Journal of Infrastructure, Policy and Development 2024, 8(9), 5404.
https://doi.org/10.24294/jipd.v8i9.5404

Article

Effectiveness of local health constitutions in surveillance the pandemic of coronavirus disease-2019 in rural community of Thailand

Pawena Limpiteeprakan[1,*], Phalakorn Suebsamran[1], Niyom Junnual[1], Sudarat Woeisan[1], Anun Chaikoolvatana[1], Cholada Chaikoolvatana[2], Jongkolnee Sirirat[3], Rapin Yuenyao[3], Wichid Pumchan[4]

[1] College of Medicine and Public Health, Ubon Ratchathani University, Ubon Ratchathani 34190, Thailand
[2] Faculty of Nursing, Ubon Ratchathani Rajabhat University, Ubon Ratchathani 34000, Thailand
[3] Civil Society Foundation of Ubon Ratchathani, Ubon Ratchathani 34000, Thailand
[4] Ubon Ratchathani Provincial Health Office, Ubon Ratchathani 34000, Thailand
*** Corresponding author:** Pawena Limpiteeprakan, pawena.l@ubu.ac.th

CITATION

Limpiteeprakan P, Suebsamran P, Junnual N, et al. (2024). Effectiveness of local health constitutions in surveillance the pandemic of coronavirus disease-2019 in rural community of Thailand. Journal of Infrastructure, Policy and Development. 8(9): 5404. https://doi.org/10.24294/jipd.v8i9.5404

ARTICLE INFO

Received: 2 March 2024
Accepted: 4 June 2024
Available online: 10 September 2024

Abstract: This qualitative research aimed to study the effectiveness of the local health constitution in controlling the spread of COVID-19. It reports the role of local communities, government agencies, and healthcare providers in implementing and enforcing local health constitutions and how their engagement can be improved to enhance surveillance. We also reported factors that influence compliance and strategies for improving compliance. We also evaluated the long-term sustainability of local health institutions beyond the pandemic. The population and sample group consisted of key members of the local health constitution teams at the provincial, sub-district, and village levels in the rural area of Ubon Ratchathani. Participants were purposively selected and volunteered to provide information. It included health science professionals, public health volunteers, community leaders, and local government officials, totaling 157 individuals. The study was conducted from December 2022 to September 2023. Our research shows that local health constitutions can better engage and educate communities to actively participate in pandemic surveillance and prevention. This approach is a learning experience for responding to emergencies, such as new infectious diseases that may arise in the future. This simplifies the work of officials, as everyone understands the guidelines for action. Relevant organizations contribute to disease prevention efforts, and there is sustainable improvement in work operations.

Keywords: efficiency; health constitution; community participation; local government organizations; public health crisis

1. Introduction

The National Health Act of 2007, sections 46 to 48, which deal with the National Health Charter, serves as a tool and mechanism that provides opportunities for the public, local government organizations, and both public and private sector agencies to regulate, oversee, and improve the health status of the population. This is to be done within the available resources and in alignment with the context of a specific area (Srisutham, 2016). The Health Constitution of the Region is a new tool in Thailand that is gaining widespread interest among healthcare professionals and community workers. It all began in small, remote villages, where the concept of a national health constitution was adapted and applied, giving rise to the "Local Health Constitution", the first of its kind in Thailand and possibly the world. Starting from these small communities, the idea of a "Health Constitution" has inspired many other areas, leading to the development of local health constitutions in various regions

across the country (Sirapanichkul, 2013).

A local health constitution is a mutual agreement that sets the direction or practices for achieving community health. Communities can develop local health rules based on willingness and readiness. Local government organizations and public agencies should actively support and participate in the development of these charters. Local health constitutions emphasize community rights, lifestyles, culture, wisdom, social capital, health data, and sustainable community health system management principles. It leads to practical community health plans with clear responsibilities for all stakeholders, particularly the community members. Furthermore, it serves as a platform for raising awareness, accessing various types of information, and promoting community development for the benefit of the community (San Pa Muang Subdistrict Municipality Office, 2017).

A local public health constitution is widely used, for instance, taking local public health constitutions and using them to promote community exercise. Social capital's collective action in exchanging and learning together, jointly analyzing the problems of the sub-district, and a shared understanding of resolving collective issues are essential for successfully driving community health constitutions collaboratively (Sriphapa, 2015). This success results from people's cooperation, community leaders' capacity, involvement in the network, support from interdisciplinary workgroups, pushing the public health constitution into practice, communication to foster public understanding, and budget support for implementation (Kahaban and Kahaban, 2022). Another significant factor in a community is the development of community work networks. The coordination of work is established through mutual agreements, using state mechanisms to foster collaboration, assigning clear roles and responsibilities to reduce redundancy in directives, and promoting continuity and participation of the public in joint thinking, doing, learning, and fostering collaborative leadership, leading to the effective implementation of the community health system (Sridawruang et al., 2021).

During the period when Thailand and the world faced the outbreak of the coronavirus disease 2019, or COVID-19, caused by the new strain of coronavirus, SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus 2), there were continuous infections, especially towards the end of the year 2020. The COVID-19 pandemic has had a significant and direct impact on the country, resulting in a national emergency. The government established emergency management mechanisms in various locations to communicate and engage with the public regarding disease surveillance and control. Although Thailand's disease control system quickly isolated and managed infected or at-risk individuals, the situation also led to changes in societal dynamics, the economy, the environment, and the healthcare system. These developments highlight significant disparities in health equity, indicating the vulnerability of a system unable to respond adequately to emerging threats and urgent healthcare needs (National Health Security Office, 2022).

It can be seen that an effective public health emergency management system should aim to build and strengthen community resilience by not only being the government's responsibility but also involving a process that addresses emergency situations and plans for long-term sustainable solutions. In others, countries like

South Korea and New Zealand demonstrated the benefits of rapid response and stringent containment measures. South Korea utilized widespread testing and technological solutions for contact tracing, while New Zealand's strict lockdowns and border controls were highly effective in maintaining low case numbers (Marome and Shaw, 2021; Rajatanavin et al., 2021). In Thailand, community resilience is considered a key direction for sustainable development, and various concepts exist for building community resilience. For example, empowering the community to self-manage is one way to achieve this, and public health constitutions are tools used to manage community health issues, allowing communities to become strong and responsive to disease outbreaks. The key principle is that everyone should participate in the design of health constitutions for health management and quality of life. This process starts with community leaders who possess knowledge, abilities, and skills and the formation of committees to create health constitutions. These committees unite all stakeholders, including local authorities, academics, government agencies, and community organizations. Linking people in these communities is a collective effort to create a strong and resilient health system that can respond to various risks. The success of applying health constitutions has started to emerge and expand into local health constitutions, which communities develop for collective use in building their health systems. These have been widely adopted through strategic implementation (Office of Community Organization Promotion Foundation, 2016).

In the year 2021, in Health District 10, the Health District Committee for the Community of Area 10 developed and implemented a health charter specific to the district level in addressing the COVID-19 pandemic in the form of the "Tambon (Sub-District) COVID-19 Charter". The results of these efforts in Ubon Ratchathani Province were significant. The Tambon COVID-19 Charter was implemented in all 25 districts and 81 sub-districts with a connected mechanism for action at the district, provincial, sub-district, and village levels. This was considered a societal learning process related to public policy during crises. It aimed to learn and improve the public health emergency management system over the long term.

Therefore, the research team was interested in evaluating the effectiveness of the local health constitution in monitoring and controlling the spread of COVID-19 in the Ubon Ratchathani Province in the form of the Tambon COVID-19 Charter. This evaluation provides insights into implementing the local health constitution and how it can enhance interagency cooperation among government agencies, local authorities, and the public. This will help to identify any challenges in the process. The results of this evaluation can be used to make improvements to enhance the effectiveness of the local health constitution and to use it as a connecting tool for collaboration with government agencies. This can be crucial in planning and policy decision-making for an efficient and sustainable public health emergency management system and also the long-term sustainability of local health institutions beyond the pandemic.

2. Materials and methods

This is a qualitative study. The population and sample group comprised stakeholders with varying roles in the community's disease prevention operations.

They included essential players from Ubon Ratchathani's village, subdistrict, and provincial health constitution teams. Participants were purposively selected and volunteered to provide information. There were 157 people, including public health volunteers, community leaders, health science professionals, and local government representatives who are working groups at the regional, provincial, district, and sub-district levels and actively driven the local health constitution in Ubon Ratchathani Province and have hands-on experience in its implementation. The study was conducted from December 2022 to September 2023.

The question in the questionnaire of this research applies Butterfoss and Kegler's (2002) Community Coalition Action Theory (CCAT), which consists of three stages:

1) Formation stage: This stage involves understanding the community context, key members, process, activities, leadership, and team structure of the health charter initiative.
2) Maintenance stage: This stage focuses on building community synergy by managing resources within and outside the community. This aims to meet members' needs, foster their commitment, and lead to the community coalition's analysis, planning, and evaluation, which will help drive policy changes, practices, and community environment.
3) Institutionalization stage: The final stage involves implementing strategies and realizing changes in the community. Success in building a community coalition is measured by developing capacities and social capital that can be applied to future health and social issues.

2.1. Data collection

Data were collected through in-depth interviews and focus-group discussions. Open-ended questionnaires will be used, with interviews lasting approximately 30–60 min per participant (Merriam and Tisdell, 2016). A structured interview question, divided into three sets as follows:

1) Interview form 1 is designed to explore the community context. It focuses on the mechanism of the drive model operation process and evaluates the outcomes of the sub-district health constitution team, including the success of the health constitution from the perspective of operators among relevant groups at the district, province, and district levels.
2) Interview form 2 serves a similar purpose but specifically targets the sub-district context. It examines the drive model operation mechanism and health constitution outcomes from the viewpoint of operators in the sub-district-related group.
3) The observation form involves studying information from related documents such as meeting summary reports, coordination operation documents, and other relevant reports.

Before collecting data, the interview team or data collectors will be prepared, which is an essential research tool. This preparation ensures a consistent understanding of the intent of the questions and findings. Focus group discussions will also be conducted, lasting approximately 60 min per session. These discussions

were categorized into groups representing different sectors: government, community, and society. The researchers will gather insights into the challenges faced in implementing the local health constitution and other recommendations for improvement. These data provide policy recommendations for primary healthcare systems. During data collection and upon obtaining complete information according to the research process, a process to check the accuracy of data triangulation will be implemented. This includes checking data obtained from various sources for consistency, ensuring each researcher has consistent findings, and confirming that the data aligns with various theories, reducing discrepancies in the study results.

Data collection techniques

1) Research team meeting: This meeting will focus on preparing and understanding the data collection tools and research methods.

2) Coordination with relevant agencies: We will contact and schedule appointments with relevant organizations to gather information from all sectors.

3) On-site data collection: We will collect data in the field through in-depth interviews and focus group discussions.

4) Research team meeting (post-data collection): This meeting will be held to gather and validate all collected data, cross-check the data from various sources, and plan data analysis.

5) Coordination with local organizations and stakeholders: We will contact local organizations and individuals involved to convene data review sessions and collaborate on policy recommendations for implementing the local health constitution and COVID-19 surveillance.

These steps outline a systematic approach to collecting data for the research, ensuring that information is obtained accurately and comprehensively.

2.2. Quality assessment of the tool

Three experts examined the tool for content validity, assessing the completeness and correctness of the content, language, and relevance to the research objectives. The Index of Item Objective Congruence (IOC) is calculated for each item. Questions with IOC scores ranging from 0.67 to 1.00 are considered valid. Feedback from experts was incorporated into the tool before further testing.

2.3. Data analysis

The qualitative data collected were analyzed using a qualitative content analysis approach with an inductive perspective (Patton, 2015). This means that the analysis process focuses on generating conclusions and insights from the data without preconceived categories or theories. The following steps were taken in the analysis.

1) Data interpretation: The data collected through surveys, participant observations, and relevant documents will be carefully reviewed to understand the phenomena related to the local health constitution and monitoring of the spread of COVID-19 in Ubon Ratchathani province.
2) Content coding: The data will be systematically coded by identifying key themes, patterns, and commonalities. The data drives this coding process rather than the predefined categories or theories.

3) Pattern recognition: After coding, patterns, relationships, and recurring themes will be recognized within the data.
4) Conceptualization: Based on the recognized patterns, the researchers conceptualized the mechanisms and dynamics of driving the local health constitution initiatives at the sub-district level, as outlined in the Community Coalition Action Theory (CCAT) framework, which is the basis for this study.

Applying an inductive content analysis approach aims to provide insights into the effectiveness of the local health constitution and monitoring of the spread of COVID-19 in Ubon Ratchathani. It will help formulate the mechanisms behind the local health constitution initiatives at the sub-district level, aligning with the CCAT framework and research objectives.

2.4. Ethics statement

This research was approved by the Research Ethics Committee of the Ubon Ratchathani Provincial Health Office (reference number SSJ.UB 2565-216, dated 23 December 2022). The study followed ethical principles based on the Declaration of Helsinki and Good Clinical Practice (GCP).

All members of the sample groups will be provided detailed explanations of the research process, their roles, and the benefits of participating in the study. Participants have the right to withdraw from the study at any time, and their decision to do so will be respected and will not result in any adverse consequences. All participants will be treated with respect and in a manner consistent with the principles of human dignity, and the data collected will be presented in an aggregate form to protect their privacy and confidentiality.

3. Results

Table 1 provides a detailed demographic overview of the respondents in the study, the study's findings showed that the sample group, consisting of 157 individuals, was predominantly female, accounting for 71.34%, while males comprised 28.66% of the group. Among the participants, those with a background as public health officers were the most prominent, representing 49.03%. This was followed by public health volunteers (32.48%), community leaders (10.19%), and local government officials (8.30%).

Table 1. Characteristics of respondents.

Respondent's characteristics	Frequency	Percentage
Gender		
Male	45	28.66
Female	112	71.34
Position (*n* = 157)		
Public health officer	77	49.03
Public health volunteer	51	32.48
Community leader	16	10.19
Local government official	13	8.30

In general, the process of creating a local health constitution comprises the

following seven principles.

1) Creating understanding (finding people): This initial step involves creating awareness and understanding among the community about the local health constitution its meaning, purpose, and how it works. It also involves enlisting the support of community leaders, such as local government officials, village heads, and others, who can help drive the process.

2) Establishing a team (finding a team): A team is assembled after generating an understanding and commitment. This team is typically formed from a network of community leaders and stakeholders who can actively participate in the development of the Constitution. These leaders can come from various levels of local governance, schools, temples, healthcare providers, and other relevant organizations.

3) Setting the agenda (finding issues): The focus of the local health constitution is determined, usually centered on preventing and addressing COVID-19 issues. These issues were identified and prioritized.

4) Drafting the local health constitution (creating a draft): The local health constitution is drafted with the issues identified. This may involve different teams responsible for various aspects such as healthcare, education, and waste management. A draft of the manuscript was prepared and reviewed.

5) Community engagement (engaging the community): The draft was presented to the community for feedback and discussion. People are encouraged to voice their opinions, agree with, or suggest modifications. This process continued until the majority of the community accepted the proposed constitution.

6) Declaration of the constitution (announcing a date): Once the local health constitution has been accepted, a date is set for its official declaration. This declaration is often made on significant community occasions, such as New Year or traditional festivals.

7) Monitoring and evaluation (finding evaluation dates): After the constitution is in effect, there is an ongoing monitoring and evaluation process. This includes assessing how well the Constitution is being implemented, identifying challenges, and making necessary adjustments.

The abovementioned process emphasizes the active involvement of community members and leaders at various levels in the creation, implementation, and adaptation of the local health constitution. This is a collaborative approach to addressing COVID-19 which align with the general principles of initiating, drafting, and establishing health charters.

4. Discussion

This study evaluated the effectiveness of local health constitutions at the sub-district (Tambon) level across 81 sub-districts from 25 districts in Ubon Ratchathani Province. The study presents findings categorized into four key points as follows:

4.1. The cooperation of the people in upholding the constitution

Those in the sample group provided information on community cooperation in adhering to the local health constitution. The community was generally seen as highly cooperative, following the local health constitution. There were a few

instances of non-compliance, primarily due to concerns about excessive control or perceived overregulation of their lives. Some residents believed that certain measures, such as imposing penalties or fines, were too stringent and deterred cooperation. This was partly linked to the behaviors and daily routines that people were accustomed to. However, in some areas, residents better understood the disease situation, leading to strong cooperation in monitoring and following health officials' recommendations. Similar to what one official mentioned. "Since we have this constitution, I think everything has improved. It depends on how we do things; it's up to you how you walk. But if there is a path for us to walk together, following steps 1–2–3–4 with a united heart, everything will be much better." In such cases, people actively collaborated to prevent the spread of the disease. After implementing the local health constitution, those who fell ill received prompt medical care at state-run healthcare facilities. Other key stakeholders, such as government and private organization employees in the region, also cooperated well because of the widespread impact of the disease on all occupational groups. Their active involvement reflects their diverse roles and suggestions based on real-world experiences in the field. In Sirimongkhol and Buadang's (2023) research, it was also found that applying the specific local health constitution to prevent and control the coronavirus disease (COVID-19) had an impact on increasing community participation, particularly in terms of knowledge awareness of disease severity and social support.

4.2. The number of COVID-19 patients in the area after implementing the local health constitution

The number of individuals affected by COVID-19 in the area has decreased since implementing the local health constitution. This decline can be attributed to several factors, including the overall status of the disease and the widespread availability of vaccines in the population. As mentioned by one community leader, "The community has come to understand each other because this constitution has played a role in fostering understanding regarding the creation of vaccine awareness." The local health constitution, which served as a model and clear guidance, played a significant role in achieving this decline. Effective communication with the public before the onset of the disease helped to inform them about the regulations and encouraged compliance. Managing the disease during outbreaks and coordinating with different stakeholders contributed to controlling the situation. There was a slight increase in the number of cases in some areas, which could be attributed to the large gatherings. In these instances, the community's level of cooperation was lower because of concerns, miscommunication, and sometimes inaccurate information. Nonetheless, the enforcement of the local health constitution in the community was directly impacted, leading to an increased understanding of individual roles, reduced conflicts, and improved communication with local communities. This ultimately enhances the efficiency of controlling the spread of the virus. After implementing the local health constitution, a general decrease was observed in the area's fatalities due to COVID-19. This can be attributed to various factors, including effective coordination, vaccine distribution, accurate information

access, and improved public knowledge and behavior. However, in these cases, some areas experienced fluctuations with both increases and decreases. These fluctuations are primarily influenced by the perceived level of fear, the community's continuous alertness, and the effectiveness of prevention strategies. While many countries have enacted policies on travel restrictions, such as flight suspensions or close monitoring of the incoming travelers on their arrival at the international airports. Some other countries have implemented social distancing and quarantine policies to fight this highly contagious disease as well as encouraging the limitation of social contacts, postponing events, locking down schools, and isolating suspected cases. Technological approaches such as telemedicine for remote consultation or monitoring have also been utilized in some regions in the period of the outbreak (Tabari et al., 2020). Overall, the local health constitution was pivotal in shaping community behavior. Nevertheless, it is important to note that the root causes of fatalities remain complex and multifaceted, encompassing aspects such as underlying health conditions, disease severity, and the potential side effects of vaccines. Health charters directly influence and guide public health practices; however, their effectiveness varies across regions, depends on the cooperation and operating model, emphasizing the need for consistent and systematic community involvement in disease prevention.

4.3. Organizations that participate or have a role

The agencies involved in driving the local health constitution include local government organizations, sub-district administrative organizations, public health offices, sub-district health promotion hospitals, village committees, community leaders, public health volunteers, community elders, temples, agricultural offices, schools, early childhood development centers, district offices, healthcare facilities, community health centers, human and social development organizations, municipalities, community health associations, community development networks, national health commission offices, public policy development centers, primary care service providers, religious representatives, local residents, and private sector individuals such as traders. As mentioned by one government official "I believe it results in community awareness, accumulated experiences of local officials, and the network community working, which leads to further developments in other health-related issues within the community that may arise in the future." The work conducted by Sridawruang et al. (2021) found that in COVID-19 surveillance activities within communities, public health volunteers were found to play the most significant role, with the majority being responsible for searching and screening high-risk groups (97.6%). This was followed by roles such as visiting households to observe symptoms (89.4%), coordinating with other agencies (87.9%), documenting and reporting the results of their activities (86.0%), maintaining lists of high-risk groups, and separating them into subgroups for symptom monitoring (84.5%) because the group of public health volunteers plays a central role in driving community surveillance activities compared to other groups.

4.4. Recommendations to improve the effectiveness

Developing a local health constitution aims to gather diverse opinions and encourage collective agreement in response to the situation. It also helps to reflect different perspectives on problems and their solutions within the community. It serves as a fundamental tool for societal development and promotes the quality of life in the area. However, this requires further investigation. They recognized that it may not always be applicable to every situation. Therefore, each region should collaborate and provide inputs to ensure that it aligns best with its specific context. Some of the recommendations for improving effectiveness

It is advisable to create motivation for local practical implementation and align it with the local action plan. As some areas may not require a health constitution, it is essential to adapt the direction or practices within the health constitution to match the disease surveillance situation and current circumstances.

Continuous development of relevant organizations is necessary. This should involve periodic reviews of principles and knowledge through meetings, analyses, or feedback on local issues. Training programs for personnel in relevant organizations should also be enhanced. When it is not necessary to use a health constitution in a particular situation, it should be subject to cancellation.

Key performance indicators (KPIs) should be established to drive health constitution implementation. This will allow for regular evaluation and adaptation in response to emergencies. Additionally, there should be continuous knowledge exchange and community engagement regarding the health constitution, focusing on involving local communities and ensuring its comprehensive implementation among children and youth.

To ensure collaboration within each area, there should be agreements between network partners (inter-agency entities at regional, district, provincial, sub-district health promotion hospitals, and local government levels). This will facilitate a shared understanding of the collaborative efforts.

Efforts should be made to enhance the efficiency of health constitution-related data sources that can be applied to different areas. This includes expanding the channels for public engagement and providing information through government agency websites or pages.

A policy should be developed to simplify complex processes, making it easier to work in emergency situations for effective disease control. Current practices may involve adhering to central agency policies, which can cause delays in implementing actions. The Health Constitution initiates a collaborative learning approach involving both community members and network partners to develop the local health system. A shift in the format of state plans or projects now enables citizens to engage from the project's inception, fostering the creation of social capital. This capital serves as a foundation for the network sector working model, addressing various issues with trust at its core. The principles of honoring, respecting, and treating each other equally underscore the belief that health is a collective concern for all citizens, emphasizing that its management is not solely the duty of government agencies but a shared responsibility.

Based on the result, the influencing factors for health constitution compliance in

the area include leadership, teamwork, and active participation of network partners (government, private sector, civil society). Successful implementation against COVID-19 is driven by a strong District Health Board, especially when the district chief prioritizes the constitution. Success is enhanced when leaders have authority and communication reaches village levels. Village leaders, trusted by the community, play a crucial role in promoting constitutional tools. Government officials emphasize the necessity of involving government mechanisms to ensure a smoother movement of the constitution. However, we need to set a systems and mechanisms for monitoring and reviewing the operation of the health constitution. Regular evaluation and improvement are integral processes for solidifying the community health system, necessitating a platform for knowledge exchange. Regularly publicizing the health constitution of the area is essential to extend the achieved results to other communities.

5. Conclusion and recommendations

The local health constitution has positively impacted the community by enabling people to stay informed, engage in discussions, and collectively devise practical measures that the community can implement. The process involves numerous steps that arise from the voluntary consensus of the majority of community members without coercion or pressure. It offers a middle-ground approach that allows everyone in a community to adapt to their way of life. Furthermore, it raises awareness of self-protection and fosters community participation within the network of stakeholders. It promotes unity and mutual assistance and ensures cooperation among related stakeholders. In some areas, while they view health constitution as a good approach, it needs further development because it may not always be responsive to specific events. Therefore, expanding the learning process to involve the public is important, because a one-size-fits-all approach may not work in every area. Hence, each area should collaborate to propose ideas and cooperate to align as much as possible with the specific context of that area.

Author contributions: Conceptualization, PL and PS; methodology, PL and PS; software, SW; validation, PL, PS, NJ and AC; formal analysis, PS; investigation, RY and JS; resources, WP; data curation, CC; writing—original draft preparation, PL and SW; writing—review and editing, PL and PS; visualization, NJ; supervision, PL; project administration, PL. All authors have read and agreed to the published version of the manuscript.

Funding: This research received a grant from the Health Systems Research Institute, contract number HSRI.66-008.

Conflict of interest: The authors declare no conflict of interest.

References

Butterfoss, F. D., & Kegler, M.C. (2002). Toward a comprehensive understanding of community coalition: Moving from practice to theory and Emerging Theories in health Promotion Practice and Research. Jossey-Bass, CA, San Francisco. pp. 157–193.

Kahaban, T., & Kahaban, N. (2022). Developing and Driving a Participatory Community Health Advocate Case Study of Kalasin

Municipality. Journal of Roi Kaensarn Academi, 7(3), 275–292.

Marome, W., & Shaw, R. (2021). COVID-19 response in Thailand and its implications on future preparedness. International journal of environmental research and public health, 18(3), 1089. https://doi.org/10.3390/ijerph18031089

Merriam, S. B., & Tisdell, E. J. (2016). Qualitative research: A guide to design and implementation, 4th ed. San Francisco, CA: Jossey-Bass.

National Health Security Office. (2022). Draft Constitution on the National Health System, 3rd ed. National Health Security Office.

Office of Community Organization Promotion Foundation. (2016). Knowledge set for the Preparation of A constitution For Healthy towards Self-Management. Community Organization Development Institute (Public Organization).

Patton, M. Q. (2015). Qualitative research & evaluation methods: Integrating theory and practice, 4th ed. Sage Publications.

Rajatanavin, N., Tuangratananon, T., Suphanchaimat, R., & Tangcharoensathien, V. (2021). Responding to the COVID-19 second wave in Thailand by diversifying and adapting lessons from the first wave. BMJ Global Health, 6(7), e006178. https://doi.org/10.1136/bmjgh-2021-006178

San Pa Muang Subdistrict Municipality Office. (2017). A constitution for Healthy of San Pa Muang Sub district. Available online: https://www.sem100library.in.th/medias/15280.pdf (accessed on 2 October 2023).

Sirapanichkul, R. (2013). Initiate-Conceptualize-Create-Implement the lessons of the Health Constitution in 6 areas (Chalae). Available online: https://infocenter.nationalhealth.or.th/sites/default/files/cKan/540401_NSA.pdf (accessed on 2 October 2023).

Sirimongkhol, S., & Buadang, S. (2023). Development of a process model for driving health constitutions in specific areas on the issue of prevention and control of coronavirus disease 2019 in the area of Ban Si Udom Health Promoting Hospital. Trakaj Sub-district, Kantharalak district, Sisaket Province Sisaket. Journal of Research and Health Development, 2(1), 39–51.

Sridawruang, C., Worawong, C., Sriring, P., et al. (2021). The Lesson Learned of Implementation Role for Surveillance, Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Communities Among Village Health Volunteers in North Eastern, Thailand. Available online: https://www.kkpho.go.th/attachments/6394_รายงานวิจัยการถอดบทเรียน.pdf (accessed on 2 October 2023).

Sriphapa, A. (2015). The development of Driving Health Constitution the exercise behaviors in Khokkwang, Bungkla District, Bueng Kan Province [Master's thesis]. Mahasarakham University.

Srisutham, C. (2016). Public Policy Process based on the National Health Act, B.E. 2550 (2007). Local Administration Journal, 9(4), 63–79.

Tabari, P., Amini, M., Moghadami, M., & Moosavi, M. (2020). International Public Health Responses to COVID-19 Outbreak: A Rapid Review. Iranian Journal of Medical Sciences, 45(3), 157–169. https://doi.org/10.30476/ijms.2020.85810.1537