Internal Ex-Post Evaluation for Technical Cooperation Project

conducted by Thailand Office: April, 2016

Country Name	**Project on Development of a Community Based Integrated Health Care and Social Welfare Services Model for Older Persons in the Kingdom of Thailand (CTOP)**
Kingdom of Thailand	

I. Project Outline

Background	Thailand became the "aging society" in 2005, in which the population of 65 years and over occupies more than 7% of the total population, and it was expected that the elderly population would increase drastically in the coming 25 years. However, there have been factors which hinder the preparation before reaching the "aged society" where the percentage of the elderly surpasses 14%, such as limited social security systems, scarce financial resources for the elderly social welfare, insufficient service care provision of the public facilities, and vertically-segmented administrative system. Besides, the social changes such as increase of the nuclear families and migration to the urban areas have made home elderly care difficult. On the other hand, further community participation in the elderly care was expected, as there were available resources such as Health Care Volunteers and Elderly Care Volunteers. In such circumstances, development of the model of community-based health care and social welfare services for older persons in which actors of different domains would collaborate with each other for efficient service provision.
Objectives of the Project	Through the pilot activities of community-based service for improving QOL (quality of life) of the elderly in some selected tambons[1], the project aimed at establishing the model of CTOP, thereby contributing to its nationwide implementation. 1. Overall Goal: The Community based Integrated Health Care and Social Welfare Services Model for Older Persons (CTOP Model) is utilized nationwide. 2. Project Purpose: The Model is disseminated for the purpose of nationwide implementation. Note: CTOP Model is defined as a community-based service for improving QOL of the elderly, initiated with the will of the community people and led by TAO (tambon authority). The service is a hybrid activity among different domains such as health and social welfare based on the needs of the older persons. The service is not one time activity but continuous activities of PDCA (Plan, Do, Check, Action) cycle.
Activities of the Project	1. Project site: CTOP pilot tambons (Yang Hom of Chiang Rai, Sa-ard of KhonKaen, Bang Si Thong of Nonthaburi and Ban Na of Surat Thani) 2. Main activities: 1) Clarification of the roles of the related organization in the health care and social welfare services for the older persons, 2) Analysis of the situations of the four pilot areas for implementing the Model and preparing the action plans for each pilot area, 3) Pilot tambons' implementation of the action plans of the health care and social welfare services in the pilot areas, 4) Developing the Model for the health care and social welfare services, 5) Training of the personnel (government officers, Care Coordinators[2], Health Care Volunteers[3], Elderly Care Volunteers[4], committee members, etc.) on the health care and social welfare services, etc. 3. Inputs (to carry out above activities) Japanese Side 1) Experts: 23 persons 2) Training in Japan: 60 persons 3) Equipment: PC, video cameras, projectors, AV equipment for community activities, blood pressure monitors, blood sugar monitors, etc. 4) Local operation cost for travel expenses, translation, etc. (16,643,459 THB(Thai bahts) as of August 2011). Thai Side 1) Staff allocated: 62 (Central level) 2) Land and facilities: Office space and basic facilities, etc. 3) Administrative cost: 4,325,000 Baht 4) Operational cost for training, meetings, monitoring, etc. (23,389,996 THB)

Ex-Ante Evaluation	2007	Project Period	November 2007 to November 2011	Project Cost	(Ex-ante)190 million yen (Actual)209 million yen
Implementing Agency	Ministry of Public Health (MOPH), Ministry of Social Development and Human Security (MSDHS)				
Cooperation Agency in Japan	Ministry of Health, Labour and Welfare				

II. Result of the Evaluation

1 Relevance
<Consistency with the Development Policy of Thailand at the time of ex-ante evaluation and project completion> The project was consistent with Thai development policies, as the promotion of the welfare of the elderly and community-based

[1] Tambon is a local government unit in Thailand. Tambons form the third administrative subdivision level below the provinces and districts.

[2] Care Coordinators are provincial medical officers assigned by MOPH. They are responsible for ensuring that a patient receives necessary health and social services and also provide care to the elders and others who require care and resources in their houses.

[3] Health Care Volunteers are representative of their communities and registered under MOPH. They are trained under the course appointed by MOPH. Their main role is to change the people's health behavior, notify health-related news, introduce and publicize the knowledge, plan and coordinate for the health development activities, and provide some health services. The volunteers receive 600 THB per month as reward.

[4] Elderly Care Volunteers are assigned by and registered under MSDHS for its program for home care of the elderly.

approach were set forth in the 10th National Development Plan (2006-2011) and 2nd National Plan for Older Persons (2002-2021).

<Consistency with the Development Needs of Thailand at the time of ex-ante evaluation and project completion >

Thailand became the “aging society” in 2005 and it was expected to reach the “aged society” by 2030. However, public care service provision was limited and home care system was not developed. There were great needs for improving health care and social welfare services for the older persons in terms of quantity and quality.

<Consistency with Japan’s ODA Policy at the time of ex-ante evaluation>

In the Economic Cooperation Plan for Thailand (2006), the response to the issues related to the society maturation was one of the priority areas in technical cooperation, and aging population was one of the issues.

<Evaluation Result>

In light of the above, the relevance of the project is high.

2 Effectiveness/Impact

<Status of Achievement for the Project Purpose at the time of Project Completion>

The Project Purpose was achieved. Pilot activities for providing health care and social welfare services were conducted in the four tambons based on the situational analysis and prepared action plans. Their experiences were compiled as CTOP model, which the project presented to the Second National Conference[5] in July 2011 and also to the National Commission of Elderly[6] in October 2011. Thus, CTOP model was ready for its nationwide dissemination by the project completion.

<Continuation Status of Project Effects at the time of Ex-post Evaluation>

As shown in the following table, CTOP experiences have been reflected in several national programs and recommended to the local governments. MOPH has published the good practices of CTOP in its websites[7] for dissemination such as: i) screening of the elderly of Nakhon Phanom Hospital and ii) long term care program of Sakohnnakhon Hospital. As supplementary information, CTOP activities have continued at all of the four target tambons including problem analysis and development of the work plan, elderly survey, training for the volunteers and care managers[8], day care center activities, health check, Mobile One-stop Service, etc. Contributing factors for these continuous activities include availability of the budget from various sources (the central government, National Health Security Office (NHSO) and Community Health Fund[9] (CHF)), commitment of TAOs and Tambon Health Promoting Hospitals[10] (THPH), etc., according to the Provincial Public Health Offices (PPHO) and Provincial Offices of Social Development and Human Security (PSDHSO) and TAOs. Tools developed by the project such as TAI (Typology of the Aged with Illustration) have been used mainly by care managers in the situational analysis of the elderly. Also, principles and tools of CTOP have been integrated into the guideline and standard for THPH in the country.

One special feature to be highlighted for CTOP activities is the role of the community-level volunteers. In Thailand, there are over one million volunteers registered under MOPH and MSDHS and the project involved such volunteers into the project activities such as home visit and care. Coupled with Thai culture to respect the elderly and virtue, they have a strong will to help the elderly who are living alone, dependent, abandoned or treated inappropriately in the community have better quality of life. Such volunteers have been the key players for the effective project implementation and sustainability.

<Status of Achievement for Overall Goal at the time of Ex-post Evaluation>

The data on the accurate number of the tambons where CTOP model is used (indicator set forth in the plan) was not available[11], because neither of MOPH and MSDHS has managed it during and after the project. However, there are examples to show the expansion of CTOP model in several provinces, as shown in the following table. First, the experience of the project at the target tambons has been spread within the same district. For the expansion of the experience, the tambon’s role has increased as the number of the elderly has increased. Second, CTOP model has been reflected in the national programs for the elderly care services, where CTOP elements such as planning initiated with the community will, needs-based planning and use of the locally available resource have been utilized. For diffusion of the model, MOPH has conducted the training on the community care and elderly survey to all other provinces and tambons than those targeted. Another factor for promoting the diffusion is the decentralization which facilitates mobilization of the local resources.

<Other Impacts at the time of Ex-post Evaluation>

According to MOPH, MSDHS, PPHOs, PSDHSOs and TAOs, there are the following impacts. First, there have been positive impacts on the handicapped elderlies and elderly widows. By participating in the project activities, they have improved their living environment such as house and toilet and come to go out for the community rehabilitation center by being more frequently visited and cared by the community-level volunteers. Second, the community has come to learn from the elderly on the local wisdom and culture. Third, the family of the elderly and volunteers have become closer and more cooperative, which enables the care for the elderly more efficient and reduces the burden of the family. As an example in Sa-ard shows, the families have become more open-minded, which allows the volunteers to take care of the elderly more smoothly. As the fourth example, the project experience in establishment of the network among the concerned organizations, data collection and analysis, etc. has contributed to the formulation of the Project on Long term Care Service Development for the Frail Elderly and Other Vulnerable People (LTOP) (2013-2017) of JICA and other national programs for the elderly welfare, including the Program of Standards for Welfare Promotion and Rights of Protection of Older Persons

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[5] The National Conference was organized by the project to present and discuss the health and social welfare services of the pilot areas with the attendants both within and outside the project. It was held twice during the project period.

[6] The National Commission on the Elderly was established by the Act on Older Persons B.E. 2546 and is headed by the prime minister. It coordinates matters related to the elderly.

[7] The good practices are available in Thai language at: http://110.78.163.74/keling/older/.

[8] Care managers are the professionals (registered nurses or social workers) to provide health care to patients and manage health care facilities. Since there is no national certificate system for care managers in Thailand, they complete the curriculum set by the project.

[9] The Community Health Fund was established by NHSO for the purpose of encouraging self-reliance at the community level. THPH and TAO can apply for the fund for implementing CTOP-related activities.

[10] Tambon Health Promoting Hospital is a health institution established in each tambon which provides the primary care to the residents.

[11] According to the information provided by MOPH in March 2016, long term care activities with CTOP elements for the elderly at the community level are implemented in 20-60% of the tambons in six regions out of 12 regions and it is calculated that these long term care activities are implemented at 16% of the total tambons. However, the data in the other six regions was not available.

of MSDHS.

No negative impacts on the natural and social environment have been produced by the project.

<Evaluation Result>

The Project Purpose was achieved and has continued; CTOP model was established and its elements have been integrated into the national policies and programs. Examples of application of the model in several provinces have been confirmed, but the exact number of the tambons which utilize CTOP model (indicator of the Overall Goal) was not available to confirm the nationwide diffusion of the model. Therefore, the project effectiveness/impact is fair.

Achievement of the Project Purpose and Overall Goal

<table>
<tr><th>Aim</th><th>Indicators</th><th>Results</th></tr>
<tr><td rowspan="2">(Project Purpose)
The Model is disseminated for the purpose of nationwide implementation.</td><td>1. The meeting to present Model at the national level is held.</td><td>(Project Completion) Achieved.
CTOP model was presented to the Second National Conference in July 2011.
Note: This indicator was not used at the ex-post evaluation, because the model was already presented.</td></tr>
<tr><td>2. Model is proposed to the National Commission of Elderly, Ministry of Public health, Ministry of Social Development and Human Security, and Ministry of Interior for the purpose of developing nationwide implementation plan.</td><td>(Project Completion) Achieved.
CTOP model was presented to the Second National Conference in July 2011, with participation of MOPH, MSDHS, MOI, NHSO, and local governments. It was presented also to the National Commission of Elderly in October 2011.
(Ex-post Evaluation) Continued.
Major elements of CTOP have been integrated in the national programs (listed in the following table): i) planning initiated with the community will, ii) needs-based planning, iii) use of the locally available resources, iv) hybrid activity of health and social welfare and v) continuous activities based on the cyclical management.
CTOP model has been presented and recommended to the local authorities for the nation-wide implementation.</td></tr>
<tr><td>(Overall Goal)
The Community based Integrated Health Care and Social Welfare Services Model for Older Persons (Model) is utilized nationwide.</td><td>1. (Until October 2014) At least 15% tambons in each province utilize the Model.</td><td>(Ex-post Evaluation)Partially achieved.
The data on the number of the tambons where CTOP-related activities have been implemented was not available.
<Supplementary information>
(1) At Khon Kaen, the experience of CTOP such as health screening (ophthalmic, dental, orthopedics), chronic disease clinic, use of the elderly wisdom, elderly care volunteer training at Sa-ard Tambon has been spread to 4 other tambons in the same district.
(2) CTOP elements have been and will be utilized in the following national programs and thus implemented in other communities than the project target area with the utilization of CHF:
<table>
<tr><th>Program (Responsible Organization)</th><th>Major activities</th><th>CTOP elements*</th><th>Target provinces</th></tr>
<tr><td>Long Term Care in the community (MOPH)</td><td>Home care of the elderly</td><td>i, ii, iii</td><td>Udon Thani, Nakhon Phanom, Sakonnakgon, NangKhai, Bungkan, Leoi, Nongburalamphoo</td></tr>
<tr><td>Diabetes mellitus and hyper tension care for the elderly in the community (MOPH)</td><td>Home care of the elderly with the diabetes and hyper tension</td><td>i, ii, iii</td><td>Same as above.</td></tr>
<tr><td>Cataract care for the elderly in the community (MOPH)</td><td>Screening cataract and providing surgery</td><td>i, ii, iii</td><td>Same as above.</td></tr>
<tr><td>Promotion of standards for welfare promotion and rights of protection of older persons (MSDHS)(Under planning)</td><td>Elderly survey and planning of the elderly welfare management</td><td>iii, elderly survey (tool developed by the project)</td><td>To be determined.</td></tr>
</table>
*CTOP elements: i) planning initiated with the community will, ii) needs-based planning, iii) use of the locally available resources, iv) hybrid activity of health and social welfare and v) continuous activities based on the cyclical management.
(Source) MOPH and MSDHS.</td></tr>
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Source: MOPH and MSDHS.

3 Efficiency

Planned and additional outputs were produced. The project period was within the plan (ratio against the plan: 100%). The project cost exceeded the plan (ratio against the plan: 111%). One of the reasons is that some Thai inputs were covered by JICA when there was a heavy flood in Thailand in July 2011, and another reason is that some activities of preparing AV materials for extension of CTOP model were added based on the recommendation from the terminal evaluation mission. Therefore, the project efficiency is fair.

4 Sustainability

<Policy Aspect>

The community-based health care and social welfare services for the older persons is prioritized in the government policies, such as the 2nd National Plan on the Elderly (2002-2021) and 11th National Health Development Plan (2012-2016). The policy on community-based health care and social welfare services for the older persons will continue, according to MOPH and MSDHS.

<Institutional Aspect>

CTOP model-related activities depend on each tambon’s needs. With community-level volunteers, MOPH implements elderly

surveys to figure out their needs once or twice a year. For implementation of CTOP model-related activities, both MOPH and MSDHS are involved. For example, as the health administration, the Department of Health (DOH) and Department of Medicines of MOPH take responsibilities in the promotion of the model, and the Office of Permanent Secretary monitors the progress, receiving the report and statistic information on the elderly from TAO and THPH. PPHOs and THPH are in charge of coordination among the concerned organizations. Training related to the model is conducted by PPHOs and DOH. According to MOPH, the number of these personnel is sufficient to exercise these functions. Coordination of implementation of community-based health care and social welfare services has been undertaken by the Working Committee which consists from TAOs, PPHOs, PSDHSOs, THPH, other health institutions, volunteers, elderly club, etc. The committee has regular meetings to share the progress and issues related to the health care and social welfare services for the older persons, and sometimes applies for the budget of the activities for the elderly to TAO.

<Technical Aspect>

CTOP Handbook developed by the project was translated, revised and distributed to PPHOs, PSDHSs, THPHs and TAOs. THPHs have revised and used the handbook as the guideline for the elderly long term care. The communities use the handbook for the activity implementation, and also the provincial governments use it for supporting such community activities. The training guideline developed by the project has been on much use, too, as THPHs refer to it when conducting training to local authorities and municipality offices. The training for the provincial-level personnel has been conducted. The trainers are the personnel of DOH and Permanent Secretary of MOPH and their number and skills are sufficient, according to MOPH and MSDHS. The training is given for the Care Coordinators, Health Care Volunteers, and Elderly Care Volunteers sufficiently to conduct the community-based health care and social welfare services for the older persons, and their knowledge and skills are sufficient according to TAOs, PPHOs and PSDHSOs in the surveyed provinces.

<Financial Aspect>

Financial data specific to CTOP-related activities was not available from MOPH, because it is impossible to separate it from MOPH's various programs. Several departments have their own disbursement under different programs and there are several disbursement lines such as PPHOs, THPH and TAOs. However, MOPH, which plays a principal role in CTOP dissemination and operation, answers that the budget is in an increasing trend and is sufficient. Actually MOPH has implemented the planned activities for the older persons including LTOP and other projects which include CTOP elements mentioned in Effectiveness/Impact section (Long Term Care in the Community, etc.).Therefore, it can be said that there has been no major financial concern. From the same reason, the exact budget for CTOP-related activities of MSDHS was not calculated. However, the Department of Older Persons has the budget of 400 million THB per year, which is sufficient for its planned activities. The budget of TAOs comes from the allocation from the central government, NHSO, CHF and Community Welfare Fund[12], and local tax. Besides, TAOs mobilize funds by organizing charity activities or collecting user's fees for the daycare center. At the provincial level, the budget comes from the central government. Thus, various budget sources with locally mobilized resources enable efficient activities for the elderly care at the community level.

<Evaluation Result>

No major problems have been observed in the policy, institutional, technical and financial aspects of the implementing agencies. Therefore, sustainability of the project effects is high.

5 Summary of the Evaluation

The Project Purpose was achieved and its effects have continued. Concretely, CTOP model was established and its elements have been integrated into the national policies and programs. CTOP-related activities have been implemented in other tambons than the project target tambons, as MOPH has conducted training on the model to the concerned personnel at provincial and tambon level. The decentralization also has facilitated TAOs to promote the community-based health care and social welfare services for the older persons. However, it was not possible to exactly confirm in how many tambons or provinces the model has been implemented. As efforts to sustain the effects of CTOP model, MOPH and MSDHS have secured sufficient budgets and personnel. Communities have contributed to the implementation of CTOP related activities by mobilizing financial and human resources. Regarding the project efficiency, the project cost exceeded the plan in order to cover some Thai inputs influenced by a flood and to make materials for CTOP dissemination.

In light of the above, this project is evaluated to be satisfactory.

III. Recommendations & Lessons Learned

<Recommendations for MOPH and MSDHS>

1. Even though CTOP model was developed in the rural areas, its elements can be applicable nationwide. It may be challenging in the urban areas with the trend toward nuclear families and relatively less communication among the residents, but it is still recommended to make use of CTOP model. For example, it may be possible to apply CTOP model by identifying residents with strong will and commitment for community welfare or strengthening the linkage of the stakeholders (patients, families, volunteers, hospital workers, social workers, administration staff, etc.) in a possible way for each community. Since the ongoing LTOP includes urban areas as project sites, it is possible to utilize the network for collecting necessary information on the characteristics and potentials of the urban areas for providing community-based health care and social welfare services for the older persons. .
2. It is recommended to continue to secure the budget for training personnel engaged in the community-based health care and social welfare services for the older persons for which needs will increase in the aging society.

<Lessons Learned for JICA>

1. At the ex-post evaluation of the project, it was not possible to verify the achievement of the Overall Goal with the indicator established at the planning phase, as it has not been managed by either MOPH or MSDHS. When the project is planned or immediately after the project has started, it is indispensable to examine whether the indicator of the Overall Goal can be monitored even after the project completion by the implementing agency with the mentioned means of verification. It is better to examine to use the indicators used in the national policy.
2. At the project target tambons, CTOP activities were actively implemented and are continued. One of the key factors is the strong commitment of volunteers who have been taking multiple tasks for health care and social welfare services for the older persons. This has been enabled in Thailand since the country has a long history of the community volunteer system especially in the health sector.

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[12]The Community Welfare Fund is a fund which is raised and managed by the people of the community and tambon. It consists of the members' contribution and aims at funding social welfare activities in the community.

Thus, in countries which have such a history or culture, making the most of the local human resources such as volunteers who have basic skills for health care services and a strong will to work for the community is promising and therefore effective means for the successful community-based activities and also for the capacity development of the community.

(Community health check event called mobile unit at Banna Tambon, Banna Doem District, Surat Thani Province)

(Home visit at Yanghom Tambon, Khuntan District, Chiang Rai Province)