of these include access to early intervention at the earliest onset of disability, access to high quality mainstream education, access to jobs in mainstream work, universal design that promotes access to buildings, and accessible mainstream transport. It is also important for ThaiHealth to include disabled people in its major risk factor plans for tobacco, alcohol, road injury control and exercise promotion, and to work with organizations of people with disabilities as partners.

In summary, reducing the prevalence of risk factors may never be identified as a top priority while more pressing issues require attention. Yet this must not be used as a reason for not addressing the higher risks in disadvantaged population groups. It is important for organizations of disadvantaged population groups to be represented as partners so that their knowledge and experience about what is likely to work in their populations are fully utilized. These organizations need to be funded so they can lead in the implementation of interventions aimed at the groups they represent.

Making the case for investing in women's and girls' health



Women have been the beneficiaries of many of ThaiHealth's programs and projects. For example: the project to empower single mothers; the project on health and media literacy; the project on women as consumers; the project on women as income independents, and the project to prevent teenage pregnancy (see Box 3.2).

The women's health program was created in 2009, and one of its first major achievements was to enforce the application of the Domestic Violence Victim Protection Act, B.E. 2550 (2007) in a trial against a woman who had killed her husband. Under this Act, the court is required to consider information relating to violence suffered by women prior to their offence. As a result, judges in several cases

reduced the penalties imposed on women, who would previously have been subjected to harsher penalties under the Criminal Code.

It is difficult to assess the women's health program as it wasn't included as a plan area. However, specific interventions such as the focus on teenage pregnancy may require a more comprehensive women's and girls' health promotion strategy to achieve greater impact. Moreover, the lack of such a strategy may explain the exclusion of some important areas such as rape, prostitution and education of girls. A women's health promotion strategy is important, not only for improving women's health status, but for improving the health of the whole community.

Box 3.2

Preventing teenage pregnancy

MoPH statistics indicate that from 2003 to 2008, teenage pregnancy increased from 39.2/1000 teenagers to 50.1/1000 teenagers. In response, the ThaiHealth Board authorized the establishment of measures to prevent teenage pregnancy⁶. Short-term measures included developing programs to promote life skills among teenagers, improved communication to create social awareness, and development of prevention measures against unsafe abortions. ThaiHealth also catalysed a national level committee, chaired by the Prime Minister (or a representative) to link relevant agencies and organizations.

Another measure was to create channels to provide sex education to teenagers through the Talk about Sex website at <http://talkaboutsex.thaihealth.or.th>. In 2011 the website had on average 15,025 visitors per month by IP address, and was ranked 12th among educational websites⁷. In addition, ThaiHealth has, in cooperation with the Ministry of Education, facilitated the dissemination of information to 900 public libraries nationwide under the supervision of the Office of the Non-Formal and Informal Education Commission. Information was also disseminated to parent networks at academic institutions in 12 education districts, comprising 122 schools.

ThaiHealth has also hosted a Healthy Sexuality Exhibition, with the cooperation of the National Science Museum and UNESCO, in order to disseminate information about sexuality to young people, parents and academic staff. More than 600,000 people attended the exhibition in 2010. Mobile exhibitions were also sent to country provinces, with more than 200,000 people attending⁸.

Finally, the Up to Me Program, developed with the cooperation of the Ministry of Education and the international NGO PATH, has produced a set of short films and handbooks, as a tool kit, including organized activities to disseminate information in 242 pilot secondary and vocational schools in 22 provinces about how to reduce sex risks and prevent unwanted pregnancy⁹.

The focus on reducing teenage pregnancy is an example of a request to ThaiHealth from the government. This shows the government's confidence in ThaiHealth's capacity to tackle a sensitive area. In order to do accomplish the goal of reducing teenage pregnancy, it is important for ThaiHealth to take a strategic approach with an integrated plan. One area of the plan might be to review the reach and effectiveness of current sex education in Thai schools. Another area of an overall strategy would be to ensure that contraceptives are available to young men and women in every part of Thailand. A third area of an integrated strategy might be for ThaiHealth to develop a strong women's health promotion strategy, which would address issues such as self-esteem of young girls, mental health, alcohol and drug use all in relation to sexual issues. Thailand's willingness to encompass these measures culturally would probably be positive considering the excellent models now in place for HIV/AIDS prevention. The Healthy Sexuality Program is based on the core concept of sensitivity towards sexuality and gender, and respect for women's self-esteem.

The lifespan approach to health and well-being

The lifespan approach is important for ThaiHealth as it potentially enables a systematic developmental approach from the perinatal period through to death. While many of the initiatives outlined below are of value, there is no evidence of any systematic strategy in the lifespan area. The vital area of early attachment and development in the perinatal period and the first years of life appear to have been overlooked. Other key omissions seem to be a robust strategy for young people (to address sexual and mental health including co-morbidities with risk behaviours), as well as a strong strategy for improving and maintaining the health and well-being of older people.

Reading is a prime example of a skill that benefits individuals throughout their entire lives, and is key to creating a learning society and to a nation's development. ThaiHealth was assigned the task of promoting reading by Prime Minister Abhisit Vejjajiva, who declared on 2 April 2009 that promoting reading would be a national priority. The Thai government's recognition that literacy is an important social determinant of health is reflected in its making ThaiHealth the catalyst of this program. The First Book Program aimed to support every family in instilling a love for reading among newborn infants. In 2010 ThaiHealth was charged with facilitating the selection of 108 good books for children by cooperating with the Office of the Non-formal and Informal Education Commission to conduct pilot programs in five cities.

ThaiHealth regards public health as a social issue that is influenced by conditions such as socio-economic status, educational and environmental factors: in short, the “social determinants of health”. In order to achieve the sustainable well-being of people, education is a core issue as it plays a fundamental role in both personal and social development¹⁰. This links well with the resolution of the World Health Assembly 2009 on reducing health inequalities through action on the social determinants of health.

ThaiHealth has supported a number of well established initiatives, one of which is the Quality Learning Foundation (QLF) (see Box 3.3). Set up in May 2010, it is a strong world-leading contribution by ThaiHealth to the social determinants of health. The QLF may be an ideal ThaiHealth spin-off organization to explore the value of early childhood enrichment and literacy programs for disadvantaged children and their mothers, and the issue of completely separating QLF from ThaiHealth is worth considering. However, there may be a model that allows for more ongoing interdependency between ThaiHealth and the QLF so that relationship between education

and health status remains a high priority for ThaiHealth¹¹.

Another important sustainable gain for Thailand, also a social determinant, has been the development of a safe radio and television environment for children and young people. In 2004 the Cabinet resolved to extend the airtime of radio and television channels for youths and families during prime time¹² and in 2008 the Public Relations Department set measures for radio and television operators to conduct ratings of their program contents¹³. The first radio station for children and families was established in 2010 with the collaboration of ThaiHealth, Radio Thailand Department and the Thai Public Broadcasting Service.

On the other hand, the development of learning centres into “creative family areas” through the Happy Family Day Card Program has been of limited value. Since 2009 only a few centres have opened creative areas for youths and their families to spend time together. This program needs be evaluated; its impact on health and well-being and its reach to disadvantaged populations and communities need to be assessed.



Box 3.3

The Quality Learning Foundation (QLF)

The establishment of the QLF by ThaiHealth as a stand-alone statutory agency is a strong and practical systematic engagement with education as one of the major social determinants of health. The QLF is addressing health literacy, but even more directly relating to a key social determinant of health, it is working to ensure equality of learning outcomes for students from disadvantaged population groups such as children with disability, refugees, minority ethnic and religious groups, as well as children from impoverished areas. In its development of the QLF, ThaiHealth has invented a new model of intervention for social determinants based on an HPF.

The QLF has established a multisectoral governance structure, working as a catalyst in partnerships, with the goal of mobilizing Thailand towards better learning outcomes and education status for disadvantaged students. This in turn will lead to better health outcomes.

One of its initiatives is to encourage inclusive education and to decrease education gaps by encouraging out-of-school children to enrol in the education system. Under this initiative, the QLF will support area-based pilot projects across the country. Seven categories of educationally disadvantaged youths were given high priority in 2011: the poorest groups, both those who have

already dropped out and those who are at risk of dropping out (3,000,000); pregnant teens (100,000); non-citizens (200,000–300,000); children in the three southernmost provinces (40,000); about 10,000 who are at risk from dropping out before they graduate grade 9; disabled children (100,000); and children and youths accused of crime (60,000).

Overcoming this problem of the low education status of disadvantaged youths requires systematic education reform, aimed at ensuring students become valued, competent and empowered. Policymakers and educators must be persuaded to focus on vulnerable and disadvantaged children to narrow the gap in education status, and this includes preventing dropout. All stakeholders must be supported to work together to create pathways back into education for many young people who drop out of school too soon.

The QLF also works with all schools at basic levels (primary and secondary and vocational education) across Thailand. Its key agenda includes bringing new strategic thinking and approaches to inspire new models for quality learning and teaching, improved efficiency of school management and education finance, and healthy schools and students (a partnership between health and education).

Well-being promotion in organizations

ThaiHealth uses the concept of Quality of Work Life (QWL) to promote health and well-being in organizations. The framework for QWL consists of four dimensions — physical, mental, social and spiritual — in order to create happiness, and it includes work–life balance.

As this section shows, ThaiHealth has funded the promotion of well-being in a variety of organizations, including the armed forces, the police, temples and the government sector. It is worth noting that while single issues such as exercise can be promoted within organizations, for long-term sustainable health promotion gain this single issue approach needs to be combined with an organizational development process to change the culture of the whole organization.

Healthy armed forces

ThaiHealth supported the armed forces to formulate policies and a master plan for promoting quality of work life among its troops, which each regimen could use to design an operational plan. Since 2007 these plans have been implemented among 250,000 regular troops and 130,000 drafted troops each year. Some regimens have working groups composed of staff from the Human Resource Department and the Health Care Unit to gather information and reinforce the implementation of the quality of life policy.

The armed forces are an important focus for health promotion. Working with such an important, prestigious network raises the status of ThaiHealth and provides opportunities to focus on a large group of people in a complex system within a number of different settings. However, it is unclear how much structural and organizational reform was achieved or whether ThaiHealth resorted to a more information-based approach, which is unlikely to have much long-term impact. An organizational and systems approach could provide a second stage to this work with the armed forces in which issues of mental health, stress and alcohol abuse would have to be the top priorities.

Healthy workplaces

The Happy Workplace Program is one of the programs that effectively combines health promotion, occupational health and human resource management aspects of healthy workplaces. The concept of the “happy workplace” is an organizational approach, composed of eight elements, the so-called “happy eight”: happy body, happy heart, happy society, happy relaxation, happy brain, happy soul, happy money and happy family. In other words, the “happy eight” encompass the four dimensions of physical, mental, social and spiritual health.

Unlike programs that offer little more than exercise opportunities in the workplace, the Happy Workplace Program is an integrated program that contributes towards the development of healthy workplaces. It has enabled health promotion in the private sector by supporting human resource staff in

100 workplaces to create health promotion policies in their organizations. In the short term, there are many kinds of health promoting activities to choose from; in the long term, efficiency and sustainability are expected to be the targets of the program. It is important that exercise opportunities are seen as a minor aspect of a much more complex organizational development approach.

Healthy police stations

The Well-Being Promotion Police Station Program aims to enforce the law banning smoking in all government premises. ThaiHealth undertook a stepwise approach to gain the cooperation of police who have a duty to enforce this law. The set of activities included: (1) publicly announcing a ban on smoking in police stations, coupled with a campaign urging police who smoked to be cautious as they must set an example to others to observe the law; (2) incorporating knowledge about health

risks from smoking into the police training curriculum; (3) communicating with police officers and family members; and (4) enforcing the law protecting non-smokers¹⁴. It is unclear what methods are used for this population group and setting. Similar to the armed forces, mental health and stress issues in relation to alcohol use would be an excellent focus for the future.

Healthy public sector employees

A program with pilot sites in 16 government agencies, aimed at improving the quality of life of public sector personnel through improved social welfare, has resulted in a reduction of health expenses in the public sector. The development followed the finding that civil servants had five times the medical expenses of members of the Social Security Scheme and the Universal Coverage Scheme. This program resulted in a 50% reduction in illness in the 16 government agencies, as well as expansion of





the program to include the Office of the Civil Service Commission, which is the pilot agency, implementing policies and mandating that all organizations should develop the health and welfare of their employees (in 2010). This is an interesting project with a potentially large catchment population and the possibility of an organizational development approach that could contribute to an improved understanding of health promotion.

Healthy temples

Temples serve partly as learning centres for youths and families. ThaiHealth has supported more than 800 temples to become learning centres and to host activities for families on Sundays. In 2010 the Ministry of Culture announced its intent to carry out the policies of ThaiHealth by coordinating with, and promoting, over 8,000 temples as centres of learning for youths and children. The focus on temples is an innovative and appropriate approach to the selection of settings that emerged from asking the question “what are the best settings for reaching particular population groups in meaningful ways?” It is now important to measure effectiveness, outcomes and impacts.

In summary, although all the settings described above are valuable, it is striking that school organizations, as settings for children, seem to be absent. While the carbonated beverage free policy described in Chapter 2 is certainly a focus for schools, there is so much more that could be achieved with schools as a target setting. Perhaps the QLF should now address issues such as child development, child literacy trends, and absenteeism from school.

Health promotion through the health system

While health promotion must be intersectoral it also must address the health sector and therefore the health system is the focus of one of ThaiHealth's 13 plans. Numerous programs and activities are supported, ranging from improving disaster and emergency response, to setting up a National Health Assembly, to advocating health promotion be included in the education and training of health professionals.

ThaiHealth assisted in formulating the strategic plan for managing emergency medicine and the drafting of the Emergency Medicine Act, which came into effect in March 2008. As a result, budgets were devolved to local administration authorities to fund emergency medical service units at local level, and to give local people a greater role in managing accident and disaster prevention in their localities. In addition, emergency services were strengthened at all levels (primary, secondary and tertiary) and provincial emergency medical service offices were established nationwide.

ThaiHealth has also been involved in the government's efforts to prepare for and respond to public health emergencies such as the flu pandemic in 2009 (see Box 3.4). In this instance ThaiHealth was called on by the government to convene all involved parties and to provide a broad and coordinated response, particularly in the area of public communication.

Box 3.4

ThaiHealth and the 2009 flu pandemic

During the 2005 outbreak of avian influenza (H5N1) the Government's communication efforts were hampered by weak cooperation and coordination between the Ministry of Agriculture and Cooperatives and the MoPH. As a result, rumours and misinformation were rife and public distrust of official statements ran high. Learning from this experience, in early 2009, when the threat of the avian flu (H1N1) pandemic loomed large, ThaiHealth was asked to act as the engine room for the Government's response to the crisis. Based on ThaiHealth's proven track record in convening diverse groups of relevant stakeholders, it was seen as the agency that could provide a sufficiently intersectoral platform to respond swiftly and effectively.

ThaiHealth funded and founded a technical working group that consisted of representatives from the Ministry of Agriculture and Cooperatives, the MoPH and other qualified experts, and developed a national comprehensive and integrated program aimed at enabling society to be well prepared through careful advance planning and preventive measures. The working group's roles were: (1) to assess all the options and identify the best for implementation, (2) to provide a reliable source of accurate, appropriate and up-to-date information and (3) to collaborate with different organizations in producing a number of public awareness campaigns.

ThaiHealth also developed cross-government and community sub-committees to promote prevention and control solutions to minimize the impact of the 2009 flu. This response served as the main mechanism in driving policy and implementation work with various relevant partners and organizations throughout 2010.

A few examples illustrate the depth and breadth of ThaiHealth's reach in its flu prevention campaign. Working together with the Ministry of Education, campaigns were run in academic institutions nationwide, reaching 20 million students. With the Ministry of Labour campaigns were conducted in more than 6,000 factories and businesses nationwide, reaching 9 million workers. ThaiHealth supported the Bangkok Mass Transit Authority (BMTA) to provide alcohol gel for hand washing on 3,514 buses and organized health promotion activities for 16,676 employees of the BMTA. ThaiHealth worked with temples to prevent flu among the more than 250,000 monks across Thailand, including raising awareness of the benefits of wearing masks when in public places. ThaiHealth in cooperation with UNESCAP, WHO-Thailand, MoPH and the National Police Bureau organized a

one-day athletic event to increase awareness about the flu as well as encourage people to exercise in order to keep fit and healthy. More than 10,000 people participated in the event.

ThaiHealth's role in the 2009 flu pandemic highlights its ability to swiftly provide an effective platform for a comprehensive, whole-of-government response to be developed and implemented effectively and efficiently. The fact that ThaiHealth was the government's first port of call indicates the government's recognition of the great value of ThaiHealth in being able to provide a quick response and a multisectoral approach. This is a great credit to ThaiHealth in its efforts to build deep intersectoral engagement with all government ministries and to be recognized as an effective organization that can deliver results.

The disadvantage of such an invitation from government could be the generation of envy from agencies which might consider that their own role is being usurped. In a future request of this kind ThaiHealth's first step might be to request that the responsible agency lead the initiative with ThaiHealth playing a more facilitative role.

Throughout its first decade ThaiHealth supported and actively engaged in a series of annual public consultations on health system reform. One of the outcomes of this learning process was the National Health Act, B.E. 2550 (2007), which endorsed an annual National Health Assembly as a mechanism for people's participation in reviewing public health policies, and scrutinizing the evidence prior to endorsement. Subsequently, many of ThaiHealth's partners have become major stakeholders in sponsoring several public policies to the National Health Assembly. As of 2011, 25 resolutions resulting from ThaiHealth-supported initiatives had been approved by the cabinet and implemented by related public agencies.

The National Health Assembly is a new and innovative mechanism for ensuring the inclusion of civil society in setting health priorities and in enabling citizens to contribute significantly to the development of methods for reaching every corner of Thailand with a focus on those most disadvantaged^{15, 16}. The National Health Assembly, which ThaiHealth helped to catalyse, is a vital forum that merits its ongoing support and participation.

As part of its efforts to transform health professional education ThaiHealth has, among other actions, supported a consortium of the deans of medical schools, dentistry faculties and pharmacy faculties to incorporate health promotion into their curricula. In 2010 the deans of 18 medical schools countersigned the Code of Practice for Health Promoting Medical Schools. The code recommends 12 practices to cultivate a culture of health promotion within medical schools, and among staff, students, patients and their relatives. ThaiHealth is fully utilizing the opportunity to introduce health promotion concepts and practices into curricula for medical, nursing and all public health education and training.

In terms of healthcare provision, the Health Intervention and Technology Assessment Program (HITAP) is a critical component of the Thai health system, studying the cost-effectiveness of healthcare interventions and providing evidence to inform decision-making. For example, from 2008 onwards a HITAP assessment demonstrating cost effectiveness of a new pharmaceutical is necessary before it can be considered for inclusion on the National List of Essential Medicines. Technology assessment is an important area, both for health and safety, and to establish measures to assess efficacy and cost benefit. It may be possible to adapt and use some of HITAP's methods to inform the necessary development of methodologies to assess the costs and benefits of ThaiHealth-supported interventions.

The Community Nursing Program by Communities for Communities, a joint initiative between Tambon Administrative Organizations and the MoPH that was endorsed by the cabinet in 2007, aims to tackle the shortage of health personnel in remote areas. The Tambon Administrative Organizations provide scholarships to local students who have completed grade 12, and MoPH nursing colleges allocate places for these applicants. In 2009 more than 50 scholarship students graduated in the Bachelor of Nursing program and were employed as community nurses at health centres in their villages or Tambons. Nurses are the front-line leaders of primary health care and are potentially strong leaders of health promotion facilitation at local level. Including community development methods as part of nurses' training is of high potential value, especially if action research evaluation methods are also included in their training.

The Tambon Health Promotion Hospitals Program aims to encourage health promotion and disease prevention activities by local

government organizations, communities, families and individuals, with support and guidance from health personnel in hospitals. More than 1,000 health centres have joined the program since it began in 2009. As part of the program ThaiHealth has prepared manuals to convey concepts and implementation approaches for public health personnel and the public.

A new and relatively simple area that ThaiHealth might wish to address would be that of physical access to community health centres and hospital: it is important that people with disabilities and older people can get into these centres. Many have been built over the past decade, but without ramps enabling wheelchair users to get in. This needs to be rectified by introducing and implementing policy to establish building standards and regulation, and advocating for a relatively small fund for ramping.

Health information system

Although ThaiHealth values evidence-based decision-making, health information systems in Thailand have problems concerning data quality (fragmented, incomplete, inconsistency between data sources, and so forth). Therefore, since 2004 ThaiHealth has supported the establishment of the Health Information System Development Office (HISO) which aims to strengthen, develop and improve the quality of health information. Major supported programs include identifying a minimum set of national health indicators and mapping its data sources, developing an information system for specific health issues, developing area-based health information, improving the standard of health information, and training personnel who are responsible for health information as well as strengthening the health information network.

In 2010 the Strategic Plan on Health Information System (2010-2019) was formulated in collaboration with HISO, MoPH, National Health Commission Office (NHCO), HSRI, NHSO, National Statistics Office (NSO) and related partners through a Health Assembly resolution on this specific issue. The resolution was used as guidance to establish a mechanism for gathering national health information and for developing action plans to improve health information in related agencies. On 20 July 2010 the cabinet endorsed the strategic plan, which is to be implemented by concerned agencies. The national health information committee was subsequently appointed.

Other major ThaiHealth programs relating to the development of information systems and information usage are summarized herein. Mobile telephone technology and SMS are being used for epidemic surveillance in local areas. The system was tested across the border between Thailand and Laos in two provinces. The system allows for the recording of messages sent and received, and the information is used in analysing the result of events, both statistically and spatially, to enable better decision-making and planning.

The development of the Web Geographical Information System (GIS) was also the result of a ThaiHealth endeavour. The Web GIS shows fatalities categorized by cause in each province from 1998 to 2008, as well as coordinates of healthcare centres, all of which can be overlaid. This is an innovative use of new technology to establish robust surveillance and to gather useful data.

Recommendations

Community

Health learning centres

- Evaluate health learning centres using action research to capture evidence and strategic lessons about:
 - exactly what is being done
 - what outcomes are being achieved
 - what could be improved
 - performance and achievement over time.
- Use benchmarking to assess and compare the performance of the centres with each other and to support continuous learning and improvement.

Pleasant Tambons

- Evaluate this program using social epidemiology to show beneficial (or not) effects on common risk factors.

Senior Citizen Volunteer Program

- Aggregate data across geographic locations (provinces or regions) and evaluate in terms of the impact of this program on the health and well-being of older citizens.
- Encourage senior citizens to become volunteers to support other senior citizens.

Development of learning centres to become creative family areas through the Happy Family Day Card Program

- Evaluate this program to assess its impact on health and well-being; and if it continues it should particularly focus on disadvantaged population groups.

Disadvantaged populations

- Include all disadvantaged population groups in major and minor risk factor plans.
- Involve organizations representing relevant population groups in devising approaches to risk factor reduction.

Disabled people and people with chronic illness

- Develop a strategy to address the social determinants of health for disabled people including:
 - access to early intervention
 - access to high quality mainstream education in local schools
 - access to jobs in mainstream work
 - universal design that promotes accessible buildings and public transport
 - access to support services
 - affordable and appropriate aids and appliances
- Include as part of an overall strategy access to quality, cost effective aids and appliances for all categories of people with disabilities.
- Improve physical access to community health centres and hospitals, including funding the construction of cheap, locally built ramps.

Women and girls

- Develop an integrated strategy addressing women's health promotion that includes applying a gender lens across all ThaiHealth plans and programs.
- Include in the women's health promotion strategy issues such as trafficking of women, rape and other sexual abuse, domestic violence including co-morbidities in relation to alcohol, and social determinants such as literacy levels of girls and women.
- Assess which of these issues are already adequately addressed by other agencies and which would benefit from ThaiHealth playing a catalytic role.

Teenage pregnancy

- Take a strategic approach to teenage pregnancy reduction with an integrated plan across relevant sections and plans.
- Review the current reach and effectiveness of school based sex education.
- Review the availability of and access to contraceptives for young men and women, including availability in regional and rural areas.
- Develop a strong women's and young people's health promotion strategy addressing co-morbidities such as: self-esteem of young girls and sexual health; mental health and sexual health; and alcohol and drug use and sexual health.

The lifespan approach

Population life stages

- Develop a lifespan strategy that includes every stage of life from perinatal to old age.
- Develop a specific plan to address issues of early attachment in the perinatal period and the first years of life.
- Integrate early childhood across relevant existing plans and consider establishing a specific plan for this.
- Use evidence regarding perinatal and ongoing mother and child attachment, breast-feeding, early nutrition and injury reduction in relation to the impact of early child development on prevention of non-communicable diseases and the promotion of mental health throughout an adult's life.
- Develop a specific strategy for young people (including the disadvantaged) measuring in large sample surveys and analysing data to take account of co-morbidities that link risk to risk factors, and including sexual and mental health.
- Develop a specific strategy for improving and maintaining the health and well-being of older people, including addressing the risk factors relating to social isolation, changes in family structure, and the need for new models of community inclusion.

Promotion of reading

- Consider devolving to the QLF all ThaiHealth programs promoting literacy.
- Focus on the literacy of disadvantaged children and their mothers.

Quality Learning Foundation (QLF)

- Articulate its clear relationship to the social determinants of health in improving education status as a key determinant of health status.
- Develop an interdependent rather than completely separate relationship with the QLF as a spin-off, so that education is included as part of ThaiHealth's agenda in relation to the impact of education status on the health status of disadvantaged groups.

Organizations

All settings and organizations

- Use organizational development to change the health culture of the whole organization as the approach for all settings, including industry, schools, hospitals and community health centres.
- Continue to select settings based on analyses about the setting's reach to priority target population groups, including disadvantaged groups.
- Include absenteeism, truancy, sick leave and injury rates in outcome and impact indicators.
- Apply robust aggregated models of evaluation to groups of similar organizations in a sector or setting, rather than to individual organizations.

Schools

- Include schools as healthy organizations even though there is a focus on schools in other plans such as children and well-being.
- Consider devolving all school-based
- Include issues such as child development, child literacy trends, and children's absence from school in a schools strategy.

Armed forces

- Begin to take an organizational development and systems approach and include mental health, stress and alcohol issues.

Happy workplace

- Integrate workplace exercise programs into a comprehensive organizational development approach to the creation of happy workplaces, including a focus on smoking, alcohol use, occupational health and safety and injury prevention.

Police stations

- Include mental health, stress and alcohol issues as part of the future focus.

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Chapter

4

**METHODS AND
APPROACHES
TO ACHIEVE
HEALTH IN
ALL POLICIES**

Chapter 4

METHODS AND APPROACHES TO ACHIEVE HEALTH IN ALL POLICIES

Introduction

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Behind the descriptions in chapters 2 and 3 of all that ThaiHealth achieved in its first 10 years is an equally impressive repertoire of methods and approaches. Underpinning all of ThaiHealth's methods and approaches is its commitment to intersectoral action and "health in all policies" (as described in Chapter 1). From the beginning, ThaiHealth has understood that the development of policy and its regulation are key to promoting health. The Foundation has catalysed policy development in every part of government and across many settings at local and provincial level. Policy has been the clear goal, not only of all its plans and actions,

but also of the range of health promotion methods and approaches described in this chapter, including advocacy, social marketing, community development, partnerships and grants.

A full list of the policies to which ThaiHealth has made a significant contribution is available on the ThaiHealth website (<http://info.thaihealth.or.th/library/academic>). These are government policies; without ThaiHealth's involvement many would still be in development and others would never have been developed at all.

Advocacy and mobilization for policy change

With its highly influential governance structure (see Chapter 6) ThaiHealth is a strong advocate of health promoting policy. As well as direct advocacy and funding existing NGOs, when necessary, ThaiHealth establishes new organizations to mobilize and run campaigns. For example, in the area of alcohol control and carbonated beverage-free schools ThaiHealth catalysed and supported the establishment of dedicated organizations to advocate for policy.

ThaiHealth's expanding networks of partners have also become tools for advocacy, taking advocacy action about their own issue and also about other health promotion issues. These networks need to be well nurtured to ensure that positive ongoing relationships are maintained and that partners with expertise in a specific risk factor also comprehend the co-morbidities and linkages between risk factors and issues. ThaiHealth's work in this area needs to be systematized as follows. First, networks for each health promotion policy advocacy issue need to be strategically identified with clear roles for each player. Second, appropriate methods for communicating with every member of the network need to be defined. Third, responsibility for each aspect of the advocacy action needs to be assigned to specific members.

ThaiHealth has rightly drawn on the expertise in Thailand's highly effective tobacco control organizations by requesting that they train other partners and networks in advocacy for different policy areas, such as alcohol control and carbonated beverage-free schools. However, this approach has not been systematized and so this could be an area for increased investment. It could even go further and establish a train-the-trainer program to ensure that advocacy skills, so well practised in tobacco control, are supported to assist every health promotion policy issue.

Through the National Health Assembly, ThaiHealth has access to a nationwide civil society mechanism for mobilizing and advocating for health promoting policy. This is already being used by ThaiHealth to support its move to develop a food and nutrition policy focus.

How ThaiHealth decides which policy areas to pursue is discussed more fully in Chapter 6 but in short, it seems to consist of analysing the burden of disease, the social determinants of health, and who else is working in the area using what resources, combined with a measure of opportunism. This seems a reasonably realistic approach, although the method of prioritization may need to be made more explicit to satisfy criticism about ThaiHealth's broad remit.

Social marketing: key to achieving health in all policies

ThaiHealth, in contrast to many countries, has generally avoided the pitfalls of aiming social marketing solely at increasing awareness with behaviour change as the desired outcome. This approach is quite controversial and has led to confusion about the depth and significance of health promotion (see Box 4.1). ThaiHealth's approaches to social marketing as illustrated in Figure 4.1 has always had the more important goal of mobilizing the community to act in ways that are conducive to health by changing society's preparedness to accept and even advocate for major policy reform that will promote health¹. With this goal in mind ThaiHealth has used social marketing as a primary tool to achieve the numerous health promotion policies it has advocated over the 10 years of its existence. The messages selected by ThaiHealth to address various health issues all have the double aim of contributing to the reduction of risk behaviour, while at the same time enabling all levels of governments, communities and organizations to develop health promoting policies.

Figure 4.1 ThaiHealth's approaches to social marketing

Encouraging sustainable healthy media structure

- Quality media for children and youth
- Healthy media policy
- Active media



ThaiHealth's approaches to social marketing



Create powerful messages that

- Empower citizens to take action
- Enhance quality media
- Develop healthier media policy

Source: ThaiHealth, 2011

When cost-benefit analysis is used to assess the efficacy of different methods, it is clear that substantial funds are required to fund national social marketing campaigns aimed at behavioural risk factors (see Table 4.1). Such campaigns need to be long-term to reach future population groups. Children will adopt risk behaviours at the rate of their parents' generation unless the culture is changed. This is why a social marketing campaign must achieve a number of key outcomes to be deemed successful. One of the most important outcomes is policy, including where appropriate, legislation and regulation to ensure a healthy environment.

Table 4.1 Comparison of average budget required for television advertisements (per campaign)

	ThaiHealth	Private sector or other organizations
Creating awareness of large programs continuously	ThaiHealth has yet to conduct campaign advertisements at this level due to limited budget	70-200 million baht per two months such as by Toyota and Pepsi
Average cost of creating awareness at the medium level	12-15 million baht per two months such as the No Alcohol on Buddhist Lent Day Program or the Quit Smoking Program	40-60 million baht per two months such as by the Election Commission, Cloret breath mints, and Oishi green tea
Creating awareness of specific programs or activities	5-8 million baht per two months such as the Holiday Traffic Accident Reduction Program and for media supporting the Alcohol Control Act and alcohol-free university initiation	

Source: ThaiHealth

Box 4.1

Social marketing, individual behaviour change and changing a culture

In some countries the term “health promotion” has become confused with social marketing for behaviour change. This means that health promotion is seen as a limited practice, and is sometimes called “preventative health”. This is the case in Australia where a newly created government agency is called the Australian National Preventative Health Agency rather than the Australian Health Promotion Agency.

This trend to emphasize prevention rather than health promotion reflects a fundamental misunderstanding and merging of health promotion with a very limited view of social marketing. Such confusion does a great disservice to both social marketing in its fullest sense, and to health promotion with all of its complexities. Social marketing, one of many health promotion methods, involves much more than merely raising awareness in order for individuals to change their risk behaviour.

One limitation of this more simplistic approach is that indicators of behaviour change are drawn from market research, such as before-and-after surveys and focus groups, with testing of awareness of messages, changing of attitudes and intentions to act. All of these hoped for outcomes from social marketing presume a linear relationship between awareness and behaviour change. This is clearly not the case; otherwise no child would ever smoke in countries where there have been long-term and extensive anti-smoking campaigns aimed at behaviour change. Although awareness among young people that smoking is bad for health is high, young people continue to smoke². This is because new generations take up risk behaviours.

Social marketing campaigns that focus solely on behaviour change need to continually be rolled out for new generations, and this is an expensive undertaking. Another problem is the need to escalate the shock value of messages in order to maintain impact. This has been noted in Victoria, Australia, where graphic road injury prevention messages have escalated over the years in their depiction of the shock and horror, and inadvertently populations have become impermeable to such campaigns and messages³. A cost-benefit analysis is needed of this approach to social marketing versus other methods that aim to permanently change culture through policy and community ownership.

Social marketing and sponsorship

ThaiHealth has used sponsorship as a key social marketing method, particularly for developing policy in tobacco and alcohol control. Tobacco sponsorship in sport was banned in Thailand prior to ThaiHealth's existence, but ThaiHealth has been instrumental in ensuring this policy was not overturned, and also in achieving a ban on alcohol advertising at sports events (see Chapter 2). In addition to the goal of removing tobacco and alcohol sponsorship from sport, ThaiHealth has strategically used its much smaller funds (compared with alcohol and tobacco industries) to sponsor sports with health promoting messages. These messages provided a stark and provocative contrast to tobacco and alcohol company funded messages that sought to persuade individuals (especially young people) to smoke and drink alcohol by playing up the glamorous association with sport. With the ban on tobacco and alcohol sponsorship from sport, ThaiHealth has been able to use sports heroes to convey health promoting messages.



The ban has also meant that ThaiHealth has been able to use some funds to leverage structural changes in sports and culture. A valuable part of sponsorship pioneered by VicHealth and Healthway is the demand (as a condition of the sponsorship) for healthy environments to be developed at sports events. This can include smoke-free areas, alcohol-free events, or events serving only low-strength alcohol beverages, with responsible serving practices, and the provision of healthy food options. In Australia where skin cancer is a significant risk, shaded areas at sporting events are also negotiated. ThaiHealth has used its current sponsorship of sport and culture to achieve smoke-free and alcohol-free environments. However, healthy food options have yet to be addressed and should be part of a comprehensive food and nutrition plan.

Developing a health promoting media

A new aspect of social marketing unique to ThaiHealth relates to the role of media as a contributor (or not) to the promotion of the social determinants of health. In this regard ThaiHealth has contributed in a major way to the development of quality media in Thailand by supporting the policy advocacy (academic study and social participation) that was necessary to launch the country's first advertising-free public broadcasting television station. Following the success of this campaign, the Thai Public Broadcasting Service (PBS) was launched in 2009. Given that the relatively new PBS is still looking for content, ThaiHealth may want to consider South Africa's Soul City television program as a model of health promoting sponsorship. This enormously

popular soap opera, which has been running for 20 years during prime time, embeds health promotion in the skilfully written, populist story lines. The issues raised include alcohol and its relationship to domestic violence, assault and injury, promotion of healthy family relationships, and reduction of community violence.

Another outcome of ThaiHealth's involvement in the media is the increase in children's television programs from 5% to 13%, and a content rating system for television and cinema that is intended to protect children. ThaiHealth has also enhanced the capacity of local media (for example, community radio programs aimed at children and families) to ensure health content, improve health literacy and promote health messages.

To improve the capacity of journalists to report on health promoting policy issues ThaiHealth contributed to the promotion of a healthy media project that takes an innovative approach, running sessions jointly with health promotion advocates and journalists. Part of the training involves presenting health promotion content from an ethical perspective; for example, challenging the ethics of supporting tobacco and alcohol interests in reportage. Extending the reach of social marketing to encompass changing the culture and content of journalism is new and farsighted. It tackles media as a social determinant of health in a practical way, and at the same time reinvents social marketing as a far more significant and meaningful health promotion method, worthy of a central place in health promotion.



Community development: the companion method to social marketing

Extending the concept of social marketing as a health promotion method even further, ThaiHealth has been involved in developing a reading culture and has contributed to tackling illiteracy among disadvantaged communities. This work is necessary because literacy and reading are major social determinants of health.

In summary, ThaiHealth has redefined social marketing from a limited concept and practice, focusing solely on behaviour change, to a leading model that has already led to significant gains for Thailand. These gains have contributed directly to health promotion outcomes, as well as indirectly by addressing the media in a way that has led to the development of major new capacity building infrastructure and sustainable systems. The very conceptualization of social marketing in the ThaiHealth way should be transferred to health promotion foundations in other countries. This may require developing papers for presenting at conferences, publishing in journals and developing training programs for both international and national markets.

Community development (see Box 4.2) is the companion method of social marketing: it provides a cost-effective, relatively cheap method of changing culture and developing healthy supportive environments at the local level for future and existing generations. Social marketing has itself been adapted to a community development approach by ThaiHealth, operating at the local level addressing issues, including messages, selected by local communities as being relevant to them.



Box 4.2

Community development in brief

Community development has been a key method of health promotion since the 1980s. Given that communities have deep knowledge about what works and what doesn't at a local level, the health promotion task was initially thought to be one of encouraging communities to make health promotion a priority. However, since the advent of social epidemiology, and in particular its application to the measurement of health impact, the approach to community development has evolved⁴. Research evidence from the late 1990s shows that health status is most likely to improve when communities set their own priorities. Even when behavioural risk factors such as smoking or protective factors such as breast feeding are not selected, smoking rates will nevertheless decline and breast feeding rates will go up if the communities have control and are empowered to use their own judgment⁵.

Local ownership, priority setting and control are all key to individual communities achieving positive results. However, there are a number of caveats. First, establishing a community development approach with sufficient numbers of communities in a nation the size of Thailand is a significant challenge. One solution is to start with disadvantaged communities, because evidence shows that they have far weaker infrastructure and decision-making capacity⁶. Any other approach would require a strong justification as to why some communities in some areas receive support for community development and others do not. Opportunism as a selection tool can mean that more affluent communities will be more likely to receive community development investment support from ThaiHealth. It is more desirable deliberately

to select disadvantaged communities, even though this requires much greater support and facilitation from ThaiHealth.

The second caveat is the lack of measurement of outcomes. While Thailand is orientated towards community development as part of its cultural and spiritual development, external critics will continue to question the use of community development for health promotion if outcomes are not adequately measured. This deficit will continue to limit its use in many countries. The same applies to priority setting. The ThaiHealth approach is quite rightly based on facilitating communities to select their own priorities, within the parameter of excluding choices that might damage health. As described in Chapter 3, communities have



chosen sustainable agricultural, chemical-free farming, volunteer caregiver schemes for senior citizens and self-reliant villages as priorities. However, the basis for selecting these priorities is unclear. A major responsibility for ThaiHealth is to provide high-quality and comprehensible local data and other information that can assist communities in making judicious evidence-based selections of priorities. This, in turn, depends on the existence of local data, which presents another challenge to ThaiHealth. The Foundation must support the gathering of high-quality local data and ensure such data are presented in a format that can be understood and used at the local community level.

Measuring health outcomes from the choices made by communities using social epidemiology is essential in order for ThaiHealth to know what works and what does not. ThaiHealth currently contributes 10% of its budget to the community development method, so it must be able to prove its value. The degree of community empowerment in the selection and execution of health

promotion programs to address its own priorities will influence the degree of improvement in behavioural risk⁷.

ThaiHealth is loosely using participatory action research to test and adjust community development efforts where partnerships between universities and communities have been established. This is a valuable approach as part of the development of a system aimed at the continuous improvement of community development outcomes and it needs to be systematically used for all communities receiving ThaiHealth support.

Building capacity at community level is crucial to the success of community development for health promotion. The community-based health learning centres described in Chapter 3 are training communities in priority setting and strategic planning as well as strengthening local government in health promotion. To sustain funding for community development in health promotion and to reinforce local ownership, ThaiHealth is encouraging local governments to contribute resources.

Organizational development

As with community development, organizational and systems development can be effective methods for promoting health. The characteristics and several examples of “healthy organizations” were described in Chapter 3. The limitation of this approach as applied by ThaiHealth to workplaces, and to some degree to hospitals, is the need to develop systems that have nationwide networks with a critical mass of organizations. In this regard, ThaiHealth should consider working with federating organizations that bring together large numbers of workplaces, schools or hospitals at a national level. Another practical way of including sufficient numbers of organizations into a system is to work in a particular province and introduce organizational development as a health promotion method to all organizations in that area.

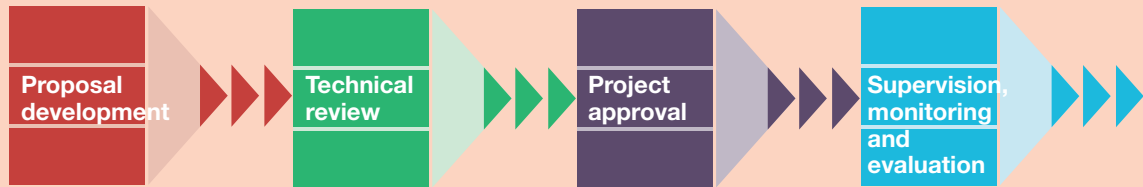
While individual organizations need feedback from evaluations in order to make adjustments and improvements (using action research), system-wide evaluations must also be put in place. It is vital to collect data across all organizations in a system: for example, data on absenteeism, sick leave, injury rates, plus additional indicators to suit each setting (such as truancy rates in schools, and cross infection and hand washing rates in health-care facilities). It is also valuable to collect behavioural risk factor data, for example, smoking rates, even if smoking rate reduction was not the aim of the organizational health program.

Collaborating with partners to develop and deliver programs

ThaiHealth relies on a partnership approach for the initiation, design, development and delivery of all its programs. This section describes how partners are selected and developed and makes a number of recommendations to improve on these processes, including creating space for open criticism. The partnership model, which accounts for 94% of the total ThaiHealth grant budget, brings together a group of potential partners for the initial creative design phase and to develop a health promotion program. This group then makes suggestions about who is best to implement the program and why. A co-development process of this kind is more likely to yield positive outcomes when the necessary time and effort has been put into assigning specific accountabilities and responsibilities to different partners. The partner designated with ultimate accountability is usually the one with the funding contract. The partnership model is described in more detail in Box 4.3.

Box 4.3

The four stages in the ThaiHealth partnership model



Proposal development:

- Organize a consultative meeting with experts on a specific subject/issue to formulate project ideas and to identify strategic interventions/activities; during this meeting, experts also recommend potential partners with competencies to implement the project.
- A ThaiHealth technical officer together with an expert (or sometimes an identified interested partner) drafts a project proposal based on what was discussed during the consultative meeting.
- Potential partners discuss the project and further fine tune the project proposal.
- The project proposal must be consistent with the criteria ThaiHealth has set out for different types of projects, namely, development, operations, research or sponsorship.

Technical review:

- Reviewers must not have any direct relation with the project.
- The number of people on the technical review panel depends on the project size, ranging from one person for projects less than 200,000 baht (US\$6,378) to seven people for projects more than 5 million baht (US\$159,440).

Project size (baht)	Number of people on the technical review panel
> 20 million	7 persons (3 persons must be members of Executive Committee); the reviewing process should be a face-to-face meeting
10-20 million	7 persons; the reviewing process should be a face-to-face meeting
5-10 million	7 persons
1-5 million	5 persons
200,000-1 million	3 persons
<200,000	1 person

Box 4.3

The four stages
in the ThaiHealth
partnership model

Project approval:

- Once a proposal has been revised as required, according to advice from the technical review panel, a technical officer will submit the project for approval by a ThaiHealth CEO, the respective Plan Administrative Committee or the Executive Board, depending on the project's size:

Project size (baht)	Authority
>50 million	1) Endorsed by the Plan Administrative Committee 2) Approved by the Executive Board
20-50 million	Plan Administrative Committee
<20 million	ThaiHealth CEO

- All board members and members of the Plan Administrative Committee considering a project proposal must sign a form declaring whether they have a conflict of interest, and anyone who does must leave the meeting room while the other members vote on the proposal.

Supervision, monitoring and evaluation

- ThaiHealth conducts a financial audit for every project and a project audit when the disbursement is more than 500,000 baht. The Board appoints an internal audit sub-committee which also reviews operational compliance and certifies financial audits and other reporting to the Board.
- Each office is responsible for internal supervision and quarterly monitoring, and each grantee is also responsible for supervision and monitoring activities in their own programs and projects.
- All projects receiving grants of more than 20 million baht (US\$637,755) must have an external independent evaluation.

An alternative to the partnership approach that is commonly used in many Western countries is the purchaser-provider model, where deliberate competition is generated between potential collaborators, often using a competitive tendering process. The tenderers can build consortia, but these are often put together to win the tender rather than to jointly design, develop and implement the program. Large consulting companies are often excellent at winning competitive tenders because they have highly sophisticated tender writing infrastructure in place. They have not always been as successful at delivery, especially if specific knowledge is required, such as sophisticated social marketing for mobilization and advocacy, or for community development. A second limitation of competitive tendering is the inability to easily build in an action research method of evaluation that leads to continuous improvement throughout the program's implementation.

On the other hand, the transparency of the purchaser-provider model contrasts with ThaiHealth's partnership approach, which at times is criticized for not allowing all interested parties to compete for the right to develop and implement a program. Therefore, ThaiHealth must be transparent about how partners are identified and selected for the initial developmental process and to deliver the program, and about how the lead organization is chosen. This is the gist of a proactive grants program approach described in Section 4.7 below. The justification for the selection of partners plus an outline of the process used to undertake that selection could be put on the ThaiHealth website.

While there are many good reasons for wanting to work with partners who have

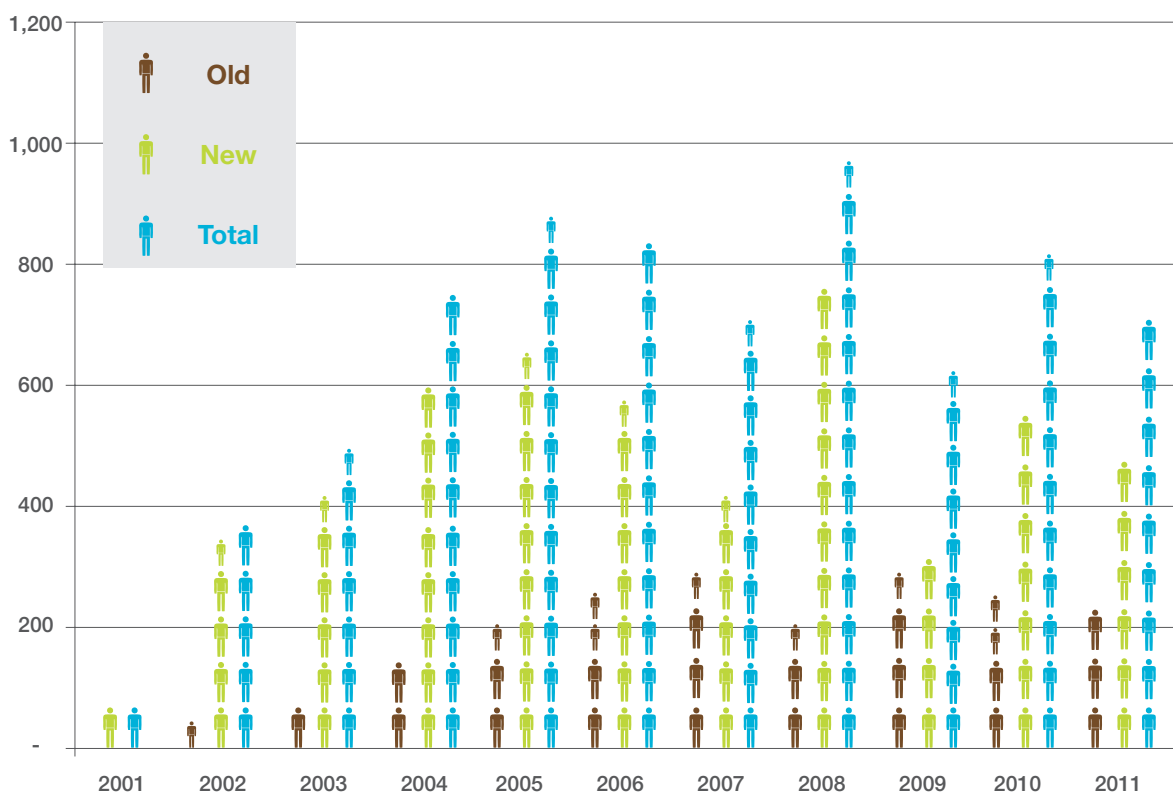
proved they can deliver, the risk is that ThaiHealth may be perceived as a club whose inner circle are those who know ThaiHealth's board and staff. The ones excluded from the partners' pool could potentially turn into critics, especially those who do not receive the grants they have applied for.

Refreshing the partner pool

It is important that ThaiHealth is not perceived as working only with partners from its established networks. In reality, as shown in Figure 4.2, ThaiHealth contracted with more new than old partners in each of its first 10 years. This is advantageous because the partnership method requires an ongoing search for new partners to meet fresh challenges, and to ensure that ThaiHealth's programs continue to be innovative. It is important that this process is transparent and open. One way to achieve this might be to establish a public register in which any organization could indicate an interest in becoming a partner, along with the topic(s) it believes it could contribute to and the reasons why its involvement would be beneficial. This could be published on the Foundation's website. ThaiHealth could then conduct a public process of assessing such indications of interest, which would include a robust due diligence process to assess the capacity (including financial if grant money is to be involved) to deliver.

ThaiHealth must also have an intelligence gathering mechanism, both to seek new partners from non-traditional networks currently unknown to ThaiHealth and to harvest new ideas. The innovations unit proposed in Chapter 6 could take responsibility for identifying new partners.

Figure 4.2 Number of new and old partner organizations, 2001-2011



Source: ThaiHealth, 2011

Collectively, ThaiHealth’s partners have the broad spectrum of expertise required to ensure that effective health promotion is delivered in all sectors, settings, organizations and systems and in all populations, groups and areas. For instance, partners include educational and school-based organizations to promote health in schools. Organizational development experts are needed to develop and deliver health promotion within workplaces. Among other things, designing innovative interventions requires detailed knowledge of the sector and/or setting as well

as knowledge about measurement, evaluation and how to scale up.

Partners with knowledge and experience of appropriate evaluation methods for the proposed health promotion program must be part of the initial design team so that the proactive partnership model delivers maximum outcomes. The evaluation approach and specific evaluation methods should be identified from the outset. This is because one of the main purposes of evaluation is for adjustment and improvement to take place

over the life of the program. Other purposes are to learn lessons and to assess the possibility of scaling up the program (or recommending its termination if it has not worked). This is not current ThaiHealth practice. How to redress this significant evaluation deficit is discussed in Chapter 5.

Partners as critics

Partners covertly or overtly criticizing ThaiHealth can create problems that are difficult to overcome. Because of the culture of politeness that prevails in Thailand, criticism can be damaging in unintended ways. Regular opportunities for frank discussion, within frameworks that encourage trust, can help to build modes of constructive criticism and productive response.

The relationship between ThaiHealth and its partners, and the degree to which partners feel equal in the relationship and how this could be improved, should be regularly assessed. ThaiHealth currently administers annual surveys (as recommended in the 5-Year Review). However, the questions do not appear to address adequately the power imbalance between ThaiHealth and its partners. Focus groups may be a far more effective way of testing partner attitudes to ThaiHealth and getting to the heart of any ongoing partner criticism of ThaiHealth. Criticisms must be brought out into the open and responded to.

ThaiHealth may also consider establishing an independent mediation and appeals system to resolve issues with partners. Some organizations have appointed an “ombudsperson”, an independent institution that reports directly to the organization’s Board. This position allows the mitigation of complaints and concerns with the organization and its management. For example, BRAC in Bangladesh (www.brac.net) has created such an office to help resolve problems and complaints involving its own staff and outside stakeholders. An ombudsperson may also be used to increase the level of satisfaction from prospective partners who were unsuccessful in being selected as such. ThaiHealth’s Evaluation Board might be best placed to take on the role of ombudsperson.

In summary, the partnership method is a realistic way for ThaiHealth to deliver its programs. An added value is that mobilizing these networks gives ThaiHealth a nationwide reach. Networks should be supportive of ThaiHealth and all its policy issues, not just the policy issues relating to their particular area of expertise. ThaiHealth must continue to undertake other more structural steps in developing and maintaining good partnerships, including clearly identifying the lead agency in a partnership and formalizing ThaiHealth’s expectations of partners and partners’ expectations of ThaiHealth.

Grants: a tool to achieve health promotion outcomes



Grants are a tool to achieve the goal of health promotion. In contrast to philanthropic foundations whose main aim is grant making, ThaiHealth's decisions about whether to use proactive or open grants are based on which is the best means of achieving health promotion outcomes.

Proactive grants account for 93.4% of ThaiHealth grant funds, and open grants for the rest. This is because proactive grants enable ThaiHealth to undertake planning and then to use a process that will closely align with the plan requirements. ThaiHealth is in the business of working with partners to generate programs jointly, rather than ThaiHealth reacting to proposals. It is important for ThaiHealth's funding to be seen as clearly targeted at health promotion outcomes, rather than the grants themselves being seen as outcomes.

As discussed in the previous section, the proactive process is a fundamentally creative process that relies on a developmental approach used to build often completely new solutions. A proactive process ensures a tailored design that is iterative, with adjustments and adaptations over the life of the grant.

The proactive grant has been used as a means of developing a broad range of projects under one umbrella or a series of interconnected projects with strategic partners in order to achieve desirable health outcomes as set out in the Master Plan. This includes building institutional capacity at both organizational and individual levels and strengthening health promotion networks to benefit people in the identified target groups or target areas.

Open grants

Open grants are a means to widen opportunities for new innovations in health promotion, including applying appropriate health promotion knowledge, for example on how to reach vulnerable people with specific needs in certain pocket areas. ThaiHealth allocates 6.6% of all grants funds to open grants. These grants are applied to community programs for communities to identify their own priorities, to disadvantaged population groups for their priorities and to partners for open grants within their programs. While open grants are intended to address the priorities of communities, ThaiHealth ensures that no harmful issues are chosen.

Using open grants as a method for ensuring that communities and population groups can set their own priorities and receive funding is core to the community development method. Open grants also generate new ideas completely outside ThaiHealth's agenda. Conceivably some of these could generate a new area such as the interface between environment and health: currently the focus of many open grants is on sustainable chemical-free farming.

Open grants also indicate to the world that ThaiHealth is willing to consider new ideas and approaches and to include non-traditional applicants from a wide range of sectors. As well as promoting new learning, this adds an element of engagement that is important for ThaiHealth's reputation as an open and inclusive organization.

ThaiHealth runs three rounds of open grants a year and may provide an amount to partners who in turn provide and manage grants, as they are closer to the community. The upper limit of open grants has increased from 50,000 baht to 100,000 baht. Payments are made in three stages throughout the cycle of a grant.

The success rate for applications for an open grant is 40%. As with proactive grants, some failed applicants have been a source of negative comment and criticism of ThaiHealth. Increasing the upper limit of an open grant has the advantage that more can be achieved with more funding. However, this also reduces the number of organizations that can receive funding.

Open grants also attract criticism from successful applicants who find that the three staged payments require smaller organizations to cover project costs until the next payment. Reducing the number of staged payments

from three to two would address this criticism. It is necessary to hold some funding back to ensure that the project is proceeding correctly, but the three payment system imposes an administrative burden on the open grant staff. Reducing payments from three to two would lift the burden on staff and at the same time reduce the criticism of ThaiHealth as unnecessarily bureaucratic in its administration of open grants.

A third criticism of open grants is that the overall model of adding an evaluator at the end of a project is not generating value. An action research evaluation process applied at the beginning would be helpful, as would aggregate evaluations of clusters of grants.

Finally, there are questions about the pros and cons of having one of ThaiHealth's 13 plans dedicated to administering the open grant process. It is unclear why the other plans could not administer open grants, especially with a sizable amount of the 6.6% going to community and population groups. This would integrate the open grants more closely into relevant program areas, and the skills base for administering the grants already exists in other program areas. It may be worth experimenting with the administration of open grants as part of the current efforts to focus on integration, and ultimately to cut out one of the plans.

Recommendations

Advocacy for policy development

- Develop an advocacy network strategy identifying networks and assigning clearly defined roles, tasks and responsibilities.
- Support tobacco control organizations experienced in developing strategies and programs to train other partners and networks in advocacy and mobilization for a range of policy goals.
- Ensure train-the-trainer capacity building is part of systematic advocacy training programs for every health promotion policy issue.

Social marketing

- Transfer ThaiHealth's social marketing conceptualization and practice to other countries, including by participating in conferences and submitting commentaries and research results to peer-reviewed journals.
- Develop and offer capacity building training in social marketing nationally and internationally.
- Consider supporting the development of a television soap opera series, similar to South Africa's Soul City, to be shown on Thai PBS.

Community development

- Continue to facilitate communities in selecting their priorities within the parameter of excluding choices that might damage health.
- Provide high-quality and comprehensible local data and other information that can assist communities in making judicious evidence-based selection of their priorities.
- Where local data do not exist, support the collection of high-quality local data in a format that can be easily accessed and used.
- Use social epidemiology methodologies to measure health outcomes from the choices made by LGOs and Tambons as well as behavioural risk factors that have not been the focus of their interventions.
- Apply participation/action research to every community development intervention to test its effectiveness, and adjust as required throughout the life of the intervention.

Partners for proactive development

- Select evaluators with knowledge and experience and include them from the beginning, when a program is being designed.
- Identify the evaluation approach and specific methods from the outset.
- Publish on the ThaiHealth website a detailed outline of the process for selecting partners, showing the steps and outcomes, and explain how the approach and methods were developed; the process should be regularly assured by the Evaluation Board.
- Set up on the website a transparent register where any organization can indicate its interest in being included as a partner.
- Apply robust due diligence to assess a potential new partner's capacity (including financial if grant money is to be involved) to deliver what it says it can deliver.
- Establish regular and clearly identified opportunities for frank and fearless exchange, including criticism from both sides.
- Consider focus groups with partners to regularly assess the degree to which partners feel equal in the relationship and how the relationship could be improved.
- Consider establishing an independent mediation and appeals system to enable partner and other issues to be resolved.

Grants

- Explain the process for making proactive grants on the ThaiHealth website.
- Ensure the process of awarding grants is regularly reviewed by the Evaluation Board to test fairness, efficacy and transparency.
- Consider reducing the number of staged payments for open grants from three to two installments.
- Require an action research evaluation process at the beginning and throughout the life of every open grant.
- Consider closing the open grants section along with its Plan Administrative Committee and trialling the administration of open grants in other program areas.

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Chapter

5

**HOW THAIHEALTH
FACILITATES
CAPACITY BUILDING,
EVALUATION
AND INNOVATION**

Chapter 5

HOW THAIHEALTH FACILITATES CAPACITY BUILDING, EVALUATION AND INNOVATION

Introduction

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This chapter assesses the methods and approaches used by ThaiHealth for building capacity, evaluation, innovation and learning. All are critical for success and will be the defining features of ThaiHealth's second decade, as is argued in the conclusion to this report. These four areas also feature prominently in other chapters because they are components of all ThaiHealth plans and programs; they are essential for effective community development, social marketing and its relationship with external partners; and they are an important part of governance and operations.

Developing capacity to embed, extend and sustain health promotion

Historically ThaiHealth has used grants as a major tool in achieving health promotion, but it must now turn more attention to capacity building to ensure sustainability and to promote strategic thinking.

Capacity building cuts across all of ThaiHealth's plans and programs and some efforts have been described in previous chapters. For example, ThaiHealth established a capacity building approach to community development in partnership with administration offices at the sub-district level. Initially a network of 18 Healthy Community Learning Centres, this network is being extended to all regions of Thailand and will eventually cover a total of 451 sub-districts. These centres should provide practical opportunities to build capacity in research.

Capacity building to ensure the sustainability of partner organizations

Ensuring the sustainability of partner organizations is a challenge, especially when ThaiHealth becomes a partner's primary funder. It is in ThaiHealth's interest to encourage its partners to develop diversified bases of funding and to assist partners in their

quest for other sources of funding. Attracting funds from many sources is a difficult task that requires support, capacity building and expertise.

It is also important for ThaiHealth to take an interest in the capacity of its partners to organize and operate in areas such as governance, risk and financial management, human resource management and information systems management. It may well be beneficial for ThaiHealth to establish a capacity building unit within its organization to deal with the capacity building, both that of its partners and its own. ThaiHealth should also consider developing a website for organizational, governance, operational and fundraising support.

The Social Enterprise Promotion Office, which ThaiHealth established in 2010 as a spin-off organization, could contribute significantly to the strengthening of its partners by building their capacity to become financially sustainable. In mid-2011 a group of senior executives at ThaiHealth and members of its board visited Bangladesh to study how NGOs such as BRAC and Grameen are running social enterprises.

As part of capacity building, ThaiHealth can also help upgrade the capacity of potential new partners in core health promotion methods. These would include areas such as advocacy, mobilization, government and community relations, community development, organizational development, systems development, social marketing and health. The information available at www.policylink.org can be used as a guide.

Capacity building for strategic thinking

ThaiHealth and its partners must build capacity for strategic thinking and apply it to design and development. This is a vital area that ThaiHealth needs to address if it is to maintain its position as a leader in health promotion.

In relation to its growing international role in capacity building, ThaiHealth may take a much more strategic and systematic approach to capacity building. This could take the form of ThaiHealth presenting a year-long program of training modules, for example. Alternatively, ThaiHealth could develop a program of capacity building in partnership with a university, or with partners themselves. Participants could include international partners as well as existing partners at the national level, in addition to local governments, provincial leaders and government ministries. Taking a systematic approach to capacity building would be an important step in ThaiHealth's continuing transfer of knowledge and information.

The 5-Year Review included a proposal to develop an academic health promotion course of study as a diploma or university degree, separate from other disciplines. This would involve both advantages and disadvantages. Many countries that have pursued this course found that such courses became the poor cousins of their public health equivalents, with lower entry requirements. Furthermore, the positions obtained by graduates with a health promotion diploma or degree tend to be mid- and low-level in organizations and

communities, allowing little opportunity to influence policy. An alternative approach is to introduce health promotion across many different disciplines and for ThaiHealth to offer short courses that may be taken in partnership with a university and that could lead to a postgraduate diploma or degree.

Capacity building for action research

Every partnering organization that receives grants of any kind should apply the fundamentals of action research. Developing a continuous learning approach to evaluation would bring significant gains for Thailand. However, none of this will be possible without major capacity building across all sectors involved in health promotion. This presents ThaiHealth with both an opportunity and a challenge. In order to systematically raise capacity in this area, ThaiHealth must take a much more consistent and decentralized approach that is an integral part of its operations. ThaiHealth should not, for example, establish a sub-contract or spin-off organization that is at arm's length.

Monitoring and evaluation for continuous improvement

Systematic monitoring of all plans, partners, projects and actions is important and is an area where ThaiHealth applies significant attention and resources. This includes project management, tracking and acquittal (confirmation that the purposes of the grant have been achieved) as ongoing core work. These systems are well developed and appear to operate seamlessly with an ongoing audit system in place for checking. It is important, however, that complacency does not set in. In order to avoid this, the audit agenda that is set in conjunction with the evaluation and governing boards should be varied from year to year. Hot spots should be identified and referred to audit and management, and most importantly, the Board should regularly review the monitoring system.

ThaiHealth is also diligent about evaluation. External evaluators typically undertake their work at the end of a program’s subcomponent, project or action. The decision to evaluate each and every program was taken after ThaiHealth was criticized in the 2007 5-Year Review for insufficient evaluation. It is now time to review this approach and improve ThaiHealth’s evaluation efforts.

The effectiveness of each of the 13 plans’ evaluation efforts was assessed as part of the 10-Year Review. The assessment concluded that the evaluations vary in quality. Some are of high quality, comprehensive and reliable, with clear conceptual frameworks and rigorous methodology, while other evaluations are poor and of no value.



112 ThaiHealth believes that the use of numerous external evaluators with different backgrounds is necessary to ensure that every program and project activity is evaluated. The problem is that the standard of evaluation is so variable that no comparisons can be made. In some cases the evaluation was added at the completion of the project, so it could not be used to improve the program as it was implemented. In a few cases, primarily relating to the major risk factors, evaluators work closely with the Plan Administrative Committee and ThaiHealth managers from the outset, and the evaluations are vastly superior as a result.

The issue of whether monitoring and evaluation should be separated must be considered and there is overwhelming evidence that it should be, even as a short-term measure. This is because the separation of the monitoring and

evaluation functions might assist in clearing up the apparent confusion about the purpose of monitoring and evaluation. This is not to say that ThaiHealth does not understand the difference between monitoring and evaluation. However, the way in which ThaiHealth set up its evaluation process for many of its plans, apart from major risk factors, can slip into quasi-monitoring. This is a problem, not only for the method of evaluation used and its timing, but also for attempts to evaluate each program, project and action. Monitoring every program, project and sub-project component is a fundamental requirement of compliance. The systems must be audited to protect ThaiHealth from a range of problems, including major programs going off track, funds unaccounted for, and unapproved changes of direction. Evaluation, by contrast, should ultimately yield significant knowledge about what works and

why (and what does not and why). Evaluation is pre-eminently a learning tool for Thailand and is at the very core of efforts to transfer and apply knowledge.

Addressing three important evaluation deficits

There are three main deficits in ThaiHealth's current evaluation efforts: a lack of action research, the absence of social epidemiology research, and inadequate research on health promotion economics relating to costs versus benefits, "best buys" and value for money.

ThaiHealth's current model of ensuring that every program and project is evaluated, while laudable, is not achieving its desired outcome. This cannot be properly achieved unless an action research model of evaluation is built in at the very beginning, or at the initial design stage. For many projects the partners themselves can evaluate, using action research, as long as they have sufficient knowledge of action research. The purpose of action research is to gather intelligence (using a participatory process) and to use this knowledge to adjust and adapt the project throughout its lifetime: not wait until the end and evaluate it to see if it worked or not. The testing and adjustment core of action research builds a culture of continuous learning, which is conducive to improving outcomes and impacts¹.

Building a culture of action research over the next decade will be a major contribution to the development of a health promotion community. Action research evaluation needs

to become an integral part of every program and activity. This will require a strong emphasis on increasing the capacity of action research among partners, communities and current evaluators. This should be a top priority for a revamped ThaiHealth approach to capacity building. Further, capacity building focusing on action research could become the first short course rolled out by ThaiHealth's new capacity building unit.

Once action research becomes a requirement of all funded programs, ThaiHealth will be in a position to develop templates to gain knowledge from intervention experiences. The knowledge can be used to improve current programs and develop new ones, and to analyse what worked, what did not, and why. This is called strategic knowledge and should be systematically collected and analysed by ThaiHealth's Centre for Health Promotion Evaluation (see Box 5.1 below).

Most importantly, strategic knowledge from action research should be a vital part of the information necessary for the development of new programs and new approaches to the design of interventions.

The second deficit in ThaiHealth's evaluation program is the absence of social epidemiology and the associated criticism of its major emphasis on community development. The development of social epidemiological research capacity in Thailand needs to be addressed. One approach is to send candidates overseas to become social epidemiologists at universities such as the University of California, Berkeley, Harvard or McMaster University. Another more cost-effective method might be to invite international

experts to Thailand to deliver short courses for the ThaiHealth Capacity Building Unit and then to supervise ongoing work. Once the capacity is built, a critical mass of social epidemiological research needs to be initiated with the community program first, and then applied to all of ThaiHealth's plans.

A third requisite in evaluation is to be able to analyse the costs and benefits of choosing one program or one method over another. Cost-benefit analysis is also needed to compare money spent on health promotion with that spent on treatment, in order to make investment in health promotion a government priority. In combination with social epidemiology, such analyses would be invaluable in estimating or assessing the value of particular approaches and interventions, as well as the value of scaling up successful interventions. Cost-benefit analysis, value-for-money estimates and best

buys are adaptations of health economics and constitute a new area of health promotion economics.

In summary, as long as ThaiHealth lacks proper evaluation methods it leaves itself open to criticism. All evaluations of major programs should include quasi-experimental designs that control for confounding factors so that a real understanding of impacts can be generated. The development of evaluation methods and tools in areas such as social epidemiology, health promotion economics and action research will assist in this endeavour. ThaiHealth may also need to invest in developing robust data sets in areas where data are insufficient or irrelevant. Intervention and evaluation research must be supported and developed in Thailand, as elsewhere. ThaiHealth is sufficiently innovative to pioneer these new areas of research and to take a leading international role in their development.

Box 5.1

Establishing a Centre for Health Promotion Evaluation

The need to strengthen social epidemiological research and develop new models of health promotion economic research, especially in the area of cost-benefit analysis, could all be brought together into a new ThaiHealth Centre for Health Promotion Evaluation.

The Centre should be party to all plan development and design of interventions. All processes for the development of programs should have the benefit of advice from the Centre, not only so that evaluation is included at the beginning of the design process, but also so that lessons from past experience can be used as a guide.

It is also important for the evaluation of ThaiHealth's work to be broadcast internationally, including via peer-reviewed journals. The journal publication strategy is currently almost non-existent. Articles about ThaiHealth's evaluation research would both add to its leadership role and transfer knowledge globally. Creating a separate and independent ThaiHealth-wide Centre for Health Promotion Evaluation would allow evaluations on an ongoing basis, and on issues that the leaders of the 13 plans consider important. Having such a Centre within ThaiHealth would allow it to work quickly and cost effectively.

Scaling up from evaluation

ThaiHealth programs and projects already enjoy a broad reach. Some of these are outlined in 60 Outstanding Performances, 2001-2009, a new publication prepared for the 10-Year Review (see <http://en/thaihealth.or.th/related-publication/60-outstanding-performance-2001-2009>). However, without a deliberate approach to scaling up the programs and projects based on evaluation, such improvements that do occur could be construed as haphazard, or even accidental.

Assessing the potential for scaling up does not seem currently to be part of the assessment or expectation of projects. Through evaluation, information is generated to make decisions about what programs or actions should be scaled up. After tobacco and alcohol control and road safety, what are the next priorities for ThaiHealth to catalyse as major national programs? ThaiHealth has some experience outside the three big risk factors in scaling up from small beginnings. One example is its development of the smart cane, a mobility tool for the disabled. ThaiHealth invested a small budget for research into an appropriate and affordable mobility tool and partnered with the National Health Security Office to test the prototype. In 2010 the two partners pledged

700 million baht to extend its use across Thailand. Another example is the policy of soda-free schools. That program has been highly successful and has been expanded to 50 education districts covering 8,853 schools. The goal is to have it implemented in all schools across the country.

There are many similar examples of scaling up activities, programs and new organizations. However, in order for ThaiHealth to stay relevant, nationwide scale-up opportunities need to be identified early in the planning process. In part, scaling up involves innovation, evaluation and keeping abreast of new knowledge. Scaling up is also important in rolling out small community projects. Identifying projects that can be scaled up to a larger area or new populations is a top priority. Of course, this too is dependent on evaluation processes in order to determine whether a particular project or plan is worth scaling up. It is vital for potential scale-up partners to be involved in the planning and evaluation stages so that they are part of the decision-making process from the start: it is unlikely that government departments will consider scaling up if they have been left out of the process and only brought in at the end.

Strategic thinking, technical expertise and innovation



Evidence-based, new knowledge that is applied to the development of strategic thinking is key to all of ThaiHealth's work, and is one of the reasons for having a foundation with sufficient funds and independence to develop new approaches and areas for health promotion. Health promotion has evolved from charters and the exchange of information at the international level (see Chapter 1). Knowledge about what works in policy development is reasonably well established for the top risk areas that are a primary focus for ThaiHealth (tobacco, alcohol and road injury). Yet there have been few advances in ideas on how to work with disadvantaged groups and communities. In other risk areas, such as obesity, mental health, teenage pregnancy, exercise, food and nutrition, interventions and evaluations are not well understood in terms of what works and what does not. There is also a lack of knowledge at the operational level, especially on how to scale up projects nationwide and how to tackle the underlying social determinants of health.

Given its strong track record in innovation, ThaiHealth has a leading role to play in addressing these major knowledge gaps. The depth and breadth of ThaiHealth's current plans, with its mix of risks, underlying risk approaches and social determinants,

exemplifies innovation. On occasion, however, ThaiHealth comes under political pressure to take a more cautious approach in its work, which can inhibit its ability to generate new knowledge.

In terms of its relationship with the MoPH and other government departments, ThaiHealth's job is to track new knowledge, trial new approaches based on the latest evidence, analyse what works and what does not and why, and determine where interventions work to ensure that the appropriate department, including the MoPH, has been included as a partner to consider supporting scaling up.

One way to ensure that innovation remains a top priority for ThaiHealth would be to develop an innovation unit. The unit could be called the ThaiHealth Intelligence Unit. Its task would be to ensure that all new knowledge and research stems from both strategic thinking and technical expertise, and is embedded in ThaiHealth's management and governing board. Indeed, a section of the Board's agenda could be dedicated to strategic thinking and innovation. This unit could then propose initial strategic approaches to developing a ThaiHealth response to new knowledge. However, it is also vital that innovation is balanced with high-quality program implementation.

One example is in the area of genomics: epigenetics and specifically gene expression may lead to innovative approaches to health promotion. It is now understood that the expression of genes can change in early child development, including during the perinatal

period, in response to early attachment, nourishment, and other external factors. This research, and the innovation in health promotion that is needed, may well make an important contribution to efforts to arrest the growing epidemic of non-communicable diseases, including obesity.

Knowledge acquisition, application and transfer

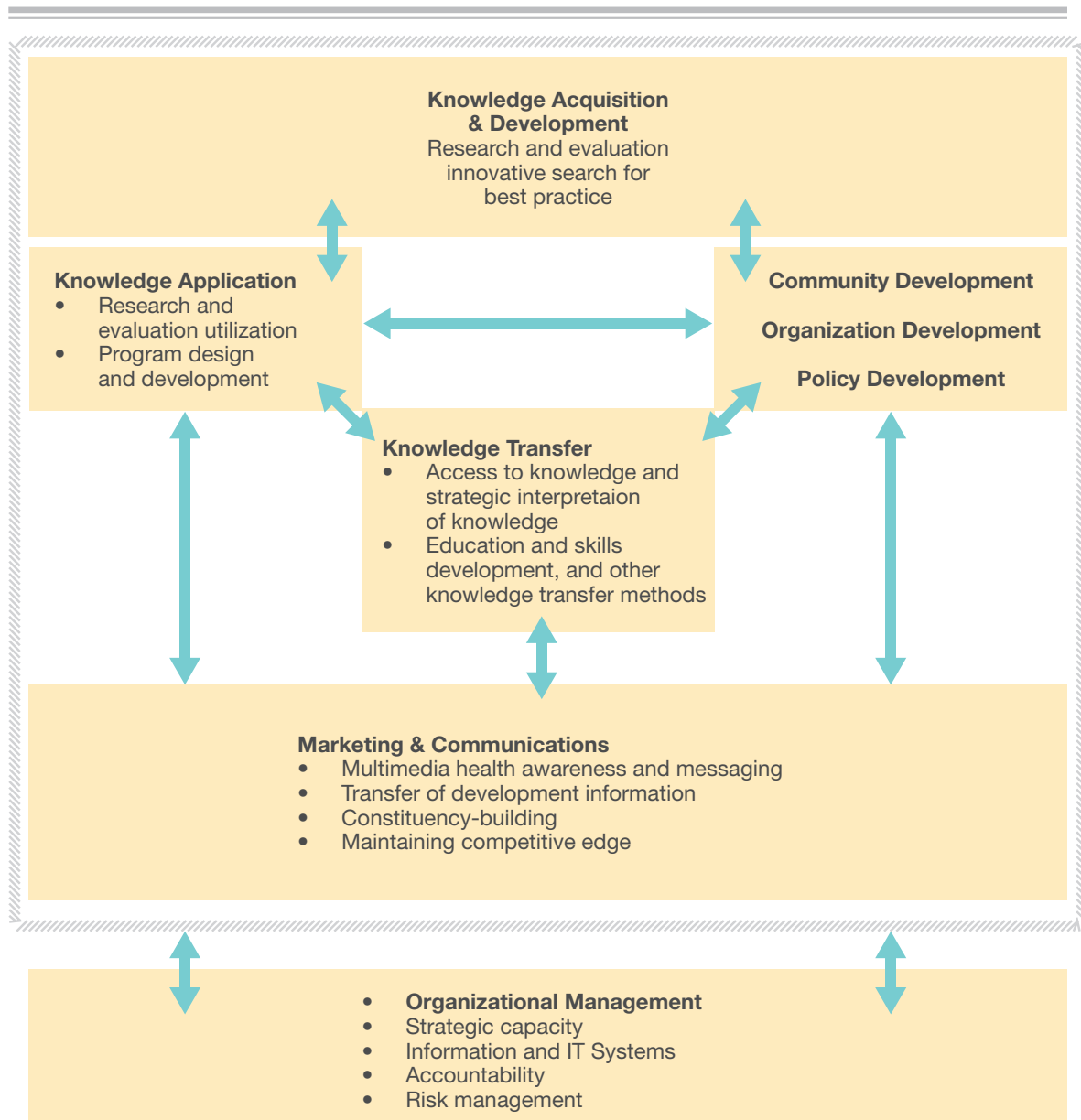
ThaiHealth has established research capacity in the areas of alcohol, tobacco and road injury by setting up research centres. However, in some other areas it takes a less formal approach to keeping up with research findings and developments related to health promotion.

Once a new research area is selected ThaiHealth starts out with a search of the literature, a review of the research and, where appropriate, the commissioning of new research. It is less clear that ThaiHealth has the mechanisms in place to alert itself to new knowledge that may come, not from health promotion (where ThaiHealth's networks are excellent), but from other areas of research and different disciplines. For example, literature about new findings on the impact of whole-of-life health status from early childhood development could lead ThaiHealth to make different decisions about resource allocation.

To keep up to date, ThaiHealth should establish an alert function that would inform ThaiHealth of new knowledge in a particular area. This work, as suggested above, could be undertaken by a dedicated innovation unit.

The area of knowledge management and transfer is another challenge. The purpose of knowledge management is to transfer knowledge to all partners and potential partners involved in the promotion of health. One approach to knowledge transfer is illustrated in Figure 5.1 below. The management and transfer of knowledge can be regarded as the main outcomes of the investment ThaiHealth makes, at least in the short term. Knowing what works and why, and being able to turn this knowledge into practical tools that can assist everyone involved in health promotion in Thailand, is a fundamental outcome and a legitimate expectation.

Figure 5.1 How knowledge is transferred



Source: Milio N. Evaluation of VicHealth, 1996.

ThaiHealth has wrestled with knowledge management and transfer, an area that remains very much a work in progress. ThaiHealth has established a Knowledge Management

Institute but it is unclear whether it was best to develop a separate organization for this or whether it might have been better to have kept the expertise in-house. Currently it seems that

ThaiHealth has to sub-contract back from its own spin-off organization, which in itself is not a problem and adds to the viability of the Knowledge Management Institute. The main issue is whether the Institute has the capacity to assist ThaiHealth to strengthen this vital area of work.

ThaiHealth should consider developing a section of a new knowledge-based website: the ultimate “how to do health promotion”, the hub of all things to do with health promotion. It could be organized around evidence, new knowledge, settings, areas, population groups and issues, using how to’s, help sheets and tools, based on information gained from ThaiHealth’s experience. All plans and their sections would be expected to prepare material. The hub could be accompanied by a regularly published e-magazine and by social network messages, highlighting new developments and attracting traffic to the site. The distribution database could also serve as a mobilization tool and should include every network that is in communication with ThaiHealth. A list of 30,000 to 40,000 would be an excellent pool to generate marketing campaigns advocating policy change. The website www.policylink.org could be used as a guide.



Recommendations

Build capacity to extend, embed and sustain health promotion

- Encourage partners to develop diversified funding bases.
- Develop the organizational and operational capacity of partners, addressing issues such as governance, risk management, financial management, human resource management, information systems management and fundraising.
- Consider developing a new capacity building unit that caters to the needs of partners and ThaiHealth staff.
- Consider setting up a website to provide organizational, governance, operational and fundraising support to partners, as part of a ThaiHealth knowledge hub.
- Explore the opportunity for the Social Enterprise Promotion Office to support the development of ThaiHealth partners.

Invest more in building capacity for health promotion

- Build capacity in core health promotion methods among current and potential new partners across public, non-government and private sectors, focusing on:
 - advocacy and mobilization
 - government and community relations
 - community development
 - organizational development
 - systems development
 - social marketing
 - monitoring and evaluation
 - strategic thinking.
- Develop a rolling year-long program of training modules as part of a new strategic and systematic approach to capacity building.
- Train ThaiHealth staff, international and national partners and potential partners, local governments, provincial leaders and other ministries.
- Consider a short-course approach that can lead into post-graduate diplomas and degrees.

Address evaluation deficits

- Consider separating monitoring from evaluation.
- Continue to monitor every project and sub-project component.
- Design evaluations to generate knowledge about what works and why (and what does not work and why).

Action research

- Build in the action research method of evaluation at the initial design stage of every program, project and activity.
- Train all partners (through the Capacity Building Unit) in the action research evaluation method.

Social epidemiology

- Address as a priority the development of social epidemiological research skills in Thailand; consider as one approach

sending potential social epidemiologists overseas to the University of California, Berkeley, Harvard or McMaster University, among others.

- Invite international experts in social epidemiology to Thailand to deliver short courses to Thai researchers in the ThaiHealth Capacity Building Unit and then to supervise ongoing work.

Impact evaluations

- Increase and improve impact evaluation and apply it to all risk factor areas.
- Facilitate data collection and maintenance where evidence of impact is inadequate.
- Control for confounding factors in strategically selected quasi-experimental design impact evaluations.

Establish a Centre for Health Promotion Evaluation Research

- Develop social epidemiological evaluation research, first with the community plan, and then for all the other plans.
- Use health promotion economics to analyse costs versus benefits, best buys and value for money.
- Focus on social epidemiological research, impact evaluation research and intervention research; and develop new models of economic research on health promotion, especially in the area of cost-benefit analysis and value-for-money research.
- Transfer the knowledge obtained from evaluation via a new, yet to be developed, knowledge hub, and through refereed journals and other publications.

Scale up from evaluation

- Develop a systematic scale-up plan based on evaluation.
- Ensure partners for scaling up are involved from the beginning of a trial or pilot.
- Build in the potential for scaling up as part of expectations and assessments of projects.
- Design evaluations to provide the information needed to enable decisions about scaling up.



Facilitate innovation and strategic thinking

- Consider developing an innovation unit.
- Assign a section of the Board's agenda to addressing innovation and new ideas with an initial approach to developing responses to new knowledge.
- Build capacity in strategic thinking so that new knowledge can be transformed into innovative strategies and applications.

Transfer knowledge

- Consider developing a hub for all things to do with health promotion, including a website organized around evidence, new knowledge, settings and areas, population groups and issues, presenting how to's, help sheets and tools.
- Examine websites such as www.policylink.org as an example of how knowledge is applied in the development of practical tools.

References

¹ Wadsworth, Y. *Building in research and evaluation*, Melbourne: Allen and Unwin 2010.

Chapter

6

**STRENGTHENING
GOVERNANCE
AND OPERATIONS**

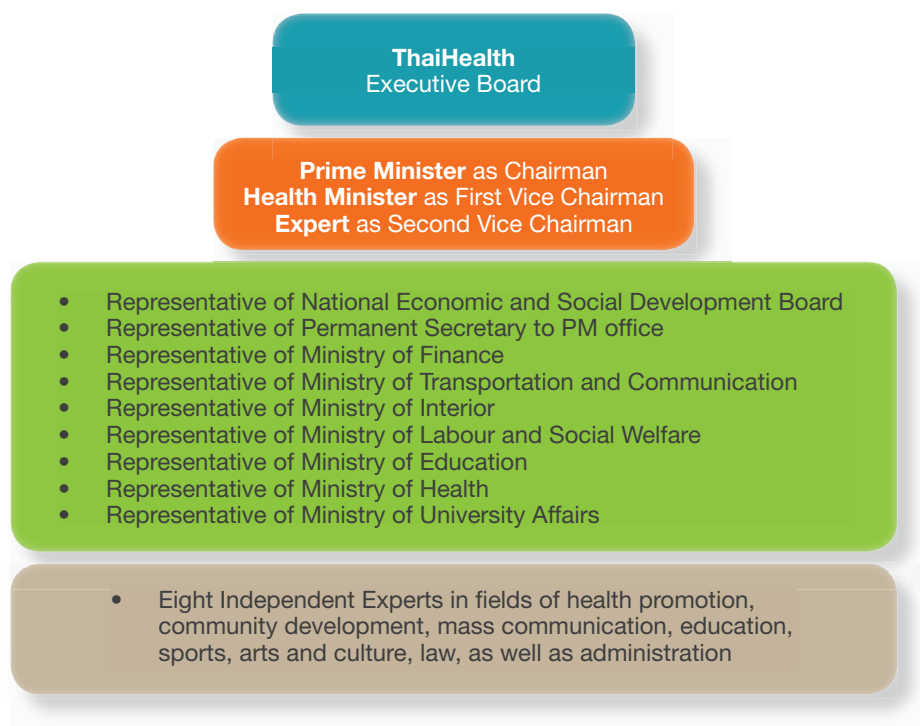
Chapter 6

STRENGTHENING GOVERNANCE AND OPERATIONS

ThaiHealth's governance structures

Along with a predictable and sustainable source of funding, the long-term viability of any organization requires good governance and robust and responsive operations. ThaiHealth was established with a governing body able to influence, intervene and guide health promotion in Thailand. The Executive Board is chaired by the Prime Minister, and the Minister of Public Health is First Vice Chair and Acting Chair. Nine high-ranking government representatives and eight independent experts from a number of different sectors and fields make up the rest of the Board (see Figure 6.1).

Figure 6.1 Governance Structure of ThaiHealth



Source: ThaiHealth, 2011.

Having the Prime Minister as Chairman of the Board ensured that ThaiHealth was positioned from the start as a high-level organization, on an equal footing with government ministries. Establishing a sense of ownership by the Prime Minister has protected ThaiHealth during times of political change. With five general elections and one coup d'état between 2001 and 2011, having a strong and constant health promotion advocate at the centre of government, irrespective of the party in power, has been key to ThaiHealth surviving its first 10 years and will be invaluable in securing its future. Designating the Minister of Public Health as Vice Chair and Acting Chair was an important signal of cooperation and has provided a strong link between ThaiHealth and the MoPH. The Public Health Minister is Acting Chair during Board meetings when the Prime Minister is absent.

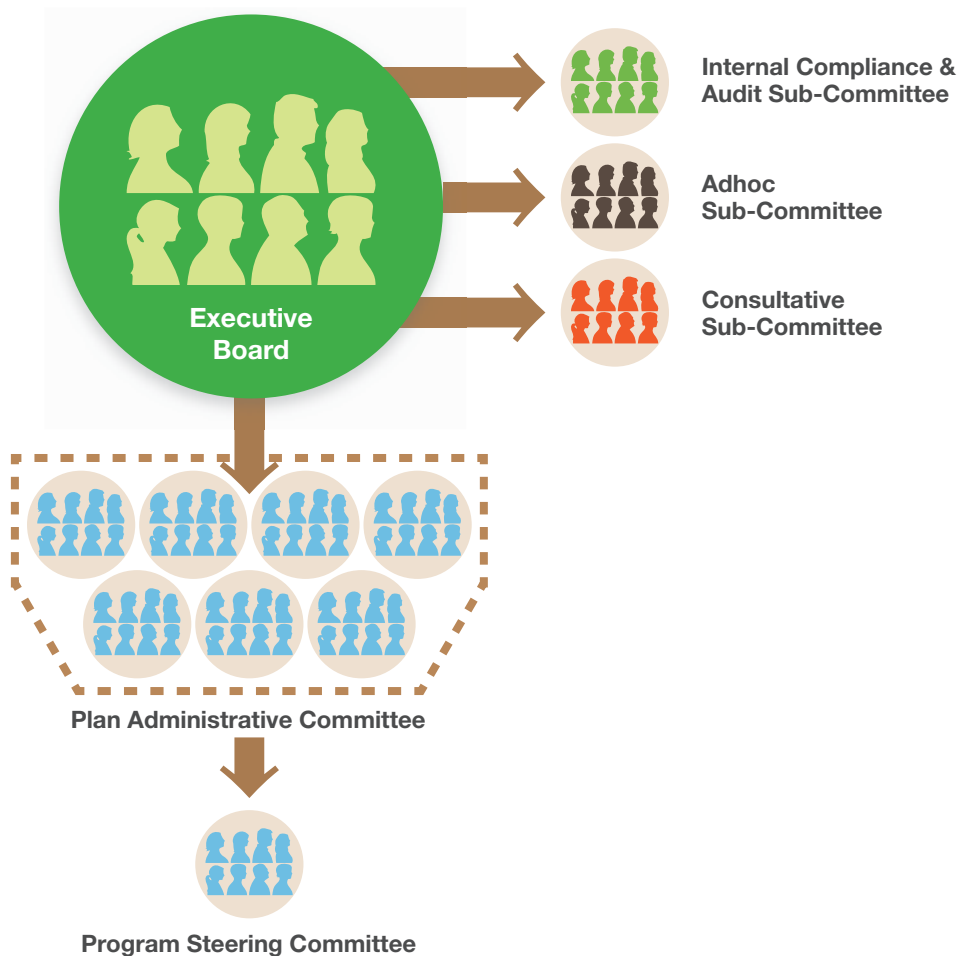
No other country has an HPF with as senior a governing board linked to the top levels of government, and therefore other HPFs are more vulnerable to funding cuts. For example, VicHealth in the mid-1990s lost one third of its revenue with the change of government, even though its Board had a member from every political party and a senior chair from the non-government sector. The relatively junior government representatives were not in cabinet and were unable to safeguard VicHealth's revenue or relevance. Some HPFs have no political representation on their boards, although the government usually selects the board. Many HPFs either get closed down or face an ongoing challenge to remain relevant to the government, especially in the early years of a new government.

ThaiHealth has been able to pursue a broad social health agenda and to advocate for policy so successfully largely because the Board comprises senior representatives from many different sectors. This is important because it has meant that ThaiHealth’s work has not been dominated by the health sector and its emphasis on treatment.

sub-committees for: finance and fiscal policy; learning centres; information technology; risk management; human resource development; health promotion integration; and internal compliance and audit. Each sub-committee consists of board members and external members, with ThaiHealth staff providing secretariat functions. External members provide a pool of future Board members well versed in specific key aspects of ThaiHealth’s work. In addition, the PACs appoint project steering committee to oversee the overall performance of any project that receives a grant of 20 million baht or more.

Fourteen committees and sub-committees of the Executive Board cover every aspect of ThaiHealth’s governance and operations. Seven Plan Administrative Committees (PACs) are responsible for the 13 plans, and there are

Figure 6.2 ThaiHealth’s Executive Board and Committees



Source: ThaiHealth, 2011.

Enhancing executive leadership

A major role of all boards is to maintain and build management's leadership. This is especially critical for an innovative organization like ThaiHealth, which aims to pioneer new directions and developments in health promotion for the benefit of all Thai people. Boards need to show leadership at a high level by providing suggestions, ideas and strategic thinking, but for quality outcomes there must be strong leadership from management.

While the Board may have to take on more of a management leadership role to protect ThaiHealth during times of political instability, after such turmoil passes it is important for the Board to resume its proper non-management role as soon as possible. If the Board stays directly involved the risk is that management would become accustomed to waiting for direction from the Board, reacting to the Board, and administering to the Board. Ultimately this could lead to management losing the capacity to be the source of leadership ideas and innovative thinking that ThaiHealth requires to maintain its position as a leader in health promotion, both in Thailand and internationally.

A major responsibility of the ThaiHealth Board is to ensure a plan is in place for a smooth CEO succession (the ThaiHealth Act requires a change after nine years). Many innovative organizations mandate CEO turnover because

this brings new thinking and new approaches. While there are different models for succession planning and transition, the highly planned approach adopted by ThaiHealth has proved effective. Between April 2009 and February 2010 there was a seamless transition from the first CEO, Dr Supakorn Buasai, to the second, Dr Krissada Ruengareerat, with an overlap of over 12 months. In effect, Dr Krissada was CEO in training throughout his nine years as Deputy CEO. The model of selecting the successor well in advance from within ensures that the successor is well versed in the intricacies of the organization. ThaiHealth as an extremely complex and subtle organization has benefited from this approach.

The Board is not responsible for any other staffing decisions or for decisions about the structure of the organization—both are the responsibility of the CEO. If the Board is unhappy with either, it can raise its concerns as part of the CEO's annual performance appraisal. To date, these appraisals have been undertaken thoughtfully and thoroughly. It is often a challenge to ensure that a key performance indicator (KPI) approach to CEO appraisal does not become a box-ticking exercise. It can be valuable to allow for a two-way process, building in room for the CEO to assess the Board's performance in relation to its supportive and clear interaction with the CEO. Another useful aspect of mutual appraisal is that it allows assessment of the degree to which the boundary has been maintained between management and non-management roles.

The CEO is ultimately accountable, although not responsible on a day-to-day basis, for everything that ThaiHealth does or does not do, so the CEO's performance appraisal is also an appraisal of ThaiHealth's performance. Setting priorities and indicators well in advance for the appraisal (as early as the first month into the 12-month cycle) gives the Board the opportunity to assess the performance of the CEO according to key challenges for ThaiHealth, such as integration and interdependency, knowledge management, capacity building and evaluation.

The Board is also responsible for assessing its own performance. This annual assessment should include reflection on and review of: its meetings; the quality of its decision-making process; its interaction with the CEO; its contribution to the development of strategic directions; and its attention to risk, fiduciary duties and conflicts of interest. Sometimes an external consultant can assist with this task, but it is important for the Board to continually review, renew and realign its performance, so it can maintain a dynamic culture and in turn continue to contribute quality governance to ThaiHealth.

Fiduciary duties

Given ThaiHealth's large annual budget from tobacco and alcohol excise taxes, the Board's fiduciary duties are quite onerous. ThaiHealth cannot afford any lapse in its high standards of management of these funds — this is the Board's responsibility. ThaiHealth has in place finance and independent audit committees and high-quality processes for finance and audit reporting. All Board members must be financially literate and able to assess the standards of finance in the reporting. Any gaps in financial knowledge must be compensated with the provision of training.

Alongside finance and audit, risk management is core to the Board's fiduciary duties, and requires regular reporting for the Board's consideration. ThaiHealth's risk management plan, introduced in 2006, is a good start to what must become an embedded risk management process. Devising a reporting format that both prioritizes risks and alerts the Board could be a helpful addition to build into risk assessment and reporting at this stage.

While the Board must manage risks and perform its other fiduciary duties, it also has a core responsibility to keep ThaiHealth at the forefront of innovation. To date, the Board has done well in balancing caution and safety while also allowing the exploration of unchartered territory. It is vital for ThaiHealth's relevance that the Board maintains its current high level of support for new ideas, taking calculated risks on decisions whether or not to pursue new opportunities.

Standing sub-committees as part of governance

Concerns have been raised about the ThaiHealth resources required to service the numerous sub-committees that all meet regularly. The number of sub-committees began to increase in 2005 when the Board appointed the seven PACs and the Internal Compliance and Audit Sub-committee. Subsequently, in 2006, the Fiscal Policy Sub-committee was established, Learning Centres followed in 2007, IT in 2008, and Human Resource Management, Risk Management and Integration in 2009. It would now be a good time to close down those sub-committees relating to internal management operations (for example, human resource management and IT) as they do not need external members, although external consultants might be used as required for specific tasks. Similarly sub-committees that have a specific purpose (for example, to establish learning centres or to improve integration) could become time-limited working parties with terms of reference and indicators for assessment of results.

In most organizations, designating a board sub-committee is usually reserved for areas concerned with funding decisions. Three sub-committees — finance and fiscal policy, internal compliance and audit, and risk management — should remain because details about ThaiHealth's financial position and forward budgeting are core to governance.

Managing conflict of interest – real and perceived

Managing conflict of interest (COI) is a top issue for all boards and key to how an organization is perceived by the external world. In ThaiHealth’s case this is critical because the high-level composition of the Board described above can lead to the perception that political interference is almost inevitable.

In response to suggestions in the 5-Year Review, the management of COI has improved in a several ways. In 2006 a two-phase study was conducted over eight months to establish COI definitions and to identify COI issues in ThaiHealth’s governance and operation^{1,2}. In response to these issues, the COI policy was reviewed by the Board in May 2006 and new regulations were produced on the conduct of executive board members with personal interests in the Foundation (see <http://www.thaihealth.or.th/files/5.pdf>).

The regulations set out the circumstances in which COI may occur, and how to deal with them. All board or sub-committee members must complete a questionnaire declaring any COI prior to participating in a ThaiHealth meeting.

The 5-Year Review recommended continuing the work to define different types of COI and suggested including the following criteria on the COI form:

“Interests in companies or other bodies dealing with ThaiHealth, ownership of property over which a conflict may arise, or hold an office in a body which may deal with ThaiHealth or which might create duties which conflict with the member’s position within ThaiHealth”.

This recommendation has now been incorporated into the regulations so that the definition of COI is clearer. Specifically, the process used by the Board for COI is as follows:

While reviewing project proposals or prior to approval of grants, as described under the partner selection process, each of the reviewers as well as members of relevant committees, e.g., Plan Administrative Committee, ThaiHealth Executive Board, are provided with the COI form to be signed. Thus, everyone has to declare whether he or she has direct or indirect involvement with such as a project/program or has known any members that have been involved with respected projects/programs. As standard practice, if a COI is identified, the member(s) must inform the Chair or the committee and then temporarily leave the meeting room until the item is decided.

Outsiders may find it hard to imagine the Prime Minister or Minister of Health being asked by another Board member to leave a meeting if there is a real or potential COI with an issue that is about to be discussed. The answer to this concern is that no exceptions can ever be made: all ideas and proposals, whether they come from the Prime Minister or a member of an NGO, must go through the same rigorous process.

This is not to imply that the Government cannot make requests to ThaiHealth: in the past it has asked for help to reduce teen pregnancies and for assistance with communications during the influenza pandemic. It should, however, be impossible for the source of any proposal, including Board members, to sidestep due process. Checking and attesting to the rigour of this process is the correct way to address COI, in addition to the procedure that needs to be followed in meetings. The continual monitoring of this area is an appropriate role for the Evaluation Board (see section 6.4 below).

In the event of a declaration of COI, at least two thirds of the Executive Board needs to vote in favour in order for that Board member to be allowed to continue his or her duties. Guidelines should now be developed that set out how to assess the relevance and significance of the COI, and these should be used as the basis for voting.

The COI process could be further improved by noting on the minutes of Board meetings when members leave the room after declaring COI and by publishing those minutes publically on the ThaiHealth website. All Board members have a duty to speak up frankly and fearlessly about any perceived COI, regardless of the status of the people involved.

The COI regulations also apply to experts invited to contribute to the Academic Screening Process. They must affirm that their participation does not contravene ThaiHealth's regulations, which dictate that only experts with no direct connections to persons proposing projects for consideration shall conduct screening. Experts must complete a questionnaire and declare any interest in or connection to the project. However, who is required to do what, and within what time frame, is unclear, and this should be rectified. The questionnaires and the assessment of any declared interest should be completed before a contract is concluded, and prior to the commencement of the academic screening.

In summary, while COI procedures must be robust and thorough, they must not be used as a stick to paralyze the Board and sub-committees. Members are selected because of their expertise in important health promotion areas and their knowledge must be tapped. At the same time they must not influence funding decisions related to their own projects. This is a balance that the Board must review regularly. It could also be useful to build in a regular (annual) review of COI policy, systems and practice and to publish on the website the findings and any ameliorating actions taken.

Strengthening evaluation

A second key part of the governance structure, which is unique to ThaiHealth among HPFs, is the Evaluation Board. Established in 2001 by Cabinet and part of the Thai Health Promotion Foundation Act, the Evaluation Board is independent of ThaiHealth and of the Executive Board. A prestigious leader in health promotional development acts as chair, currently Professor Dr Kraisid Tontisirin. The Chair has a three-year term, and an age limit of 70 years. The six other members come from different sectors and disciplines including education, economics and child development (see Annex IV). The Evaluation Board sets out an agenda year by year and provides important impetus for improving all ThaiHealth processes. Its annual reports are rich in valuable insights and suggestions, and over the years have reassured the Executive Board and Parliament that ThaiHealth is on track in its general direction.

With the support of a small secretariat, the Evaluation Board's role is to assess the overall quality and effectiveness of ThaiHealth's governance and operations, as well as its plans, programs and activities. One example relating to governance and operations is evaluating the COI policy and practice as it applies to the Executive Board and to the selection

of and contracting with partners in the proactive granting process. Any concern about COI should be addressed and resolved by the Evaluation Board; the Board may wish to formalize this role by undertaking an annual assurance report on COI relating to governance, partners and proactive granting, attesting to the application of due process in all areas where COI may arise.

The Evaluation Board also evaluates operational efficiency and effectiveness issues such as the number of sub-committees, human resource management systems and procedures, ICT, and so forth. Assurance reporting could also be applied to each of these areas.

As far as the detail of monitoring and evaluating plans, programs and projects, the Evaluation Board rightfully takes a macro approach, providing an overall assessment: Is it working? Does it need more action research? Is there sufficient economic, cost-benefit and value-for-money evaluation? Is there a realistic plan to establish social epidemiology and far stronger impact evaluation?

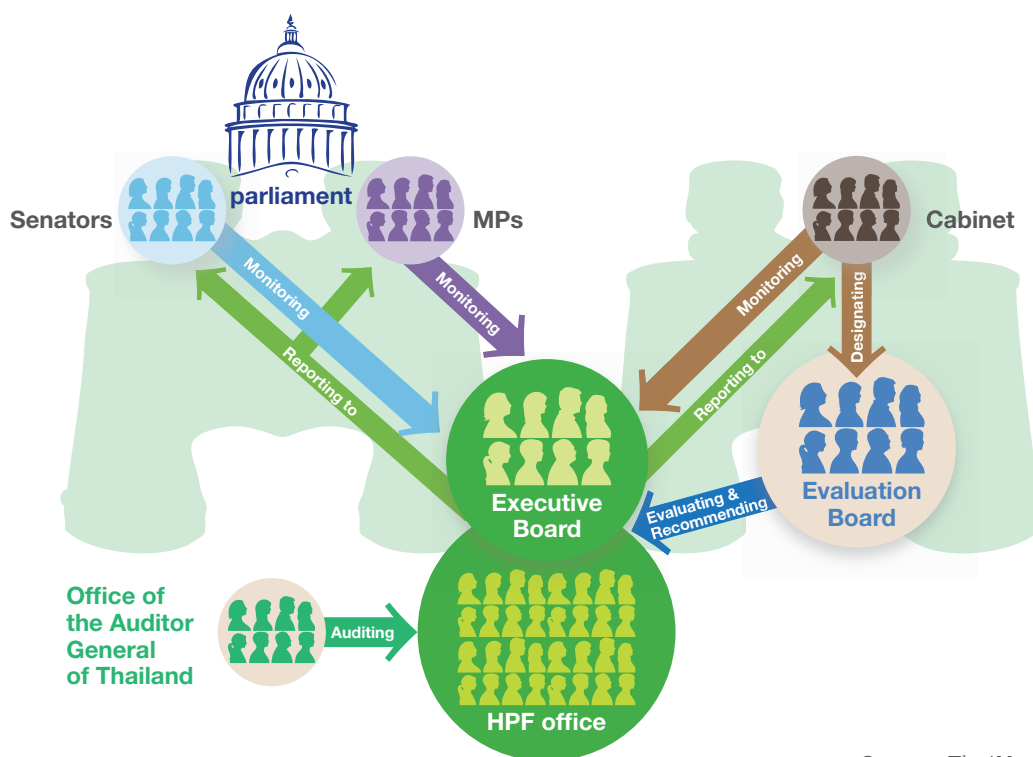
Many of the recommendations emerging from the 10-Year Review refer to the need

for health economics, impact evaluation, action research and social epidemiology to strengthen ThaiHealth’s evaluation efforts overall. It is recognized that the availability of these skills is limited in many countries, Thailand included. However, it is critical that ThaiHealth is able to prove that its funding decisions offer value for money, especially because at some point the funds it receives from tobacco and alcohol excise taxes may need to be justified to the Ministry of Finance. Cost-benefit analyses can also be applied to social epidemiological data to prove the benefits of some of the seemingly softer

approaches to health promotion, such as community development. The Evaluation Board should play a role in ensuring that steps are taken so that over time these capacities are developed and become available to ThaiHealth.

It is important that the role of the Evaluation Board does not become confused with ThaiHealth’s internal compliance and audit functions, which are a core area of the Executive Board’s fiduciary duties (a sub-committee reports to the Executive Board). Figure 6.3 illustrates the relationships between the two boards.

Figure 6.3 Interrelation between ThaiHealth, its Boards and national authorities



Source: ThaiHealth, 2011.

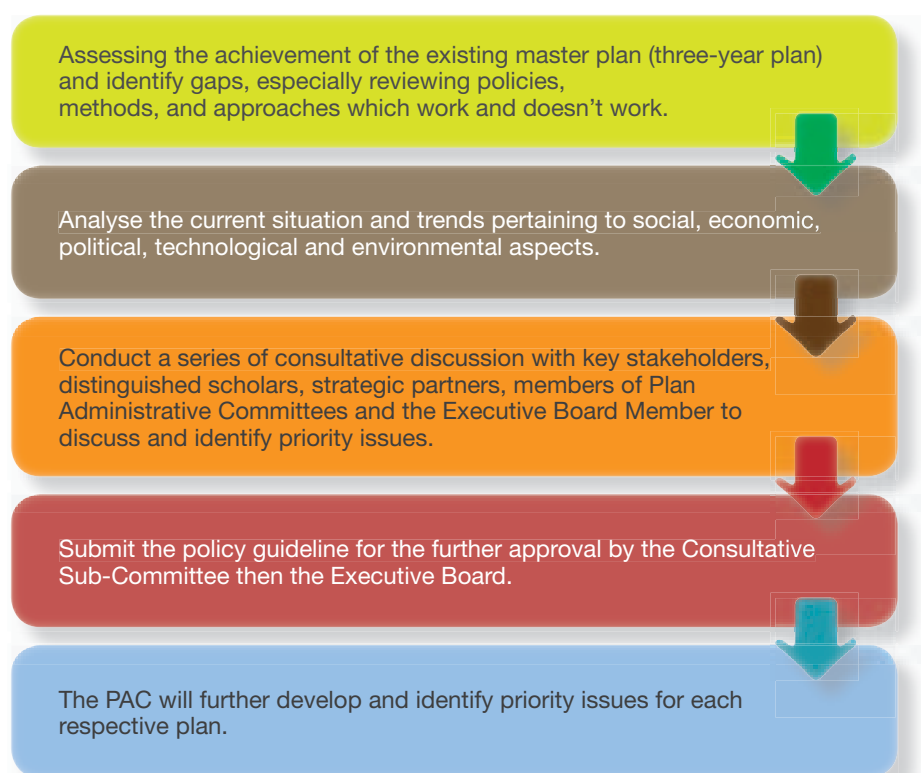
Priority setting and planning processes

ThaiHealth should be publically accountable for the methods it uses to set priorities, and be able to explain why some issues have been selected and not others. Its current model is based broadly on: legislative requirements (tobacco and alcohol); burden of disease (tobacco, alcohol and road injury); the funds available from other sources (hence the exclusion of HIV/AIDS even though it is high up on the burden of disease ladder); the social

determinants of health; opportunism based on a combination of ingredients necessary for success, such as leadership, partners and strong interest; and government referral to ThaiHealth (teenage pregnancy and influenza pandemic).

The method for assessing an issue for inclusion in one of ThaiHealth's plans is shown in Figure 6.4.

Figure 6.4 ThaiHealth's priority setting process



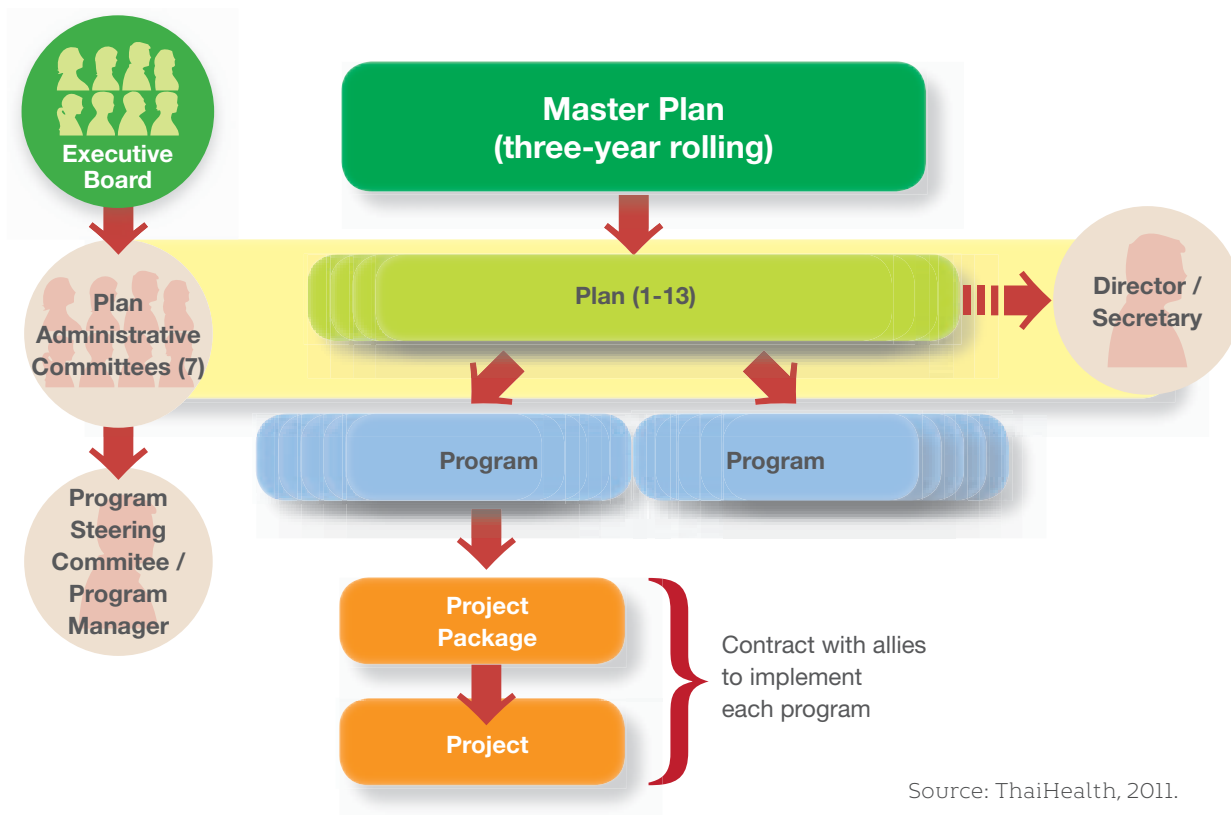
Source: ThaiHealth, 2011.

Evidence of value for money and cost-benefit analyses from evaluation research both in Thailand and internationally are also needed to inform priority setting.

The planning cycle is three yearly with an annual review of the plans (see Figure 6.5). This annual review generates policy directives by

the Board to the CEO and to the seven PACs. The PACs spend two months working on the details of the plans with external partners, and then management integrates all separate plans into a three-year Master Plan. Finally there is a one-day meeting of the PACs with a final document produced for Board approval.

Figure 6.5 Structure of a plan and its mechanisms



Source: ThaiHealth, 2011.

While the planning cycle and process is thorough, it could be considered to be exhausting rather than exhaustive. Because all plans are developed independently of each other, the only opportunity for integration is when they are brought together in the Master Plan. However, without an integrated overview or even the identification of integrating opportunities as guidance for the separate

plan endeavours, it is not surprising that the outcome is plan specific.

Even area-based and population subgroup plans are developed in isolation and thus are not integrated with risk factor plans or health system plans. The segmented plan development process can also lead to bidding competitions where plan chairs see their

primary task as maximizing funds for their plan. This discourages the PACs from taking the integrated interdependent approach that is required to meet the overall goals of ThaiHealth.

However, the major concern with the planning process is that the leadership skills of management may be delegated to the PACs. As discussed above, without management leadership, the organization becomes one of primarily servicing the committees and the Board, rather than an organization where all staff contribute to new ideas and approaches that can be brought to the Board for advice and support. An alternative planning model that might be considered is to request that management does all preliminary planning, so that the two-month PAC process could be dispensed with. ThaiHealth management would do all the checking and engagement work, receiving inputs from executive members, external partners and staff members, and then make recommendations to the PACs.

Most important, however, is the need for an integrated approach to be developed by management and brought to the Board for endorsement as the starting point for all planning, including budget and fund allocation. This could be organized around key integrative themes.

Whatever the decision about the best way to build in integration from the outset of, rather than at the end of, a series of vertical planning processes, there is no doubt that it must be led from within the organization. This will require the Board to step back and receive advice rather than initiating and leading the process.

Interdependent governance and operational issues

This section addresses a number of issues that span governance and operations. Risk management, organizational structure, time for reflection and staff development are topics of joint concern for the Executive Board and management, and all have shared roles and responsibilities.

Risk management

Risks range from the obvious, such as corruption including actual fraud, finance, ICT and system crashes, through to external perceptions of ThaiHealth such as with COI. It is a risk for ThaiHealth to be perceived as bureaucratic and unresponsive; it is a risk if ThaiHealth does not adequately communicate what is doing and its successes. There is a risk if the evaluation system does not provide adequate information or does not effectively communicate results. In early 2010 the Prime Minister announced a new set of risk management policies (see Box 6.1) that aims, among other things, to improve integration and interdependency between sections. This is a welcome development because an effective risk management system is the hallmark of any modern flourishing mature organization.

Risk reporting should be on the Board's agenda at least of every second, if not every, monthly meeting and presented with an assessment of the degree of risk (high, medium or low).

Box 6.1

ThaiHealth's approach to risk management

On 3 February 2010 Prime Minister Abhisit Vejjajiva, the Chairman of the Thai Health Promotion Foundation Board, made the following announcement regarding the Foundation's risk management policies. Risk management is an important strategic tool that falls under good supervisory principles and can aid in allowing work administration and implementation to efficiently achieve organizational objectives and mission, in addition to reducing the impacts of undesired events that may occur.

The Thai Health Promotion Foundation Board invoked authority from Section 21 (1) of the Thai Health Promotion Foundation Act of 2001 during its assembly on 15 January 2010, and set the following risk management policies:

1. Risk management shall be carried out at the organizational and operational levels according to international risk management standards or generally accepted risk management standards.
2. Risk management plans shall be established, and should cover risk identification, risk prioritization in all areas, in addition to methods to manage risk to reduce them to acceptable levels.
3. Risk management plans should be periodically reviewed at least once a year to ensure appropriateness to current situations.
4. A high ranking administrator who is at least an assistant manager shall be responsible for setting risk management plans. At least one member of personnel shall be specifically assigned to be responsible for risk management.
5. Communications shall be carried out to make risk management a part of normal work operations and part of the organizational culture of the Thai Health Promotion Foundation.

The aim is to change the high and medium risks into low risks as soon as possible. This traffic light approach to risk requires assessing risks in all of their complexity, and brings to the Board a thorough and sophisticated analysis. ThaiHealth's risk plans must specify the measures to be mitigated, and the expected outcomes, with timescales for their achievement. Selecting key performance indicators is an important task as they provide a pathway to risk mitigation, and they can be signed off as completed within the allotted timescale.

However, the most important task of all is identifying who is accountable for mitigating a particular risk. Accountability is assigned to the person in charge of a section, whose performance will be measured according to the mitigation of risk achieved. Responsibility should also be assigned in the risk plan, although this does not need to be brought to the Board. Once accountabilities and responsibilities are assigned, risk management can be traversed in the everyday work of each risk owner.

Organizational structure

Organizational structure is usually a matter for the CEO and management, but in the case of ThaiHealth the plans seem to dictate the organization's structure, and the plans are therefore a matter for the Board. It may be that, in the first instance, the Board needs to give management a clear mandate to come up with new approaches to plans and to the restructuring necessary to implement the plans.

Although organizational restructuring for its own sake has no value, there are indications that ThaiHealth needs a new structure. Lack of horizontal engagement between plans, complaints about heavy workloads, and need for more executive innovation and leadership are all indicators that the organizational structure is not optimal and that it might be helpful to experiment with clusters for integration, or with a more profound restructuring. There is also value in taking people out of their comfort zones and enabling them to learn about new issues, methods and areas. This is not a proposal to move to a managerial approach where there is no building of a substantive knowledge base in health promotion. The management team in an area that is working well could be transferred to another area to use their generic skills in management, innovation and leadership to improve the performance of the less successful area.

Time and space for reflection and review

One of the most important tools for thoroughly assessing the value of new approaches to organizational development and management is space for review and reflection, which must be made available within ThaiHealth's busy week. These are times when management can frankly discuss what is working in their areas and what could be improved, and then for the group as a whole to contribute to the development of lateral and experimental approaches worth trialling. ThaiHealth's commitment to these activities will pay off in assisting it to become a robust, sustainable and

healthy organization. A healthy organization can allow itself to reflect on hard questions such as: Does it have sufficient leadership among its staff, and if not what can be done to promote this? Is the culture sufficiently tough to enable ThaiHealth to assess itself from a value-for-money and cost-benefit perspective? Is the best organizational structure in place for both innovation and risk management and mitigation?

Managing human resources

Apart from the appointment of the CEO, human resource management is led by the CEO. The selection of quality staff is the most important job: staff who are continuously learning, able to think and innovate, able to manage their areas safely and, most importantly, able to work across programs, plans and sections and manage interdependency.

It is important that all job descriptions of senior staff are developed in line with the Master Plan and the 13 plans, with accountabilities, responsibilities and interdependencies clearly identified. The value of key performance indicators in ensuring performance is questionable as they have a tendency to become routine and predetermined. The challenge is to ensure such indicators are meaningfully agreed in a dynamic group interaction that should ideally include all senior managers. This is because the key performance indicators of any one manager should have an interdependent impact on many other managers; they should become the organization's business, rather than the private business of an individual.

This organization-wide approach to key performance indicators would also assist ThaiHealth to drive more integration across plans.

There is a premium for ThaiHealth in investing in the development of all of its employees in ways that are focused on the organization's requirements. One example is the internal capacity building program for staff called "Learning While Working".

The importance of leadership and leadership training has led to a burgeoning business worldwide. However, much of what is called leadership training is actually management training, which in itself is valuable but does not lead to an improvement in leadership skills. All ThaiHealth senior managers need to be able to turn knowledge and evidence into programmatic and operational possibilities, and then to forge links and lead others to deliver outcomes. This leadership capacity is the core of ThaiHealth's requirement of its senior staff. ThaiHealth might consider developing in-house leadership training for senior staff and offering it more broadly for partners and intentionally via the proposed ThaiHealth Capacity Building Unit.

The retention of staff is an important human resource management function and, as shown in Table 6.1, ThaiHealth's retention rates were high over the years 2007-2011. However, the value of some refreshment in senior staff needs to be balanced with the retention of skills and the investment in capacity that is built over a period of time.

ThaiHealth may not be a large enough organization to provide a career path within its own ranks, so its ability to retain staff may also

Table 6.1 Retention rates of ThaiHealth staff, 2007-2011

Year	Retention Rate
2007	98.4%
2008	100%
2009	98.81%
2010	93.94%
2011	94.90%

include factors such as giving staff the choice to work flexibly at home where appropriate. This could be especially valuable in a country where commuting to work can take many hours. ThaiHealth seems to have modern practices in place that would allow staff to work a nine-day fortnight, and to telecommute from home using ThaiHealth supplied technology.

The issue of pay scales is a thorny one. One perspective is the ThaiHealth ethos that there is more to value than pay. The other side of this argument is that ThaiHealth salaries should be on a par with those in the wider community and in ministries such as the MoPH. ThaiHealth should undertake a salary assessment of senior positions to provide information about

parity with other organizations and to assess the correct value of various positions. It could be considered unfair for ThaiHealth's staff to be expected to work to a lower rate of pay, especially as their workload is high.

While there is no information available on workload, information from focus group discussions on time management and staff's time allocation between various tasks indicates that ThaiHealth staff spend two thirds of their time on downstream development such as supervision and monitoring, staff capacity building, reporting, meetings and risk management.

Assessing workload in relation to the danger of burnout is also a task that needs to be systematized; it could be included in a work value assessment. It is a management responsibility to ensure that workloads are achievable and do not end up causing stress, which can result in absenteeism, sick leave and even workplace injury. HPFs have a tendency to drive themselves to the limit, partly because of the continual pressure to prove value to a critical world. However, even with this as a common HPF workplace culture, as a health promotion leader ThaiHealth should set an example by ensuring that staff workloads are realistic.

Information system management

ThaiHealth's information system has evolved over the past 10 years and will continue to do so. Achievements to date include an online grants management system (GMS) that interfaces with records management and sub-project accounting systems. Partners have access to the online GMS and sub-project accounting systems, although their use is optional, and some partner program managers choose to use their own systems.

ThaiHealth is introducing the Data for Decision Making System (DDM), which is a fully integrated online GMS with built-in accounting and reporting modules. The advantages of ThaiHealth and all its partners utilizing the same system are significant for monitoring, compliance checking and the aggregation of information about population groups in relation to areas and risk factors. There would seem to be no justification for any partner to adopt a different system. The move to one common system should be an early aim, and could become a condition of funding. Once partners have gone down the track of developing their own systems, moving to the common system will be more expensive.

The Information Management System interfaces with the system for collecting, interpreting, presenting and searching knowledge; one source of knowledge would

ostensibly come from program and project evaluation. The information management system needs to be developed to include templates, indexes and update mechanisms. This is pioneering work on the HPF front: no HPF has yet developed a satisfactory knowledge management and transfer system. This is key to ThaiHealth's interface with capacity building.

A second area for information management systems development is a tool to facilitate the integration and links between plans and sections as an internal knowledge management and transfer system. While ThaiHealth has a website it has not attempted to develop it as a repository of all information that any Thai organization or community, from a large multisite industry to the smallest Tambon or school, would wish to know about health promotion: particularly how to instigate, design, develop, implement and evaluate a program or intervention. ThaiHealth has an enormous amount of knowledge that could be broken down into carefully indexed, searchable banks of help sheets and how to's as part of an online health promotion hub. The challenge is to build an open source approach that would allow partners to contribute, while at the same time ensuring a high standard and accessible format, style and presentation so that every entry in the hub is clear, simple and easy to understand.

Recommendations

Enhance the Executive Board's leadership

- Move the Board back into a non-management leadership role.
- Limit the Board's responsibilities for staffing decisions to the appointment of the CEO.
- Allow the CEO to appoint all staff and to change the organizational structure, and hold the CEO to account via the annual appraisal.
- Consider making the CEO appraisal a two-way process, building in room for the CEO and the Board to mutually assess: (1) the performance of the Board in relation to its supportive and clear interaction with the CEO, and (2) the extent to which the boundary has been maintained between executive and non-executive roles.
- Develop and implement a mechanism for the Board to regularly assess its own performance, including: (1) the quality and effectiveness of its meetings; (2) the quality of its decision-making process; (3) its interaction with the CEO; its contribution to the development of strategic directions; and (4) its attention to risks, fiduciary duties and conflicts of interest.

Streamline the sub-committees

- Reduce the number of sub-committees by closing down all those that relate to what is more appropriately management's responsibility.
- Transfer sub-committees that have a specific purpose (for example, to establish learning centres or to ensure integration) to limited life working parties with terms of reference, time frame and indicators for assessment of results.

Do more to manage conflicts of interest

- Improve the processes and procedures for all aspects of selecting and funding programs to make them more rigorous, robust and transparent.
- Ensure the Evaluation Board assesses these processes and procedures and provides an annual COI Assurance Report.
- Never make exceptions, no matter where a proposal has come from; even a request from the Prime Minister's office to tackle an area of concern such as an influenza pandemic or teenage pregnancy needs to be assessed for conflict of interest.
- Note in the minutes of Board meetings when members leave the room after declaring a conflict of interest, and publish all related details on the ThaiHealth website.
- Review the conflict of interest policy regularly to ensure that a balance is maintained between using Board members' expertise and avoiding conflicts of interest.
- Continue ongoing work to define different types of conflicts of interest.
- Clarify what experts who play a role in the Academic Screening Process are required to do and by when: they must complete a questionnaire to declare any interests in or connections to the project; the questionnaires and assessments of any declared interest should be completed before a contract can be concluded and prior to the commencement of academic screening.
- Allow a Board member with a declared conflict of interest to continue his/her duties if at least two thirds of the Board votes in favour of such action. Develop guidelines on how to assess the relevance and significance of conflicts of interest and use these as the basis of voting.

Strengthen the role of the Evaluation Board

- Clarify that Evaluation Board's roles, among others, are to:
 - evaluate the governance and operations of ThaiHealth, including the overall efficacy of its evaluation models and approaches;
 - focus on areas such as the rigour of the processes for selecting partners and setting priorities, including ensuring that these and other processes and procedures are sufficiently stringent to protect ThaiHealth from any conflicts of interest.
- Formalize this focus into assurance reporting.
- Consider extending the role of the Evaluation Board to include an ombudsman and arbiter of complaints.
- Ensure there is no overlap between the Evaluation Board's roles and the compliance and audit functions of the Internal Compliance and Audit Sub-committee.

Broaden priority setting and planning processes

Priority setting

- Include evidence from value-for-money and cost-benefit analyses when setting priorities, in addition to other indicators and methods.
- Audit priority setting processes for robustness and rigour.
- Outline the priority setting process clearly on ThaiHealth's website.

Planning

- Have management undertake all preliminary planning instead of the two-month PAC process, including soliciting staff recommendations and inputs from all necessary partners and networks.
- Have management develop an integrated approach to programs, including budget and fund allocation, organized around key themes such as early childhood development, and food, nutrition and exercise; bring this to the Board for endorsement as the starting point for all planning.

Invest in human resources

- Develop all job descriptions for senior staff in line with the Master Plan and the 13 plans, setting out accountabilities, responsibilities and interdependencies.
- Negotiate key performance indicators with senior staff in a dynamic interactive group, so that the indicators become the organization's business rather than just the private business of an individual.
- Indicate clearly any interdependencies between the key performance indicators of any one manager with those of other managers.
- Have all senior managers undertake systematic capacity building in leadership.
- Consider developing in-house leadership training for senior staff and offering it more broadly to partners via the ThaiHealth Capacity Building Unit.
- Consider undertaking a work-value assessment of senior positions to provide information about parity with other organizations and to assess the correct pay scale for various positions.

Develop ICT

- Develop a strategy for ensuring that all partners adopt ThaiHealth's ICT systems.
- Develop an ICT system for collecting, interpreting, presenting and searching program and project evaluations, including templates, indexes and update mechanisms.



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Chapter

7

THE WAY FORWARD

Chapter 7

THE WAY FORWARD

Introduction

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The previous chapters contain a number of recommendations, all of which are important for improving ThaiHealth's future. This final chapter highlights three interconnected organization-wide priorities that should be pursued urgently: integration, decentralization and relationship building. It concludes with a vision of what the second decade of ThaiHealth would look like if the majority of the recommendations from the 10-Year Review were implemented. Among other things it would be an era of evaluation and capacity building; an era of strategic thinking, learning and innovation; and a time when ThaiHealth would be applauded for its transparent, efficient and effective processes and relationships.

Improving integration

Improving integration between ThaiHealth's 13 plans is a top priority. One of the reasons why vertical programs are unacceptable is that risk factors share co-morbidities: for example, alcohol with smoking, alcohol with traffic accidents, and alcohol with smoking and teenage pregnancy. Communities are affected by all the risk factors, and disadvantaged communities have higher risk profiles.

The silos created by vertical programs mean that opportunities are often missed for important health promotion development, resources are wasted, and mistakes can be repeated. Different teams may be working in the same community or with the same group but with no coordination, and the resulting chaos compromises effectiveness and can lead to public disaffection with health promotion efforts.

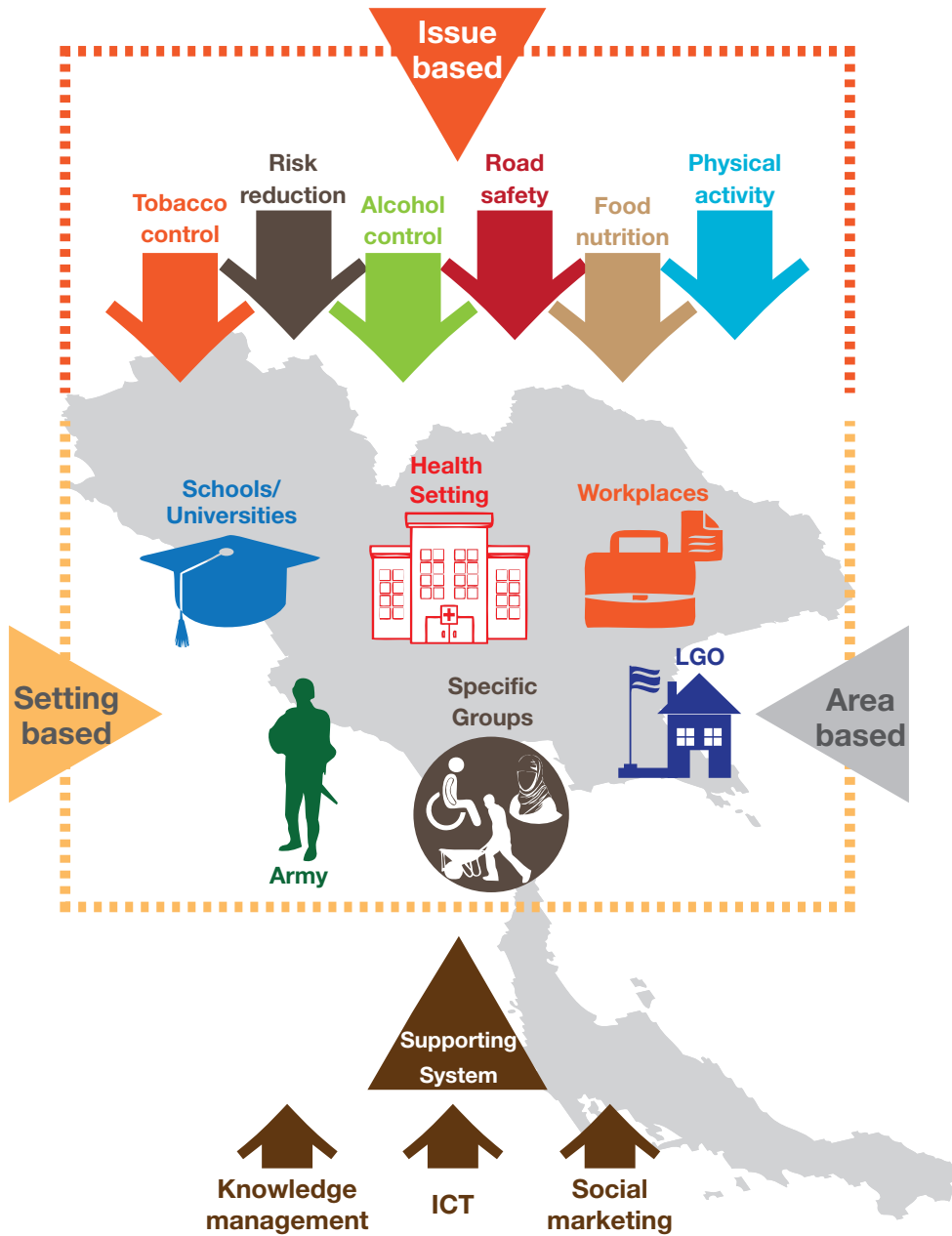
ThaiHealth has already taken major steps towards integration. In 2009 it adopted an area-based approach, dividing the country into nine different zones. Each zone has been assigned to a Plan Administrative Committee (PAC), whose mandate is to survey risk factors and other health promotion issues in the area and to develop a database of groups, organizations and systems. These activities are in addition to the PACs' responsibilities for the development and delivery of plans, and there are concerns that the new system has increased staff workloads too far. Although

recruiting further staff to run the area-based integration would be a difficult decision for ThaiHealth, which has always tried to limit its size, nine extra staff would not make a significant difference to its overall staffing numbers.

In addition, ThaiHealth would have to trial some other approaches. One example would be to target health promotion efforts by age group: infants, children, adults and the elderly. Regardless of the approach it is reasonable to expect that all risk factor control programs (tobacco, alcohol, road injury, exercise) could ensure that specific population groups (Muslims, disabled people, stateless refugees, informal workers) are clearly identified in their respective plans.

Another approach to integration would be to restructure the 13 plans. Some of the plans are issue-based, some are setting-based, some are area-based and others are supporting system (see Figure 7.1). Given that ThaiHealth's mandate is to work on risk factors such as smoking, alcohol, road accidents, and so on, it could be helpful to consider these as the core plans and then design interventions around them. Other plans such as the involvement of communities (Plan 6) and social marketing (Plan 10) could then be considered as crosscutting, and could be integrated with the core plans.

Figure 7.1 Integration of different types of ThaiHealth-funded projects



Facilitating decentralization

Thailand is a large country and as a result ThaiHealth is still considered irrelevant in some provinces and areas. In the past, to extend its reach, ThaiHealth has considered dispatching staff to provinces where its presence is unknown or placing staff in Community Learning Centres. Dividing Thailand into nine areas for the PACs is one possible solution, but as this will require more resources in order to succeed, it remains to be seen whether it will produce the intended result.

Another solution might be the development of decentralized work programs across Thailand. Such a systematic capacity building program could be delivered across the country, consisting of short courses, symposia, workshops and regional conferences. ThaiHealth could run these programs itself or partner with an external agency, but would use its own staff for keynote sessions and to establish its leadership presence in the provinces.

Another way to decentralize ThaiHealth is through greater involvement at the provincial level. ThaiHealth could choose 10 provinces with committed PACs, for instance, and

give each province grants to execute health promotion plans. In this scenario the provinces would implement the plans and ThaiHealth would provide technical oversight and supervision. ThaiHealth could contract with a province to develop a plan to cut smoking by 5% over three years, for example. The provinces would then receive funds based on performance. Such an approach would also enhance capacity at the local level.

In summary, the 10-Year Review recommends three actions relating to decentralization.

- Develop a strategic capacity building plan consisting of short courses, symposia and workshops that would be delivered across Thailand, and organize four to five regional conferences.
- Brand all capacity building programs and encourage staff to share their expertise in order to establish ThaiHealth's leadership in the provinces.
- Consider setting up a provincial or regional-based approach to proactive program development, proactive grant funding and open grants (outcome targets would need to be developed).

Building relationships in Thailand and with the rest of the world

Maintaining good relationships with parliament and government, especially with the MoPH, is critical to ThaiHealth’s “health in all policies” objective, as well as for its own sustainability. It is vital for ThaiHealth to improve the understanding of health promotion at the parliamentary level, and in particular an understanding of the issues it tackles and the approach it takes in all of its programs. Recently ThaiHealth established a small unit to liaise with Members of Parliament (MPs), providing them with updates about health promotion and ThaiHealth’s priorities and activities, arranging for health checks and running programs about healthy work environments. This work should be a high priority. All newly elected governments, for example, need to understand the various dimensions of health promotion and also about the importance of the social determinants of health.

The MoPH is one of ThaiHealth’s most important partners, but relationships between national health promotion foundations (HPFs) and health ministries are often tense, especially during periods of political change or economic downturn. Relationships tend to come under pressure when the HPF has funds available for innovative programs, while the health ministry has little access to untied funding and thus

little room to innovate. The reality is that HPFs need to work closely with health ministries. HPFs can initiate and advocate in areas core to public health, such as tobacco and alcohol control and food labelling, and health ministries can deliver policies, systems, operations and regulation.

Health ministries cannot easily undertake sustainable intersectoral work, however, and that is another reason why HPFs are so valuable. HPFs have established intersectoral governance structures and operational platforms that penetrate deep into local communities. HPFs are also important because, unlike the MoPH, where staff tend to change with governments, HPF staff remain relatively consistent, weathering most political changes, thus providing continuity and valuable institutional memory.

There are many examples in countries and provinces where knowledgeable and energetic health promotion leaders work in the MoPH and champion this area. This can give a major boost to health promotion, but it is difficult to ensure that gains are sustainable in the long term. This may be because the increased emphasis on health promotion relates to internal advocacy by the health promotion leadership, which may include a Minister. When they move on, for example because of a change of portfolio, of government or of job, the emphasis on health promotion often declines. This is an important reason for establishing an HPF as an institutional focus for health promotion that can survive change in personnel or government.

A second source of tension between health ministries and HPFs lies in the HPFs’ duty to produce realistic responses to the challenges of the social determinants of health. This leads

HPFs into a range of methods and areas that would not be seen as relevant to most health ministries, and may at times appear to be so far outside a mainstream public health agenda as to cause tensions. A visionary health promotion leader within the MoPH can mediate such tension for a time, but the momentum of the MoPH's mainstream role inevitably challenges unconventional incursions into many sectors and tends to revert to focusing on protection, services and treatment.

Ideally, a health ministry should value the work of an HPF in terms of its ability to trial new approaches, take risks in testing innovation, and rally support for health promotion across different sectors. This allows the health ministry to focus on what it does best: developing legislation and regulating service provision. Obviously it is vital for health promotion that the two institutions maintain a close working relationship.

ThaiHealth and the MoPH must continue to consult and involve each other in the development of strategic plans for health promotion. ThaiHealth needs to ensure that its strategy fits with national priorities, and the MoPH should be represented on the governing board of ThaiHealth. Indeed a cross-section of high-ranking civil servants from the MoPH should be represented on ThaiHealth's planning committees and working groups.

In summary, to maintain strong ties with the MoPH, ThaiHealth should:

- ensure that the MoPH is strongly represented on the Board of ThaiHealth and on ThaiHealth's plan advisory committees and working groups; and
- explore opportunities for MoPH staff to work on rotation in ThaiHealth.

Forging international health promotion networks

ThaiHealth is making a significant contribution to the expanding network of HPFs worldwide. And as one of the strongest HPFs, and one of the few funded from a health-promoting funding mechanism (an excise tax on tobacco and alcohol) ThaiHealth is an important role model at the international level. Transferring the model from Thailand to other countries in the region and further abroad is a laudable goal in its own right. Further, the development of more HPFs makes ThaiHealth's own political sustainability more secure. By exporting HPF development expertise to other countries, ThaiHealth and the government of Thailand are making an extremely valuable contribution. Already ThaiHealth hosts top policy makers and government leaders from around the world who are interested in setting up HPFs. ThaiHealth ensures that senior members of the Thai government and civil servants are also involved in these visits. It would, however, be desirable to systemize such visits to ensure the minimum possible disruption to ThaiHealth.

Another way in which ThaiHealth could transfer knowledge globally would be to run regular short courses on HPF leadership. Such courses could be organized by the proposed Capacity Building Unit, and international aid agencies could cover the fees for participants from developing countries. Regular training opportunities of this kind would not replace visits by dignitaries, but they could build in the next step. Also, using funds from outside of ThaiHealth's budget would avoid any criticism that it was using domestic funds for international work.

The suggestion made in the 5-Year Review that ThaiHealth should benchmark itself against existing HPFs may need to be revisited. Since that report was published in 2007 it has become clear that HPFs are all at very different stages of development and often take very different approaches. VicHealth of Australia might be similar to ThaiHealth in its approach, but it is has been encouraged to reposition itself in relation to new imperatives unique to Australia. These include new funds destined for the Ministry of Health from a national partnership on prevention. That means that VicHealth must define its role in relation to the Victorian Ministry of Health, which is now quite active in the health promotion field.

In Western Australia, Healthway was established primarily as a sponsorship body similar to New Zealand's Health Sponsorship Council. Healthway has an interesting research program in addition to its sponsorship of sports, the arts and health promotion programs. The Australian National Preventive Health Agency (ANPHA), which was established very recently, is functioning primarily as a technical policy adviser to the federal and, where appropriate, state governments, as well as taking on the responsibility of Australia-wide social marketing programs. Although focused on individual behaviour change, ANPHA's five-year strategy envisages establishing a knowledge management and transfer function in the form of a knowledge hub. Experience in setting this up could be shared between ANPHA and ThaiHealth. Similarly, ANPHA has much to learn from ThaiHealth, particularly on the funding front, and its use of tobacco and alcohol excise taxes for health promotion.

HPFs in Austria and Switzerland have very different origins, remits and funding sources.

Unlike ThaiHealth, there is no expectation that they will lead health promotion efforts. Although their programs are valuable to track and learn from, benchmarking would be difficult and would not necessarily be a good use of ThaiHealth's time or resources.

The International Network of Health Promotion Foundations (INHPF) was established in 1999 and the secretariat moves each year to a new foundation. Without an independent source of funding, however, the network is vulnerable and weak. With new HPFs coming on stream at a greater rate, it is important to strengthen the INHPF's funding base.

The newest HPFs in Southeast Asia and the Western Pacific are those in Laos, Malaysia (already established inside the Ministry of Health), Mongolia, South Korea and Vietnam. The South East Asian Tobacco Control Alliance (SEATCA) and the WHO Regional Office for the Western Pacific Region are both driving the development of new HPFs. SEATCA, a Thai-initiated organization that emerged from Action on Smoking or Health, is particularly interested in ThaiHealth's tobacco-excise funding mechanism. There is a strong case for ThaiHealth to establish a formal partnership with SEATCA and develop a Memorandum of Understanding to clarify the expectations of both organizations. Not only is SEATCA's HPF agenda of importance to ThaiHealth, but so too is its regional tobacco control agenda because of the cross-border trade in tobacco. Given the strength of the two organizations, it would be worth considering having the INHPF secretariat based at ThaiHealth for a period of at least three years. This would allow ThaiHealth to support and strengthen new HPFs as they come on stream.



Using ThaiHealth’s budget to fund these activities, however, remains an issue that could become politically problematic. Some people are bound to ask: why use Thai baht to support international development activities? That attitude could be avoided by attracting funding from external sources, such as international philanthropic organizations and the Thai aid budget, as well as from international participants in ThaiHealth’s capacity building programs. This would enable ThaiHealth to systemize its international work, contribute to the development of new regional HPFs in partnership with SEATCA, and bring best practice to the INHPF.

The recommendations for ThaiHealth international endeavours are summarized in the following points.

- Develop a formal partnership between SEATCA and ThaiHealth with an MOU clarifying expectations for both organizations.
- Initially base the INHPF secretariat at ThaiHealth for a period of three years.
- Approach external funding sources, such as international philanthropic organizations and the Thai aid budget, to support international participants in ThaiHealth’s capacity building programs.
- Focus on systematizing international work and developing new regional HPFs in partnership with SEATCA.

ThaiHealth's second decade: What success looks like

ThaiHealth was set up in 2001 after a 10-year campaign that began in the 1990s. The roots of the campaign came from Thailand's successful tobacco control movement. The model used to establish ThaiHealth's funding base were excise taxes that also promoted health. The first was a dedicated levy on tobacco (a so-called sin tax) that not only provided funding for ThaiHealth but also raised the price of cigarettes and therefore lowered smoking rates. ThaiHealth was also built on a levy on alcohol, another sin tax that also reduces the volumetric rate of alcohol consumption.

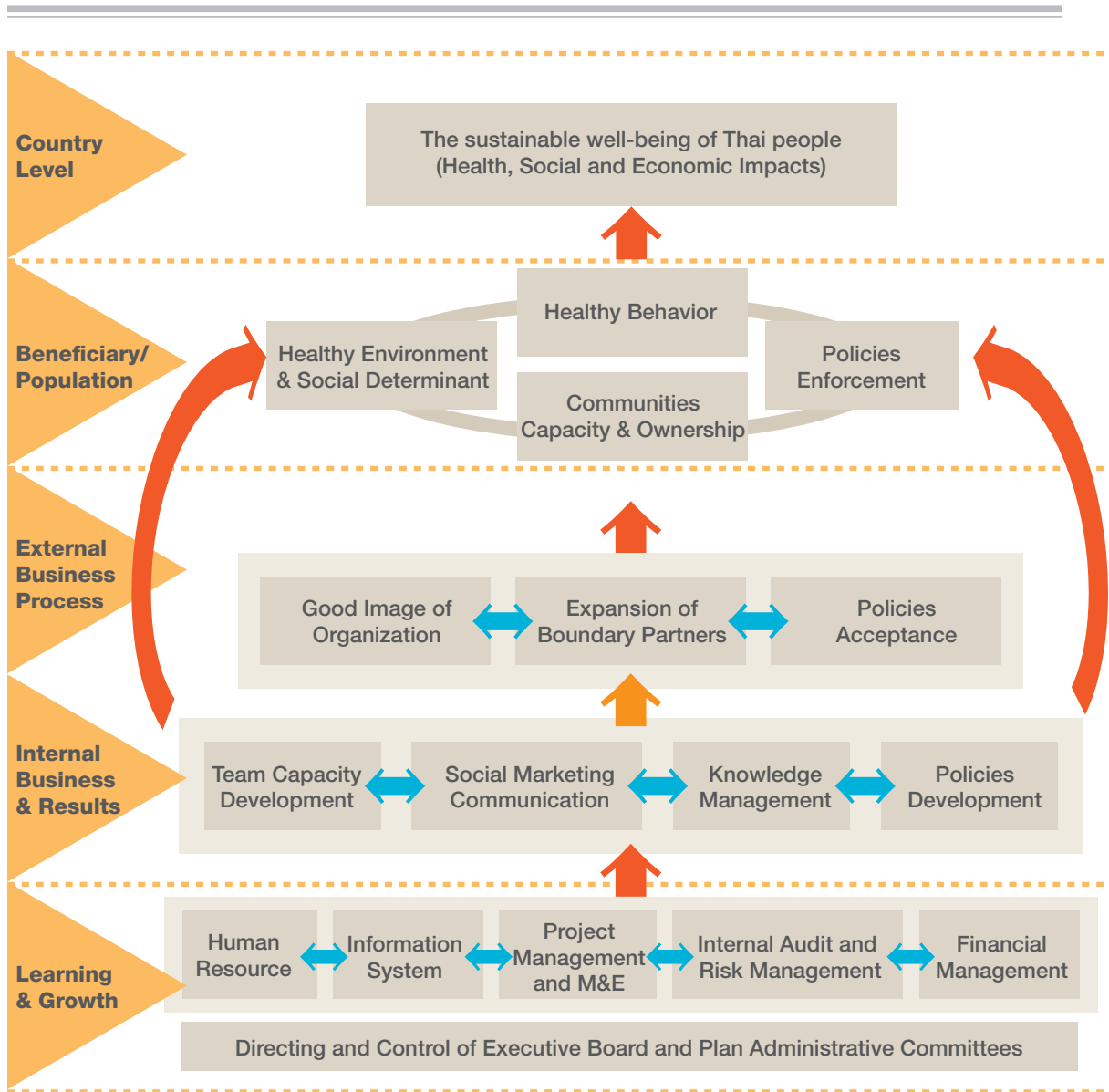
The platform ThaiHealth developed was aimed at enhancing the culture of health promotion across Thailand. It took a multi-sectoral approach to reducing major risk factors that spanned different communities and settings. As a result ThaiHealth has a broad reach, both geographically and across the country's diverse population groups.

ThaiHealth has achieved success in risk reduction programs for smoking, alcohol use and road accidents. It has also achieved successful outcomes in education, public broadcasting and consumer protection. ThaiHealth has made seminal contributions in the development of infrastructure such as the National Health Assembly, which has enabled civil society to participate in health promotion nationwide.

ThaiHealth has become a beacon in the network of HPFs, called on to transfer knowledge and experience to an increasing number of countries looking to establish similar mechanisms to ensure that health is promoted with sustainable resources on a multi-sectoral platform.

ThaiHealth is now entering a new decade as a mature organization. In order for it to maintain its leadership role, both in Thailand and on the international stage, it needs a new focus that emphasizes strategic thinking. The conceptual framework presented in Figure 7.2 would be a good place to start.

Figure 7.2 A new conceptual framework for ThaiHealth



Source: ThaiHealth, 2011.

In particular, new rigour must be brought to ThaiHealth's measurement endeavours. In its efforts to spread health promotion, ThaiHealth has left itself vulnerable by not yet establishing a sufficiently strategic approach

to evaluation. If it fails to set up robust mechanisms for evaluation and a strategic evaluation plan, ThaiHealth may find it increasingly difficult to prove its value, particularly in this era of slowing global growth and volatile economic environment.

The era of evaluation

The title of the 5-Year Review, Many Things to Many People, has generated lively discussion about whether or not ThaiHealth has been too many things for too many people. Part of the explanation of why this is not the case lies in the fact that for its first 10 years ThaiHealth concentrated on establishing the relevance of health promotion and developing a health promotion culture across the country in which prevention forms an integral part. ThaiHealth still has a significant way to go to achieve health promotion as a top priority in Thailand. While its reach is broad and has led to many valuable outcomes, ThaiHealth's efforts to maintain its relevance, especially strategically, must remain a top goal for ThaiHealth in the coming decade.

Another question that has arisen from the 5-Year Review is: does ThaiHealth's program try to address too many issues? The answer is this: if an intervention does not result in strategic knowledge, if learning is not transferred from each intervention, if evaluation and cost-benefit analysis are not robust components of all plans and programs, and if the value of an approach cannot be proven, then there may well be too many issues on ThaiHealth's agenda.

Over the next decade, decisions about which issues to add and which to delete must include the capacity to assess possible outcomes and their impacts. This means that ThaiHealth has to tackle evaluation full on. Applying knowledge from evaluation to the strategic selection of priorities would mean that disadvantaged population groups would become a much stronger focus for ThaiHealth, especially in areas where risk factors are greatest. There would be a greater focus on one or two settings using an organizational development

approach to evaluation with clear indicators, outcomes and data on impact. Communities and local government organizations would remain a priority, but evaluation and knowledge transfer would be built in from the outset. Early childhood would be emphasized, especially to reduce non-communicable diseases across Thailand.

The era of capacity building

In order to ensure that ThaiHealth is addressing frontier issues and approaches, it must upgrade its capacity for strategic thinking, both within the organization and among its partners and potential partners. Capacity can only be built, however, when it is understood what works, what does not, and why. ThaiHealth must therefore link its need to build capacity with a vastly improved approach to evaluation. Learning, and ultimately knowledge, must come from evaluation so that the most important issues requiring capacity building can be identified. A virtuous circle needs to be developed, connecting evaluation to learning and knowledge and then connecting knowledge to capacity building.

Capacity should be delivered using a decentralized approach. This would enable ThaiHealth to reach every corner of Thailand, every community, and potentially, using cost-recovery methods, the international community. ThaiHealth should carefully plan its capacity building strategy on a ten-year horizon. Where new skills and knowledge are needed (social epidemiology, action research, impact evaluation, health promotion economics, and strategic thinking) an approach should be developed to ensure that these areas are part of a systematic capacity building plan that can be rolled out over a realistically shorter time frame.

The era of strategic thinking, learning and innovation

ThaiHealth's future depends on its capacity to be innovative and to systematically apply the knowledge and experience gained from its programs and from health promotion efforts in other countries.

While strategic thinking must be built in as an expectation for ThaiHealth, it should not be viewed as ThaiHealth's job alone. Maintaining a permeable organizational boundary is imperative. This means welcoming new coalitions, new wisdom and new expertise that could come from anywhere. ThaiHealth must be an open and alert organization that is constantly working to develop good relationships with all stakeholders. Quality relationships are necessary to ensure scale-up from ThaiHealth trials, and scale-up partners, including government departments, must be involved as partners from the beginning of the process.

Some of ThaiHealth's most innovative programs have resulted in spin-off organizations. The connections and interdependencies with these spin-offs should be emphasized: strong systematic engagement will enable these programs and organizations to complement ThaiHealth's need for ongoing innovation.

The era of transparent, efficient and effective processes and relationships

In order to maintain its credibility, ThaiHealth must continue to ensure that all processes and procedures regarding grants, partner selection and governance are clear and transparent. It is now time to introduce a system for attestation of these processes. The role of the Evaluation Board should be increased to include the task of assuring and attesting to all ThaiHealth processes that could give rise to conflicts of interest for the Parliament; the Executive Board should ensure continuous progress towards that end.

The next decade will be challenging. It must be an era of strong strategic thinking. Evaluation and capacity building must drive ThaiHealth's momentum within transparent and fully accountable processes. The invaluable contribution that ThaiHealth has made to date in cutting-edge health promotion knowledge at home and abroad can then be maintained.

Annex I

Terms of Reference for the 10-Year Review

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TOR 1: Mission and Strategy Assessing the relevance and adequacy of ThaiHealth's missions to the national priorities:

This TOR is designed to assess ThaiHealth's flexibility: its willingness and ability to change direction and respond to new challenges, threats and opportunities. It should also gauge ThaiHealth's ability to obtain and assess new knowledge about health promotion and prevention strategies, and to respond innovatively, and thus to influence the direction of national priorities.

TOR 2: Governance and Operations Assessing the appropriateness of ThaiHealth's governance structures and the appropriateness of the operational structure and systems, such as human resource management, information system management and information technology utilization:

This TOR is designed to assess core business processes, such as grants management and project development processes, to gauge the adequacy of fully justified and transparent systems. In addition, this TOR should assess the processes for contract management, including the appropriateness of the auditing, monitoring and evaluation of funded projects.

This Governance and Operations TOR is vital to the ultimate assessment of ThaiHealth's maturity and ability to become a sustainable organization, with robust systems. ThaiHealth has many observers, some of whom are ready to criticize any governance and operational issues, such as conflict of interest. Specifically this TOR should cover questions such as: is there too much opportunity for (and examples of) political interference? Is the structure sufficiently inclusive of new opinions and personnel from outside its established networks? Is the combination of governance and operations too cumbersome causing ThaiHealth to become an impenetrable government department, rather than a responsive, non-bureaucratic agency?

As for as the detail of operations, the TOR requires questions to be asked such as: are the operations as contemporary as possible, taking full advantage of new information and communication technology (ICT) applications? Does ThaiHealth's human resource management approach lead to the recruitment and retention of the best workforce possible? Is the level of transparency in all systems adequate to protect ThaiHealth from real or perceived criticism? Are the systems

sufficiently robust to ensure ThaiHealth is seen to be a leader in purveying new knowledge and transferring research results for a new era of health promotion?

Because ThaiHealth is funded by a dedicated tax on tobacco and alcohol, it has a special obligation to ensure sound fiduciary management, value for money and accountability.

TOR 3: Achievements of Major Programs Funded by ThaiHealth
Assessing the achievements in tobacco control, alcohol control and road injury reduction, the sports and exercise program is to be assessed as a major risk factor, as is social marketing as one major health promotion method:

These major programs are flagships for ThaiHealth, with the reduction of tobacco and alcohol consumption and road injuries cited in the legislation as key programs, instigated to reduce both the burden of disease and injury, and their cost. However, the rationale for adding physical exercise as a major program, in isolation from other risk factors for non-communicable disease control, is questionable. Three of the major program areas should arguably remain as priorities (tobacco, alcohol and road injury), but the procedure involved for a minor program to become a major program also needs to be assessed.

TOR 4: Overall Achievements of Other Programs Assessing the achievements in other risk areas, population groups, settings, systems and organizations:

One of the challenges in assessing the remaining program (plan) areas is to understand the criteria for inclusion of particular issues (such as physical exercise as a major risk factor). ThaiHealth's method of selecting other risk factors, the geographic areas for community programs, the particular settings, population groups, methods and approaches, needs to be clearly understood.

One of the most significant challenges for a health promotion foundation (HPF) is the expectation that it undertakes a fully comprehensive approach. It is difficult to justify the omission of any one aspect of health promotion. How can a life stage be omitted? How can a method or a relevant setting be excluded? How can a health risk be overlooked? Add to this the underlying social determinants and we are faced with an incredibly complex program that is spread very wide, hence the title of the first 5-Year Review: Many Things to Many People. This raises the perennial question: is ThaiHealth spread too thin? This is accompanied by a further question: would ThaiHealth do better to select fewer issues and invest more heavily in them?

Before these questions can be answered, it is necessary to assess ThaiHealth's role as a catalyst and innovator. Is there a process in place which enables continuous assessment of the breadth and depth of ThaiHealth's portfolio, to ensure that it is not diverging from its remit without producing measurable outcomes?

Assessment is also required of ThaiHealth's capacity to measure its catalytic contribution, in order to justify its input into many of the new developments in Thai society.

TOR 5: Sustainability of Health Promotion Supported by ThaiHealth Assessing the approaches to achieving intergenerational sustainability of health promotion:

This TOR requires assessment of the depth and effectiveness of the partnerships established with all levels of government, NGOs and businesses. This includes assessing ThaiHealth's role in building capacity, both externally with partners and internally with its own staff.

Another issue requiring assessment is the method for selecting partners, and for expanding the partner pool with new partners from organizations with fresh ideas and approaches. The transparency of partner selection is part of the tension with a developmental approach, where capacity for participating in the strategic development of the program is a prerequisite for a partner's selection. ThaiHealth is inevitably, and necessarily, the leader in this process: as facilitator, and ultimately as partner selector. An assessment is needed of ThaiHealth's choices, in its balancing act between previous partners with a track record of good delivery, and new partners with innovative input.

Assessing sustainability also includes assessing the capacity of all partners to diversify their funding sources, so that ThaiHealth need not remain the only funder and can move into new areas. This requires assessment of specific capacity building programs to support partners' fundraising abilities and their organizational strengths.

TOR 6: Best Practice of Other Health Promotion Foundations Assessing what ThaiHealth can learn and, as importantly, what it can offer other HPFs:

The country-based context is vital to all considerations when comparing ThaiHealth with other HPFs, several of which are from small (population) European countries or from states (or provinces) of Australia. Assessment is required of the differences in the funding mechanisms for the HPFs: using the dedicated levy on tobacco and alcohol is currently unique to ThaiHealth.

It is also necessary to assess the role ThaiHealth should play in the international movement to develop country-based foundations. Should its domestic budget be used for this purpose? Should it be playing a leadership role in assisting countries and developing a strong network between HPFs? A useful addition to this TOR would be to assess the value to Thailand and ThaiHealth, not only of the development of HPFs, but also of the global movements in the areas of tobacco and alcohol consumption control, and in the future, junk food control.

TOR 7: Recommendations for Improvement to Fit the Circumstances for the next 10 Years

The crux of the Review are the recommendations for a different emphasis, for new areas and for different approaches. Recommendations must be based on practicality, taking into account trends and context. Suggestions and ideas will be presented throughout the Review, and recommendations made only when there is some certainty about the capacity to implement them.

Annex II

Interview List

Thai Health Promotion Foundation

ThaiHealth Executive Board

Dr Vichai Chokevivat	2nd Vice-Chairman
Dr Charuaypon Torranin	Member
Assoc Prof Dr Joompol Rodcumdee	Member
Mr Somporn Chaibangyang	Member
Dr Suwit Wibulpolprasert	Member

ThaiHealth Evaluation Board

Prof Dr Kraisd Tontisirin	Chairman
Assoc Prof Dr Chai Podhisita	Member
Prof Dr Direk Patamasiriwat	Member
Assoc Prof Dr Kanjana Kaewthep	Member
Dr Uthai Dulyakasem	Member
Dr Manit Prapansilp	Secretary

ThaiHealth Plan Administrative Committees

Prof Dr Udomsil Srisangnam	Chairman of Plan Administrative Committee 1
Mr Kitisak Sinthuvanich	Chairman of Plan Administrative Committee 3
Prof Dr Chanika Tuchinda	Chairperson of Plan Administrative Committee 4
Prof Emeritus Krairit Boonyakiat	Chairman of Plan Administrative Committee 7

ThaiHealth Sub-Committees

Mr Suphol Kunaporn	Chairman of Internal Audit Sub-Committee
Mr Pairote Kaewmanee	Internal Audit Sub-Committee

ThaiHealth Management Executives

Dr Supakorn Buasai	Former Chief Executive Officer
Dr Krissada Ruengareerat	Chief Executive Officer
Asst Prof Dr Supreda Adulyanon	Deputy Chief Executive Officer
Dr Sirikiat Liangkobkit	Director of Health Risk Control 2 Section
Ms Duangporn Hengboonyaphan	Director of Healthy Community Strengthening Section
Mrs Penpan Chittasenee	Director of Healthy Child, Youth, and Family Promotion Section
Assoc Prof Dr Wilasinee Adulyanon	Director of Social Communication and Campaign Section
Mrs Ngamjit Chantrasatit	Director of Health Innovation and Opportunity Promotion Section
Mrs Benjamaporn Jhantharapat	Director of Health Systems Development Section
Dr Charnwitaya Wasantanarat	Director of Healthy Organization Promotion Section

Partners

Dr Atapol Sughondhabirom Na Badalung	Program Manager of Drug Knowledge Management
Dr Chantana Ungchoosak	Program Manager of Thai Children Against Sweetened Food
Mr Chavarong Limpattamapranee	Head of Thai Journalist Association
Mr Chayun Sirimas	Director of Integration Section, Department of Disaster Prevention and Mitigation, Ministry of Transport
Mr Detcharut Sukkumnoed	Program Manager of Alternative Energy
Dr Hatai Chitanondh	President of Thailand Health Promotion Institute
Mr Jaded Chaowilai	Manager of Friends of Woman Foundation
Dr Kamolporn Suansomjit	Program Manager of Health Promotion for Royal Thai Armed Forces
Assoc Prof Dr Khanitta Nuntaboot	Program Manager of Community Systems Strengthening Projects
Mrs Kannikar Bunteongjit	Deputy Secretary General, National Health Commission Office
Dr Kasem Nakornkate	Expert on Physical Activity and Sport for Health

Ms Kemporn Wirunrapun	Program Manager of Healthy Child Media
Mr Narong Tiemmake	Expert on Physical Activity and Sport for Health
Dr Narongsak Ungkasuwapala	Former Director-General Department of Health, Ministry of Public Health
Ms Nattaya Bunpakdee	Program Manager of Sexuality Health Promotion
Prof Dr Parichart Sthapitanonda	Professor, Faculty of Communication Arts, Chulalongkorn University
Ms Parichart Siwaraksa	Evaluator, Alcoholic Beverage Consumption Control and Traffic Injuries and Disasters Prevention Plan
Dr Pongpisut Jongudomsuk	Director of Health Systems Research Institute
Prof Dr Prakrit Vathesatogkit	Executive Secretary of Action on Smoking and Health Foundation
Dr Prapon Pasukyud	Director of the Knowledge Management Institute
Dr Somsak Chunharas	Secretary-General of National Health Foundation
Mr Suriya Yeekhun	Community Leader, Tambon Prik, Songkhla
Dr Tanapong Jinvong	Director of Information Centre for Road Safety
Dr Tantip Thamrongwaranggoon	Expert on Health Promotion for Community
Mrs Tasanee Sinlapabutra	Expert, Office of Transport and Traffic Policy and Planning, Ministry of Transport
Mr Teera Watcharapranee	Director of Stop Drink Network Office
Mr Tepchai Yong	Managing Director of Thai Public Broadcasting Service
Dr Thaksaphon Thammarangsee	Director of Center for Alcohol Studies
Prof Dr Vicharn Panich	Former Director of the Knowledge Management Institute
Dr Wachara Riewpaiboon	Program Manager of Health Promotion for People with Disability
Mr Wanchai Boonprapa	Program Manager of Family Network
Dr Witaya Chadbunchachai	Program Manager of Accident Protection in Community

Politicians

Dr Anusak Kongmalai	Secretary to the Senate Standing Committee on Public Health
Mr Boonyod Suktinthalai	Member of the House of Representatives