Social Participation Mechanisms in Governmental Response to COVID-19 in Thailand

by

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Abbreviations

APO	Autonomous Public Organisation
CCSA	The Center for COVID-19 Situation Administration
CHC	Community Health Charter
CI	Community Isolation
EOC	Emergency Operation Center
NCDC	National Communicable Disease Committee
NHA	National Health Assembly
NHCO	National Health Commission Office
PHA	Provincial Health Assembly
SAO	Subdistrict Administrative Organisation
WHO	World Health Organization

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1.Introduction

1.1 Rationale

Discovered in late 2019, the novel coronavirus disease, COVID-19, soon became one of the greatest global health crises, which had overarching impacts on every aspect of society, be it human, social, political, or economic (Bonotti & Zech, 2021; Parks, Chatsuwan & Pillai, 2020). Thailand was the first country outside of China where a positive COVID-19 case was confirmed in early January of 2020 (World Health Organization, 2020). To respond to the spreading of COVID-19, the Thai government implemented several executive measures, ranging from the announcement of COVID-19 as a dangerous communicable disease to the enforcement of a security-oriented state of emergency and the introduction of a nationwide lockdown (see Leelapatana & Tangthavorn, 2021).

How governments responded to COVID-19 is a matter of policy and politics which was dependent on many variables such as social policies to crisis management, political regimes, formal political institutions, and state capacity (Greer et al., 2020). Interestingly, even though governments faced the same problem, they responded differently (Capano et al., 2020). A study of the relationship between the quality of governance and pandemic management in 185 countries around the world found that governments with better governance are more effective in embracing and implementing suitable responsive policies and receive more public trust (Nabin, Chowdhury & Bhattacharya, 2021). Trust is another imperative element shaping the governance and effective policy-making in the COVID-19 crisis (Cairney & Wellstead, 2011; Jennings et al., 2021; Robinson et al., 2021). Furthermore, a comparative study on regime type and governmental policy responses to COVID-19 suggests that regime type significantly influenced how governments responded to the crisis (Bunyavejchewin & Sirichuanjun, 2021). In this sense, it can be argued that

the more authoritarian the government is, the stronger the centralisation of its policy response becomes.

Like many other countries, Thailand has struggled to effectively respond to COVID-19, particularly to ensure inclusive decision-making and measures. In terms of health measures, health scholars suggest that the government has not been successful in controlling the outbreak at first but then learned and adapted lessons from the early wave to control the infectious rate (Rajatanavin, et al., 2021). In terms of social measures, research on the Thai state's welfare policies in response to COVID-19 during the pandemic found that social welfare provided was inadequate and could not meet people's needs. This compelled people to take responsibility for their own health and rely more on private and philanthropic organisations than the government (Saengkanokkul, 2021).

Consequently, although the Thai government and the health sector have been effective in controlling and limiting the spread of COVID-19, scholars argue that the government has overlooked, or even failed, to address the multiple dimensions of the crisis, such as the social, economic, and cultural impacts (Marome & Shaw, 2021; Saengkanokkul, 2021; Preechasinlapakun, 2021; Boossabong & Chamchong, 2020; Ungsuchaval & Kumlungpat, 2020; Ungsuchaval, 2020a, 2020b).

The underemphasis on social and economic elements in policy-making and response to the health crisis of the Thai government arguably comes from many reasons. First, the government is seen to highly centralise its policy and governance mechanisms that directly respond to the crisis through a group of technocrats, experts, and governing elites (Boossabong & Chamchong, 2020). The centralisation of the Thai government affected how policy responses were made in the country. For example, research on the role of the government-supported village health volunteers during

the pandemic discovered that the centralisation of the public health system in Thailand has made the health volunteers conform to the "state agent" tradition, which is heavily concerned with health-related activities and relied on the government chain of command and organisational silo (Sudhipongpracha & Poocharoen, 2021). This is different from a decentralised system in which the health volunteers increase their community outreach activities before complying with the government directives and operate beyond the area of health and disease control. Under the centralised system of the Thai government, regulations and relief measures were issued without considering people's social and cultural differences (Saengkanokkul, 2021). Besides, even in local areas where measures against the crisis were supposed to involve multi-level and multi-sectoral collaboration, resource mobilisation to address the crisis was also seen to be exclusively issued by and centred around the provincial governor's hierarchical orders and governmental legislation (Suepsak, 2021).

In practice, the government established the Center for COVID-19 Situation Administration (CCSA) as a highly hierarchical, single command unit to manage the crisis, chaired by the prime minister. The operation of the CCSA was criticised for its mobilisation of authoritarian-militaristic power to impose a strict, 'paternalistic-nationalist' style of lockdown and surveillance measures to beat the virus, which unexpectedly resulted in counterproductive socio-economic consequences instead (Leelapatana & Tangthavorn, 2021). It has also been seen to use the rhetorical theme of militarisation in policy-decision making to battle the virus (Aunphattanasilp, 2020) as well as in communication with the public, which emphasises one-way communication and the preservation of the security of the state (Chinjorhor & Buddharaksa, 2021).

Second, governmental responses to COVID-19 were developed and embedded in political tensions within the health sector (Ungsuchaval & Kumlungpat, 2020). This led to a fragmentation

in policy coordination and ineffective policy responses to socio-economic issues relating to the crisis. Third, overwhelmingly occupied with limiting the number of COVID-19 cases, the government paid inadequate attention to enhancing the country's resilience to the crisis in an environmentally or socially sustainable way (Marome & Shaw, 2021). It overlooked the multiple dimensions of the crisis. Therefore, governmental and policy responses to the crisis, in general, were rather exclusive.

Consequently, it can be argued that community and people's voices were not adequately consulted and included in designing and delivering the governmental response to COVID-19 (Rajan et al., 2020). In Thailand, although civil society activism has operated actively in the public space during the crisis (Lorch & Sombatpoonsiri, 2022; Auethavornpipat & Tanyag, 2021) and civic involvement with public services in response to the crisis, notably as village health volunteers, was regularly seen (Kaweenuttayanon et al., 2021; Nawsuwan et al., 2020), the government has been reluctant to facilitate interaction with civil society in policy-decision making and institutional politics. Little space in developing and making policy responses has been given to non-state actors. Civil society has initially been allowed to be involved in a limited way in the governmental response to the crisis (Nixon, 2020), albeit its later acknowledged prominent role in substituting governmental service delivery. For instance, overlooked by the government, civil society organisations played an essential role in relieving the suffering of slum residents in Bangkok during the COVID-19 outbreak by providing food, survival kits, jobs, and access to COVID-19 tests (Pongutta et al., 2021). Arguably, the way the government has allowed the involvement of non-state actors is seen more in service delivery than in policy-decision making. Participatory attempts at developing and making policy decisions and responses were challenging and limited.

Research suggests that to deal with the COVID-19 pandemic effectively and mitigate its effects on society, the reliance on healthcare and medical professionals alone is no longer adequate. For example, a study on public governance of the pandemic in China, where the virus originated from, found that relying only on disease control experts and bureaucracy to deal with the pandemic is doomed to failure (Qi et al., 2020; Gu & Li, 2020). There is a necessity for the central government to engage citizens, non-state organisations, and even governmental bodies at all levels in policy-making processes and implementation (Weible et al., 2020). 'Whole-of-Government' and 'Whole-of-society' approaches to address the pandemic, which stress the importance of coordination among several policy actors across levels and sectors, are recommended, especially in developing countries (Chowdhury & Jomo, 2020). Deliberative exercises, which prioritise dialogue and involve citizens, experts, and policymakers, are suggested as an inclusive form of developing policy responses during the crisis which can benefit every party and does not limit the solution to merely technically 'right' or 'wrong' answers (Pearse, 2020).

In Thailand, mechanisms encouraging social participation in developing policy responses to the crisis are prominently facilitated by the National Health Commission Office (NHCO). Established by the National Health Act in 2007, the NHCO is an autonomous public organisation which aims to develop the national health system based on a participatory public policy process and multi-sectoral collaboration. The NHCO advocates a 'Health in All Policies' '(HiAP) approach in government policy decision-making (Mathurapote et al., 2017).

The NHCO annually organises the National Health Assembly (NHA), a participatory, multi-sectoral platform to discuss and develop policy frameworks and solutions which encourage dialogue and deliberation among stakeholders (Rajan et al., 2019; Rasanathan et al., 2012). In specific, the NHA features interaction between (1) government technocrats, policymakers and

politicians, (2) civil society, communities, and the population, and (3) academia, think tanks, and research institutions in discussing critical policy issues and defining joint solutions. Solutions of the NHA are not legally binding, yet they are a critical element of government policy formulation. The interactive approach to policy development underlying the NHA is based on a certain policy advocacy and policy development strategy so-called the "Triangle that Moves the Mountain", which has been successfully used to reform the Thai health sector during the last decades (Rajan et al., 2017; Wasi, 2000). The 13th NHA held in December 2020 generated a policy solution on "participatory health crisis management for pandemics", which aims to establish a policy framework for government organisations and other relevant stakeholders to integrate management efforts and bring about active social participation in health crisis management from all sectors ("Health Assembly 13 Resolution 2," 2020).

Health assemblies are also conducted in local areas across the country, known as Provincial Health Assembly (PHA), by providing multiple local organisations with a small seed funding from the NHCO (Ungsuchaval & Songpracha, 2022). During the outbreak, PHAs across the country received this special support from the NHCO to become a coordinating mechanism for the implementation of Home Isolation and (HI) Community Isolation (CI) (National Health Commission Office, 2020).

Furthermore, the NHCO enhanced social participation at community levels by promoting the participatory development of community measures in response to COVID-19. For example, during the outbreak in 2020, the NHCO collaborated with other government and community organisations in Bangkok to create Community Health Charters (CHC) as a localised guideline for communities to deal with COVID-19 and a communication tool that communities use to contact

responsible governmental agencies (National Health Commission Office & World Health Organization South-East Asia, 2021).

In addition, in 2020, the NHCO became a key coordinating body of the newly formed partnership between multiple governmental organisations across policy areas dedicated to COVID-19 response (National Health Commission Office, 2020). This partnership is seen to leverage the existing social mechanisms to engage civil society in COVID-19 response and complement the CCSA.

Nonetheless, against the aforementioned exclusive policy background, the NHCO's attempts to enable social participation mechanisms in response to the COVID-19 pandemic have not been entirely smooth and effective. Yet, they were consequential. Hence, this research studies the social participation mechanisms initiated and enabled by the NHCO. In particular, it has threefold objectives: 1. It investigates the social participation mechanisms initiated and implemented in response to COVID-19 by the NHCO; 2. it examines the way the mechanisms operate at national and sub-national levels; and 3. it explores the link between the mechanisms and the government's response to COVID-19.

The findings of this research are expected to provide a beneficial contribution for global and Thai communities in two ways: first, it would like to contribute to the development of knowledge on social participation and COVID-19 preparedness and response; and second, it aims to develop recommendations on social participation mechanisms including their institutionalisation and operationalisation that promote effective participatory pandemic preparedness and response.

1.2 Research Questions

In order to reach these objectives, research questions are formulated as follows.

Q1: What NHCO social participation mechanisms were used to engage people in COVID-19 responses?

Q2: In what ways did these mechanisms operate, and engage and empower people in response to the COVID-19 crisis?

Q3: What challenges did the mechanisms face when they were institutionalised and operationalised to address the COVID-19 pandemic?

Q4: In what ways did the mechanisms relate and contribute to the government's response to COVID-19?

1.3 Methodology

In order to answer these questions, this research applies a qualitative approach and purposively selects and investigates three case studies which reflect key social mechanisms facilitated by the NHCO. Although these three mechanisms have been established and functioning long before the COVID-19 outbreak and helped foster active citizenship and build community strength, they contributed to the development of participatory policy response to the outbreak in an interesting way.

The first case study is the 13th NHA resolution on “participatory health crisis management for pandemics” in 2020. The NHA can be seen as a distinctive social participation mechanism at the national level, which widely engages stakeholders from different sectors in society to address specific issues together. Therefore, the NHA resolution can be seen as one of the first dedicated

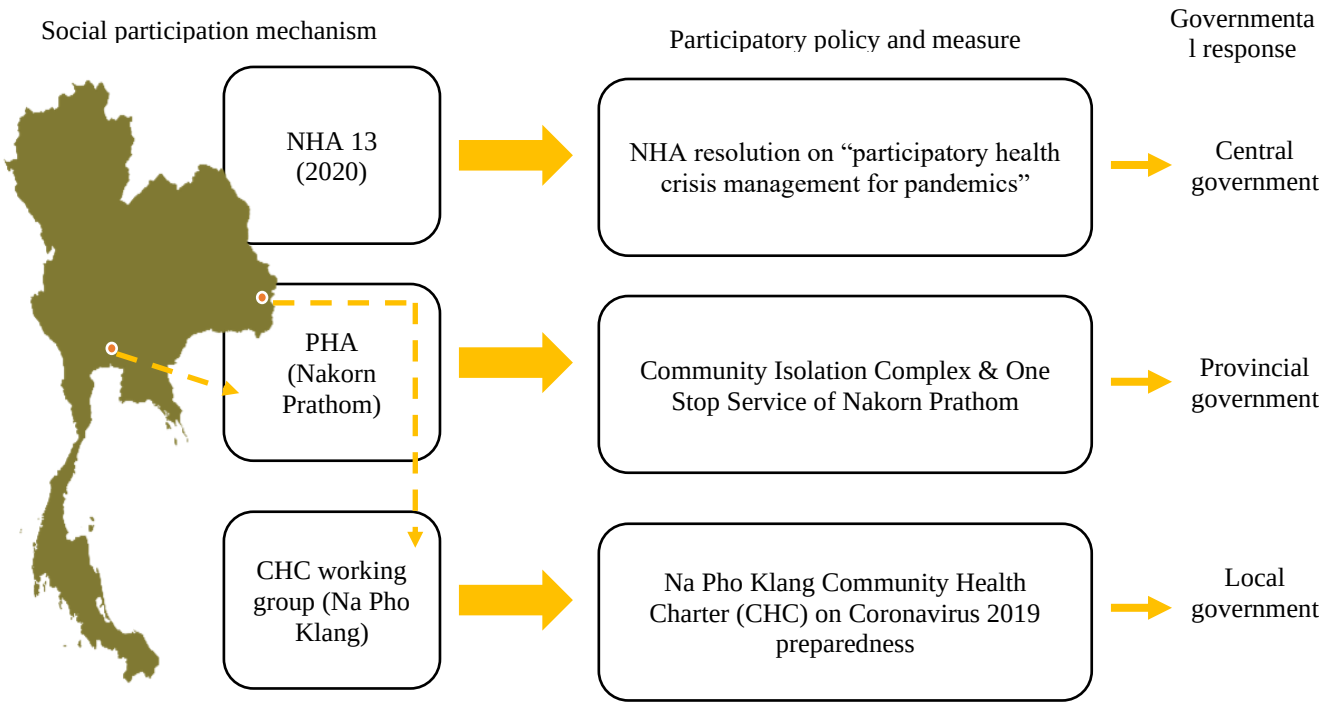
participatory policy frameworks addressing the pandemic in Thailand and connecting with the central government.

The second case is the PHA of Nakhon Pathom Province, which developed the Nakhon Pathom Model in COVID-19 Response and Community Isolation Complex. This PHA reflects a multi-sectoral collaboration between the government, businesses, and civil society in response to COVID-19 at a provincial level. The model was adopted by other provinces as a social participation model to address the crisis and link with the provincial government.

The third case is the community health charter (CHC) of Na Pho Klang, Ubon Ratchathani Province, which considers community agreement and actions on COVID-19. Initiated and implemented by a joint-working group between the local government and the community in the area, the CHC of Na Pho Klang created community-initiated responsive measures for dealing with the pandemic that complemented the government's measures. The CHC of Na Pho Klang was the first of its kind enphasising COVID-19 prevention and response in the country and has brought the local government to accept its idea and approach. This has resulted in the expansion of the development of CHCs in other areas within the same participatory regional health zone (Region 10).

These three cases form the unit of analysis in this study (figure 1.1) and suggest social participation mechanisms that empower people, enable them to voice their concerns, and advocate for them to hold responsibility for health and social development (World Health Organization, 2021). They transform people into active agents and bridge the gap between the government and civil society. The social participation mechanisms also complement government policy and actions, which help improve the quality and acceptance of the government's policies and decisions in response to COVID-19.

Figure 1.1 The unit analysis of the three participatory mechanisms in Thailand



Data was mainly collected through in-depth interviews between January and March 2022. Key informants were purposively chosen based on their engagement, experience, and expertise with the three social participation mechanisms and their relation to COVID-19 responses. They were public officials who have been involved with COVID-19 responses at a policy or managerial level or community and civil society leaders who have been actively engaged with the social participation mechanisms and involved with COVID-19 responses. Each interview lasted around 60-90 minutes. The interviews took place both onsite and online according to the participants' preference.

Furthermore, two group interviews were conducted to gain additional information and insights from field agents involved with the participatory mechanisms in practice. The first group interview was conducted on 3 March 2022 with the CHC working group of Na Pho Klang, Khong

Chiam District, Ubon Ratchathani Province. The research team also conducted an observation at the seminar "Lessons learned on implementation of the Subdistrict Health Charter against COVID-19" of the Participatory Regional Health Commission (Region 10) on 2 March 2022, in which the CHC working group of Na Pho Klang participated. The second group interview was conducted on 23 March 2022 with the PHA of Nakhon Pathom Province. In total 21 interview participants were involved in the research (see appendix 1).

Each participant was given a code name and the interviews were transcribed anonymously. The researchers communicated the study's results to the informants as requested before finalising the study.

The data was analysed using thematic analysis. Codes and themes were selected from the research's conceptual framework, the data emerged that from the field, and the researchers themselves. Ten codes were chosen in total: participation, inclusiveness, intensity, influence, COVID-19, community, government, health, decision-making, and implementation.

After the initial analysis of the data, an expert meeting with three distinguished specialists on health and social participation from WHO-SEARO, IHPP, and the NHA was organised on 23 May 2022 to provide comments and recommendations on the data analysis and presentation.

In terms of ethical consideration, this research was approved by the Committee for Research Ethics (Social Sciences) of Mahidol University, Thailand (certificate of approval no.2022/009.2401) in January 2022 (see appendix 3).

1.4 Structure

The structure of this work is divided into eight sections, including the introduction. The second section provides a framework for investigating social participation mechanisms and

government responses to COVID-19. The third section offers important background on the Thai government's response to COVID-19. It is followed by three sections (4-6) which examine key social participation mechanisms in practice that operate at different levels of government, namely the national, the provincial, and the local. These sections present the main results of the study. The seventh section critically discusses the three participatory mechanisms following the framework mentioned in the second section. Finally, the study ends with the eighth section by summarising the results and providing some recommendations on the development of social participation mechanisms in response to COVID-19.

2. Framework: Social Participation and Governmental Response to COVID-19

Participation of non-state actors has been found to benefit the way governments responded to the COVID-19 crisis, especially how they gained public trust and developed inclusive and locally responsive policies that direct attention to the role of and impact on different sectors of society (Keskindemir, Rurka & Skoric, 2021).

A comparative study of 28 national responses to COVID-19 in 2020 revealed that engaging in multi-sectoral partnership and having multi-level coordinating mechanisms through a whole-of-government approach, is a key element for governments to implement high-performing responses to the crisis (Haldane et al., 2021). On the other hand, failure in establishing such partnerships or denying participatory efforts of social groups were seen to be associated with low-performing responses.

In 2020, the UN Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association strongly stated that no government could successfully deal with the COVID-19 crisis alone and that a state of emergency is not a legitimate reason to halt the freedom of association and social participation. The UN Special Rapporteur also called for civil society involvement in governmental response to the crisis as it can help governments develop inclusive policies and provide social support to those in need (United Nations, 2022).

In this sense, successes in government responses to social issues, particularly during crises and emergencies, are not always achieved through centralised, formal authority held alone by the

government. As societies have been changing, becoming much more complex and diversified, governments are expected and driven to govern in a network-like environment. Civil society and non-state actors consequently are inevitably regarded to play a significant role in public policy and management, resulting in a new public governance where collaboration between sectors is advocated (Osborne, 2010). As a result, the government's power is decentered. However, this has not diminished the role and responsibility of the government towards society. The government transforms itself and exercises its authority in a new fashion, which is indirect and more reliant on interactive, non-hierarchical modes of coordination such as markets and networks (Pierre & Peters, 2020; Torfing et al., 2012). Looking at responses to COVID-19, various research found that good government responses involve various adaptations of policy and governance mixes from different sectors rather than a single governmental tool (Capano et al., 2020). This implies that public capacity to deal with COVID-19 cannot merely depend on bureaucratic governmental action, but needs a bundle of social participation by many actors from different sectors such as the public sector, the business sector, and the third sector at different levels of society.

Research also suggests that social participation is needed to reach effective and inclusive government responses to COVID-19 (Smith et al., 2021; Rajan et al., 2020; Boossabong & Chamchong, 2020). Social participation can be defined as:

> the processes of collective reflection through which the population is enabled to construct significant information…, and to deliberate on the basis of this in order to make decisions through participatory mechanisms, in collaboration with the institutions responsible for them and involving them both in the planning and subsequent implementation of these decisions (Francés et al., 2016, 4).

Given the definition, social participation is significant in government responses to social issues because it:

(1) promotes the inclusion of the previously absent or excluded collectives in controlling the allocation of resources, information, and services;

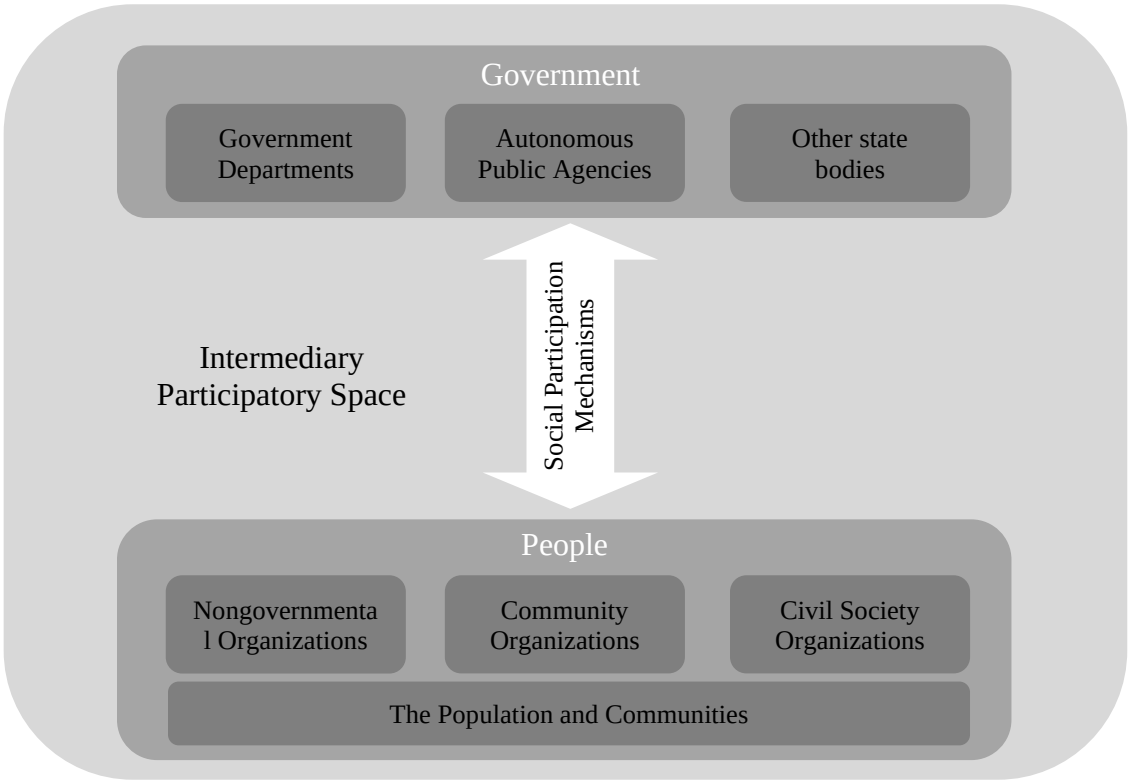
(2) raises people's self-awareness, responsibilities, and knowledge through collective reflection; and

(3) contributes to community development. In this sense, social participation helps people to "know their own situation better and are motivated to solve their common problems… [which] enables them to become agents of their own development instead of passive beneficiaries" (World Health Organization, 1978, 50).

A recent WHO study on social participation additionally points out that social participation mechanisms should create "an environment where people feel empowered to speak their voice" (World Health Organization, 2021, 2) which in turn encourages people agency over their everyday lives. They function in an intermediary participatory space which connects the government with the people and vice versa (figure 2.1).

Ultimately, the aim is to bridge the gap between experts' and policymakers' perspectives and people's interests to benefit from greater government accountability to society (Cornwall & Gaventa, 2001). This means that the mechanisms must facilitate the inclusion of perspectives and experiences that go beyond the instrumental-technical ones underlying common government responses and champion participatory public policy and governance (Fischer, 2012; Ungsuchaval & Kantamaturapoj, 2021). Through this, social participation mechanisms should thus be embedded in deliberative practices for policy development (Hajer & Wagenaar, 2009; Fischer & Boossabong, 2018).

Figure 2.1 Social participation mechanisms and intermediary participatory space



Source: adapted from World Health Organization (2021, p.9)

Social participation mechanisms can be assessed through three major dimensions (Francés et al., 2016; Fung, 2006): (1) inclusiveness, the degree of openness to participation of people; (2) intensity, the extent to which participants interact and influence decision-making in the participation process; and (3) influence, the orientation of participation processes in relation to government responses. In other words, the first aspect concerns who participates (or how participants are selected), while the second is concerned with how participants communicate and make decisions. Finally, the last aspect is focused on how processes and mechanisms of participation are linked with the policy actions of the government (Fung, 2006).

Further, social participation mechanisms can be regarded as contributing to government and policy responses to COVID-19 in three related aspects: decision-making, information and communication, and implementation (Gao & Yu, 2020; Ungsuchaval & Kumlungpat, 2020).

First, social participation mechanisms can enhance the government's decision-making. How well the government can initiate and develop appropriate policies and plans to cope with the situation relies on the degree of participation. Building joint decision-making mechanisms with key bodies from both the government and non-government parties responsible for identifying problems, assessing risks, and selecting choices then reflects a suitable employment of the mechanism. Also, quick and professional decisions are required during an emergency. Quick means, the decision made should not be delayed by bureaucratic obstacles. Slow decision-making can lead to severe negative consequences resulting in a pandemic (Qi et al., 2020). Professional means, the decision should include various types of expertise, including nontechnical, traditional knowledge and beliefs, and be made based on different types of facts and data.

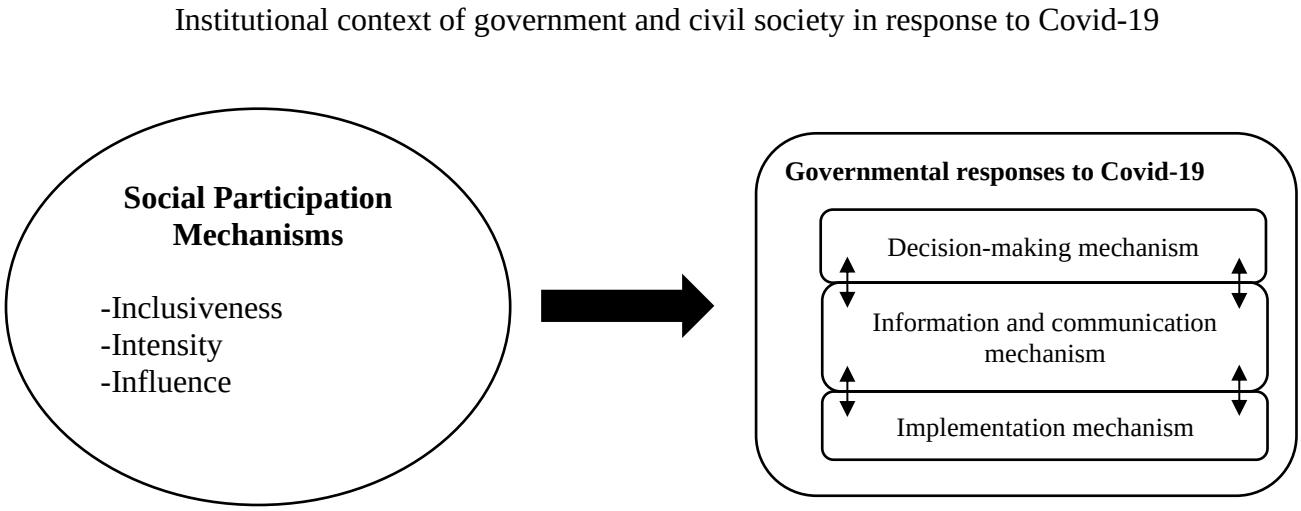
Second, social participation mechanisms can create a better way of information exchange and communication flow. Clear and comprehensive information and communication are at the heart of crisis and emergency response. Receiving accurate information on risks through friendly channels helps people understand and realise the situation and, in turn, behave in a proper manner during crises and uncertainties (Weible et al., 2020). The mechanism can bring better decision-making and implementation because it gives flow in coordination. Creating coordination between individuals and organisations will contribute to an effective governmental response.

Third, social participation mechanisms can facilitate effective policy implementation as they strengthen the role of the government in controlling and mobilising resources within its jurisdiction in relation to other actors. This means that the government is not the sole policy actor

responding to COVID-19 but there are many non-governmental actors sharing the resources. The government is then tasked with the responsibility to ensure that relevant parties do have enough resources and capacity to implement policies and plans and have a sustained connection with each other. In some situations, non-state actors play an active role in policy implementation, giving rise to social innovations dedicated to specific local problems. They can also co-produce public goods and services with public agencies (Pestoff, Brandsen & Verschuere, 2012) and ultimately build a more effective way to implement policies.

Therefore, a conceptual framework to guide the study of social participation and engagement in Thailand response to COVID-19 can be developed, as shown in figure 2.2.

Figure 2.2 Social participation and governmental response to COVID-19 framework



3. Background on the Governmental Response to COVID-19 in Thailand

This section provides key background information on the governmental response to COVID-19 in Thailand in three major areas: the public administration system, governmental mechanisms dealing with the pandemic, and social participation in health development.

3.1 Public Administration

The way the Thai government responded to COVID-19 significantly rested on the public administration. Since the late 1950s, public administration has been acknowledged for its pivotal role in driving the country's modernisation and social and economic development (Lee, 1999). Essentially, the bureaucracy and centralised government departments have been the centre of Thai public administration (Ungsuchaval & Kumlungpat, 2020; Ockey, 2007; Riggs, 1966). In practice, the Thai public administration is classified into three major levels: central, provincial, and local.

The central government, run by the Cabinet, is responsible for the overall administration of the country. Operated through government ministries, the central government decides and implements national policies. The central government also appoints provincial governors, the heads of provincial governments, and tasks them with implementing central government policies. Apart from the governors who administrate provinces (*changwat*), the biggest area unit, there are district officers (*nai amphor*) who administer districts (*amphor*), subdistrict chiefs (*kamnan*) who administer subdistricts (*tambon*), and village chiefs (*phuyai baan*) who administer villages (*mubaan*). District officers are appointed by the central government like governors. Sub-district chief candidates are selected from among village chiefs whom the villagers then elect. However,

these two local leaders function under the guidance of governors and district officers, who are in turn controlled by the central government. For the local government, there are three bodies in general: the Provincial Administrative Organisation (PAO), municipalities (*tessaban*), and the Tambon Administrative Organisations (TAO). The operation of these three local bodies is considered relatively weak compared with the central and provincial governments and sometimes overlaps with the operation of local leaders of the provincial government (Wongpreedee & Mahakanjana, 2011). This implies that decentralisation in Thai public administration is limited.

Contemporary Thai public administration also heavily involves autonomous public organisations (APOs) as a result of agencification and the autonomization of the state (Ungsuchaval, 2020; Bowornwathana, 2013). These APOs are non-departmental public agencies that operate more flexibly and innovatively than traditional bureaucratic departments. Moreover, they tend to focus on specific social and economic policies. For instance, the NHCO is an APO that is dedicated to participatory healthy policy development. APOs in collaboration with the government, therefore, are key agents of public administration underlying governmental responses to COVID-19.

3.2 Government Mechanisms in Response to COVID-19

During the outbreak of the coronavirus disease 2019, the Thai government aimed at alleviating the severity of the incident. Therefore, the key operational guidelines encompassed preventing and containing the pandemic and aiding those affected through formal mechanisms and tools, whether in form of royal decrees, government gazettes, announcements, orders, requirements, regulations, guidelines, and sectoral cooperation. The mechanisms aforementioned can be divided into three segments, namely the (1) central government administration; (2)

provincial administration; and (3) local government administration (Jamsai & Budin, 2021), with details as follows.

3.2.1 Central Government Administration

At present, all powers and duties are centralised and executed by the Office of the Prime Minister, ministry- and bureau-level government departments, department-level government bodies, government-regulated bodies, organisations and state enterprises. Upon the occurrence of an emergency, there will be meetings engaging the above entities whereby key mechanisms are leveraged to manage the incident.

(1) Operational mechanisms that are crucial to the overall communicable disease incidents

The National Communicable Diseases Act was promulgated in the Thai Government Gazette on 5 May 1934 and has progressively evolved and been developed through time to reflect the directions of the government and the country's situation. The current edition is the National Communicable Disease Act, B.E. … (A.D. …), authorising relevant parties to appoint regulators at different levels, including the National Communicable Disease Committee, Provincial Communicable Disease Committee, Bangkok Communicable Disease Committee, and the Communicable Disease Control Officer to ensure surveillance, prevention and containment of communicable diseases with compensation and penalties clearly provided (Thai Government Gazette, 2015). At present, the Communicable Disease Act B.E. 2558 (A.D. 2015) is in the revision process with three batches of stakeholder meetings held to 1) obtain opinions of representatives from entities constituting the National Communicable Disease Committee and agencies under the Department of Disease Control during 15-16 September 2020; 2) obtain

opinions from representatives of the Provincial Public Health Office during 27–28 September 2020, and 3) obtain opinions regarding the drafting of the Communicable Diseases Act (No. ...) B.E. ... (A.D.…), which was confirmed in its entirety by the Office of the Council of State between 10-28 April 2021 (Department of Disease Control, 2021).

Through consideration of the National Communicable Diseases Act, B.E. 2558 (A.D. 2015), which was amended amid the COVID-19 pandemic, there were four issues found as follows: 1) There were no clear guidelines on how to handle persons suspected of being infected with the disease. It was all at the discretion of officials only. In reality, there was often no proof of infection, resulting in the restriction of rights and freedom of people who were ordered to be isolated or put under detention; 2) There were no clear instructions on handling patients or their relatives who withheld their travel history or other important information from medical personnel, resulting in the medical personnel being subjected to risks or being infected with the disease while also bringing about threats to health or even life. Moreover, this situation led to a shortage of medical personnel; 3) Concerning disease prevention and containment for public transportation, a site exposed to increased risk of infection, no clear prevention mechanisms were provided; and 4) Unauthorised transportation of human tissues, secretions, blood or blood constituents. There were no clear instructions provided for such transportation, and incorrect actions taken could cause a rapid spread of the disease (Somnuek, 2019).

(2) Operational mechanisms that are crucial to contagious disease emergencies:

The Emergency Decree on Public Administration in Emergency Situations (Emergency Decree)

The first Emergency Decree on Public Administration in Emergency Situations was enacted and executed during the government of Field Marshal Plaek Phibunsongkhram around

1952 to provide a strong footing in public administration during emergency situations that affected national security. Later in 2005, the emergence of violence due to a conflict in the country's three southern border provinces and four districts of Songkhla Province led to the enacting of the Emergency Decree on Public Administration in Emergency Situations, B.E. 2458 (A.D. 1915) to bring the violence under control. The law provides the state with the powers and duties to control, supervise, prevent, correct, suppress, contain, inhibit situations; rehabilitate and assist people, in order to bring about security and safety of the state, protect rights and freedom of people to ensure return to normalcy as soon as possible, and is to be employed to an extent only necessary (The Secretariat of the House of Representatives, 2020).

However, in declaring a state of emergency in the Deep South according to this law, Thailand encountered seven problems as follows: 1) Lack of control processes in the use of appropriate administrative authority as the powers granted by the Emergency Decree were carried out by the Executive, at its sole discretion (Chantarasombat, 2020); 2) Definitions of emergency situations are ambiguous, unclear, and generate unwanted gaps that enable the state to exercise powers broadly at its sole discretion, resulting in the undermining of the rule of law and international obligations; 3) There was a problem regarding government bodies authorised to declare a state of emergency. The enactment of the Emergency Decree aims to provide powers to the Executive or the Cabinet. However, recently, the balance of powers was reduced, and authority was given to the prime minister in a dictatorial fashion, which is considered against the law; 4) Centralisation of powers after declaring a state of emergency without limiting the time period. The longer the state of emergency is enforced, the more it undermines the rule of law and the principle of democracy; 5) Restriction of freedoms, which was determined based on the severity of the situation. However, whatever the severity level is, it is contrary to civil rights and freedom; 6)

Judicial issues occurred as officials could arrest offenders simply based on suspicion, which does not conform with the country's judicial process that requires informing suspects of the allegation prior to the arrest (Tubtong, 2005); and 7) Problems regarding the jurisdiction of the Administrative Court that caused an unnecessary burden as the judicial process was not conducive to delivering justice to the injured parties (Tubtong, 2019).

During the outbreak of COVID-19, the Prime Minister and the Minister of Defence issued a Statement of the Prime Minister's Office on the promulgation of the Emergency Decree B.E. 2548 (A.D. 2005) or the Emergency Decree to contain the situation, which became effective on 25 March 2020 and was extended from 1 April 2022 to 31 May 2022 to cover all localities throughout the Kingdom as per 17th announcement. The statement was intended to provide the state with legal means to control or administer the situation and issue specific requirements, prohibitions or practices to suppress the spread of the disease and thoroughly allocate resources, medical supplies and services to the population. In other words, it can be considered a centralisation of power, which may precipitate difficulties for the people for a period of time. However, some measures were later eased and adjusted in correspondence with the ongoing situation (Prime Minister’s Office, 2020b).

The Center for COVID-19 Situation Administration (CCSA)

The CCSA came into being as a result of Order No. 76/2563 dated 12 March 2020 under the State Administration Act, B.E. 2534 (A.D. 1991), by the Office of the Prime Minister, with the prime minister being the chairman of the board, and the secretary general of the National Security Council and the commissioner of the national police as committee members. It is responsible for setting policies and launching urgent measures during the outbreak of COVID-19 and issuing orders to engage relevant parties within their scope of duties and legal powers based on six key measures, including public health, preventive medicine, clarification and grievance mechanisms,

foreign affairs, prevention measures and measures to alleviate and remedy sufferings, as well as intersectoral cooperation from the private sector to activate implementation of policies and urgent measures (Prime Minister's Office, 2020a).

Emergency Operation Center (EOC)

Communication and government operations related to the health crisis were to be carried out through a public health agency equipped with the medical mechanisms and public health knowledge for emergency incidents. Therefore, the Ministry of Public Health launched the Emergency Operation Center, whose operations are based on the principle of "Incident Command System (ICS)": The permanent secretary of the Ministry of Public Health serves as the commander to assign work based on four structural groups, including a group focusing on situation analysis and knowledge extraction, a group responsible for disease control within a designated area, a support group and a risk communication group. The ICS was later championed as a model for many other countries (Ungsuchaval & Kumlungpat, 2020).

3.2.2 Provincial Government Administration

Under the Public Administration Act, B.E. 2534 (A.D. 1991), Section 51, regional public administration is decentralised and divided into two forms: the province and the district (Thai Government Gazette, 1991). Both are responsible for containing and alleviating the COVID-19 situation. At the regional level, local authorities follow orders and implement policies from the central government; however, each locality has its own specific powers and authority. For example, according to an order from the central government, every province was required to establish a Provincial Communicable Disease Committee, with the provincial governor acting as the chairperson, responsible for executing policies and guidelines, creating systems for disease

surveillance, prevention and containment as prescribed by the National Communicable Disease Committee. Moreover, the Committee has the duties to provide action plans, report current situations of communicable diseases or diseases of which the cause is being unknown to the director-general of the Department of Disease Control; support, promote, monitor and evaluate performance, and report it to the central government; appoint a working group to carry out control measures, monitor entry and exit ways of provinces adjacent to other countries; summon experts to provide facts or express opinions, and submit information for consideration as well as taking other actions as assigned by the provincial governor, or as prescribed in the Communicable Disease Act, B.E. 2558 (A.D. 2015) (Department of Disease Control, 2016).

Each Provincial Communicable Disease Committee was to establish subcommittees and working groups to be responsible for different fields. For instance, under the Order of Nakhon Pathom Communicable Disease Committee No. 2/2563, three subcommittees were established and regulated by the Nakhon Pathom Communicable Disease Committee to be responsible for the following:

(1) Subcommittee Surveillance and Control of COVID-19 with the first provincial deputy governor being the chairman and representative of related positions from public entities acting as subcommittee members and secretary. The subcommittee is responsible for executing guidelines determined by the Cabinet, the National Communicabel Disease Committee, and the Nakhon Pathom Communicable Disease Committee. It also monitors and supervises the performance of relevant officials to ensure prompt and effective action-taking, provide clarifications to the general public and the private sector in order to consolidate collaboration in executing required measures; invite individuals to attend meetings or seek information, documents, evidence from relevant

sectors to benefit operations and other actions to be taken as assigned by the provincial governor (Nakhon Pathom Provincial Communicable Disease Committee, 2019).

(2) Subcommittee Aid and Remedy, consisting of the second provincial deputy governor being the chairman with representatives of relevant positions from public entities acting as subcommittee members. It is responsible to monitor actions taken in aiding people affected by the situation, collect financial and material donations to support related missions, as well as alleviating of people's suffering in conformity to laws and official regulations; invite individuals to attend meetings or seek information from an individual or an entity to benefit the government's operations as assigned by the provincial governor (Nakhon Pathom Provincial Communicable Disease Committee, 2019).

(3) Subcommittee Facilitation, Support and Risk Communication, consisting of the third provincial deputy governor being the chairman with representatives of relevant positions from public entities acting as subcommittee members. It oversees data management, provide emergency response plans, prepare human resources, equipment, and resources to aid those affected; communicate and clarify information, and conduct press conferences for the general public to benefit the government's operations as assigned by the provincial governor (Nakhon Pathom Provincial Communicable Disease Committee, 2019).

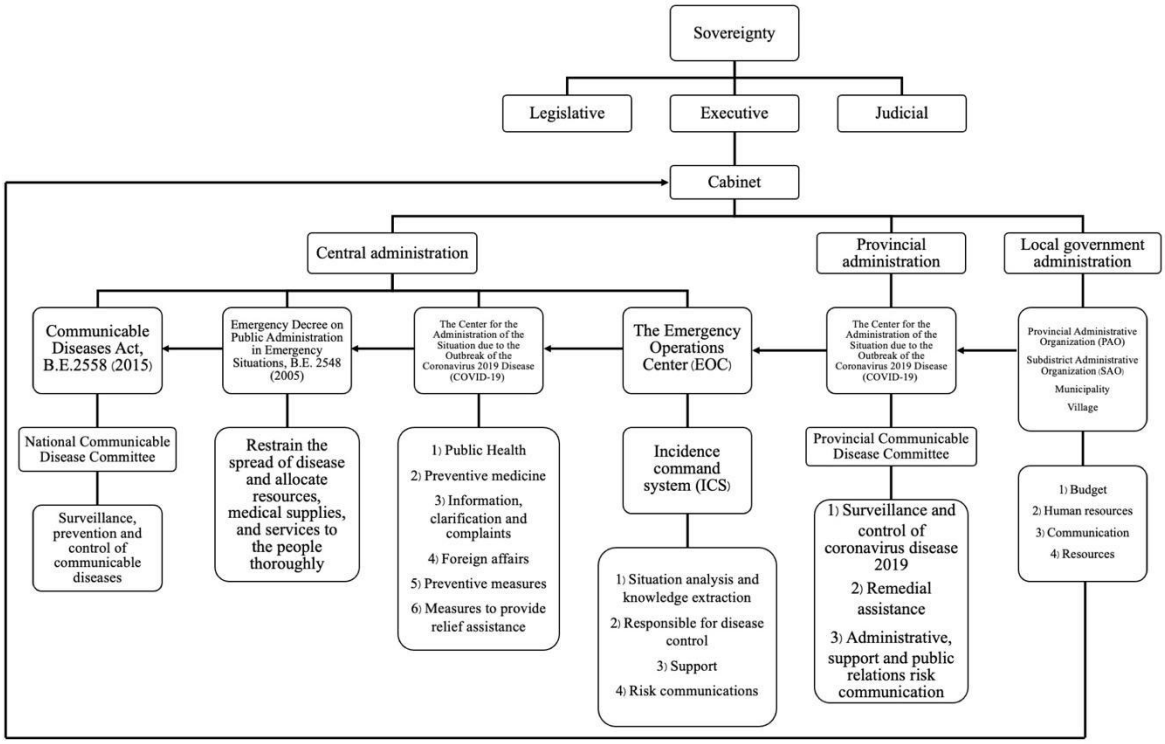
3.2.3 Local Government Administration

In managing the COVID-19 outbreak, the local government administration was responsible for four areas including 1) Budget: There were ad-hoc budget allocations for public health to treat patients and handle those exposed to risk of infection. However, the budget could not be forecasted and the amount was relatively small. A supporting budget could have helped

solve the problems better; 2) Personnel: The central government has decentralised to localities in several missions, resulting in a larger quantity of work, even though the capacity of the workforce remained the same. Therefore, it could not be responsive to situations and public needs as much as it should; 3) Communication: Concerns were vertically communicated to relevant parties, including district public health offices, village health volunteers and heads of villages, to conduct health screenings and communicate important information to facilitate mutual understanding within the community; and 4) Resources: Each locality prepared isolation centres which accommodate patient beds and comprehensively take care of the public, whether those travelling from high risk areas or infected individuals, as both can register to obtain treatment at the site with medical personnel providing care. However, budgets allocated by the central government to be spent on prevention resources such as PPE, disinfectants, gloves, alcohol sanitizer, hygienic masks, etc., were relatively small, thus, not sufficient to accommodate all the needs of people in the locality (Srakaew & Sripokangkul, 2022).

Public administration and key government mechanisms during the COVID-19 outbreak mentioned above can be summarised as shown in figure 3.1.

Figure 3.1 Mechanisms and tools for public administration during the outbreak of COVID-19



Source: adapted from Jamsai & Budin, 2021

Tools harnessed in the three areas of the public administration mentioned above are considered tools under the government mechanisms of the state, which are key drivers that engage all relevant sectors with a strong focus on the public sector. This is noticeable from the orders to establish related subcommittees or working groups, whose members were all representatives from the public sector, as the emergency situations required prompt decision-taking. Moreover, it consists of three tools that represent governance mechanisms of public health, COVID-19 prevention and control including decision-making mechanism, communication mechanism, operation mechanism, which are considered appropriate in design and actions taken during a specific period of time (Ungsuchaval & Kumlungpat, 2020).

However, it can be argued that the aforementioned government tools and mechanisms lacked active and comprehensive participation from all sectors. If considering the laws, announcements or orders regarding active participation, it is clearly noticeable that most of them are participations from the public sector. Conversely, if the NHCO's mechanisms had been integrated as part of the government's tools, it would have resulted in more an efficient management of the emergency situation.

3.3 Social Participation in Health Development

Social participation in health development has taken root in Thailand since the Alma-Ata Declaration on Primary Health Care. The Village Health Volunteer program, which was introduced in Thailand in 1977, is one of the examples demonstrating that the government has given space to people to take part in health development. The role of village health volunteers is to complement the work of medical doctors and public health officers in rural areas and serve as mediators between health professionals and people on self-care issues. This engagement has continued even during the COVID-19 pandemic. The village health volunteers played a significant role in conveying messages on COVID-19 prevention and control as well as information about vaccinations administered by health professionals and the Ministry of Public Health.

However, the level of social participation in the primary health care era, especially the role of the village health volunteers, is described as "implementation without deliberation" (Chuengsatiansup, 2005). Although the government allowed people to play a certain role in health development, participation was limited to an implementation level and not present at a decision-making level. Additionally, decision-making was made exclusively by health professionals due to the prevalent biomedical perspective of health development at that time.

The spread of HIV/AIDS in Thailand in the mid-1980s made non-governmental civil society and grassroots community organisations recognisable in health development. Non-state actors complemented the work of government agencies in response to HIV/AIDS, particularly reaching out to the marginalised and promoting an anti-stigma campaign for people living with HIV. The role of non-state actors has increasingly expanded from providing health services and helping people in need to advocacy and knowledge production, for example, through an anti-smoking activist group and a consumer protection network. Professional associations, such as the Rural Doctor Association and the Community Pharmacist Association, have also played an active role in health development.

Not until the late 1990s did Thailand make efforts to reform its health system and scale up the level of participation in health development from an implementation level to a decision-making level. This resonated with the Ottawa Charter on Health Promotion in 1986, in which one of the five action areas is to strengthen community action in setting priorities, making decisions, planning strategies and implementing them. The output of this endeavour was the promulgation of the National Health Act in 2007, leading to a participatory health governance. This Act has become an essential tool to enhance social participation in health development because its definition of health is broad and beyond a biomedical perspective. The National Health Act redefined health as well-being that embraces physical, mental, social and spiritual aspects. The broader health definition built confidence and increased the role of people in determining the direction of health development.

Based on this new definition of health, it became possible to establish a new health governance body known as the National Health Commission. One-third of its commissioners are drawn from NGOs and civil society groups, which are self-elected from 76 provinces in Thailand.

The rest are representatives of the government sector, academia and professional groups. As an advisory board to the Cabinet on health policies and strategies, the National Health Commission enhances the role of the people in health development.

4. National Health Assembly (NHA) and COVID-19

This section introduces the National Health Assembly (NHA), a distinctive national-level social participation mechanism developed two decades ago. It begins by examining the background of the NHA and then investigates how the assembly responded to COVID-19. As the NHA was itself affected and transformed by the pandemic, this process is also briefly explained. The chapter ends by describing some of the challenges the NHA faced in dealing with the pandemic.

4.1 Background of NHA

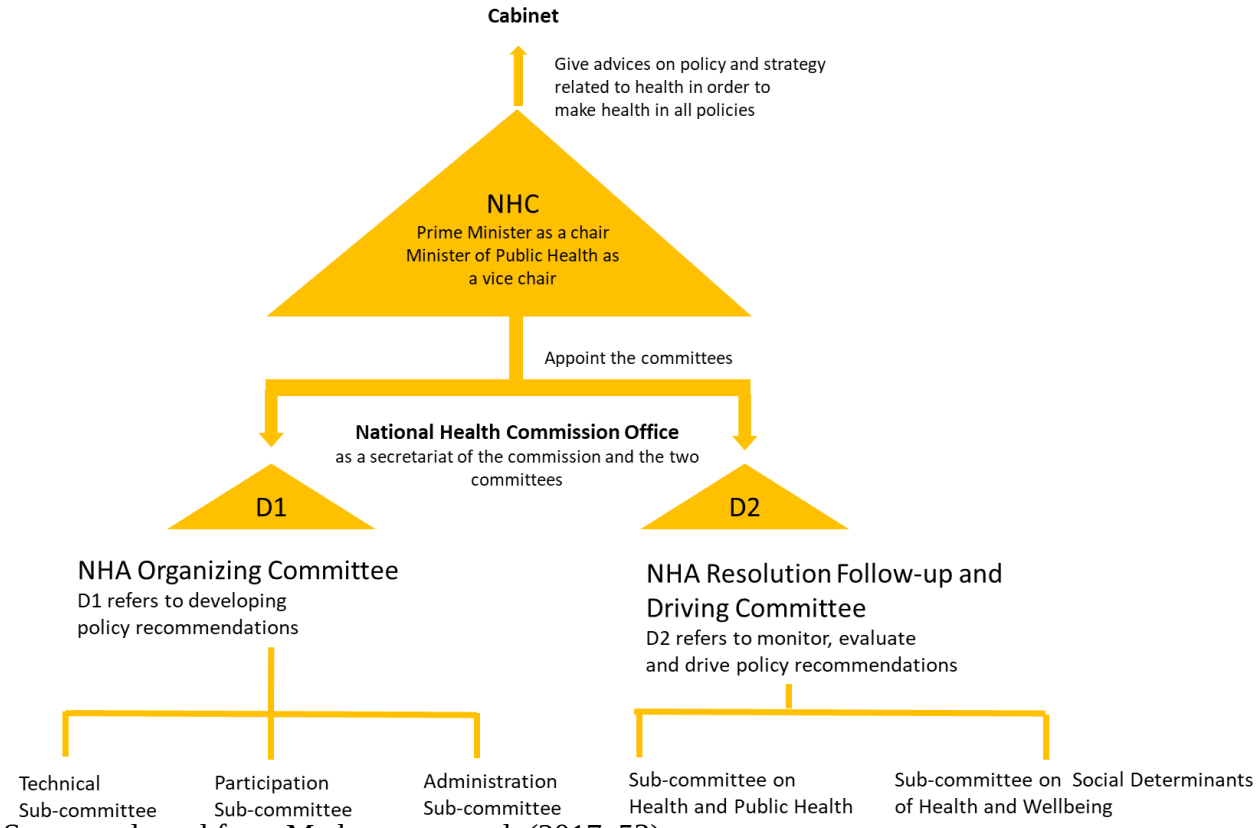
The concept of a health assembly was first initiated around 2000 prior to the promulgation of the National Health Act in 2007. At that time, the 1997 Constitution motivated Thai society to develop new organisations, mechanisms and processes of social participation for the country's development. As a result, the health assembly was employed as a public hearing platform for the National Health Bill (Chuengsatiansup, 2008). The format and process of the health assembly were simple, aiming to open space for people to address health problems and discuss their ideas of desirable health systems. The first official, national-level health assembly was organised in 2008 after the enactment of the National Health Act. Consequently, the National Health Assembly (NHA) is an official and legitimate participatory platform in Thailand (NHA01 interview, 21 January 2022) that has been organised for 15 years.

The formality of the NHA's mechanism, format and process was gradually created. Unlike the health assembly in the period of the pre-Act, the NHA has two multi-sectoral committees appointed by the National Health Commission to carry on the cyclical process of the assembly. The first committee is the NHA Organising Committee responsible for developing

policy recommendations, including drawing up the rules and guidelines of the NHA process, classifying and defining constituencies, setting agendas, drafting resolutions and convening the NHA. The organising committee consists of three subcommittees: the technical subcommittee, the participation subcommittee and the administration subcommittee. The second committee is the NHA Resolution Follow-up and Driving Committee, which is in charge of strategizing and facilitating the implementation of NHA resolutions, monitoring and evaluation, reporting on the progress or outcomes at the NHA and revising the past resolutions, if necessary (Mathurapote, et al., 2017). The NHA Resolution Follow-up and Driving Committee has two subcommittees, one on health and public health issues and another on social determinants of health and wellbeing issues. Both committees have civil society or nongovernmental organisations (NGOs) or representatives from Provincial Health Assemblies as members.

The design of the NHA mechanism shows that it is no longer a mere public hearing platform but a policy development platform. Through the NHA, the people's voice receives a formal channel to submit policy recoomendationss to the National Health Commission (NHC), chaired by the prime minister, and further to the Cabinet. The uniqueness of this policy development platform is the engagement of multiple actors, which is not limited to the Ministry of Public Health or other government agencies. Civil society, NGOs, members of Provincial Health Assemblies, academia, professional groups, and the private sector attend the assembly and form its constituency. The constituencies are eligible to participate throughout the entire process of the NHA, from submitting an agenda to the National Health Assembly Organising Committee, drafting and giving feedback to the draft technical document and resolution, organising side events, and adopting the resolutions at the NHA, as well as implementing the resolutions.

Figure 4.1 Thailand National Health Commission Governance



Source: adapted from Mathurapote et al. (2017, 53)

In summary, organising annual NHAs consistently for 15 years strengthened the capacity and empowered non-state actors, especially in enabling civil society and NGOs to collaborate with the government sector. The NHA levelled the playing field for the civil society sector, which was previously rarely involved in policy-making at the national level (Rajan et al., 2017).

4.2 NHA Response to COVID-19

The agenda items of the NHA vary from health to agriculture, environment, trade or electronicsports issues indicating the social determinants of health perspective in health policy

recommendations derived from the NHA[1]. The resolutions in 2020 and 2021, in particular, have contributed to COVID-19 problem-solving in various aspects reflecting public concerns about the pandemic beyond health care services. For example, issues of participatory health crisis management for pandemics and food security during the crisis were discussed at NHA 13 in 2020, while NHA 14 in 2021 included discussions on a healthy environment during COVID-19, communication management in a health crisis and equitable access to health services by vulnerable populations in crisis.

This chapter focuses on the development of the resolution of NHA 13 on participatory health crisis management for pandemics that covers the issues of governance for pandemic preparedness and response, communication and information system, public health staffing and infrastructures, measures to mitigate health, economic, social, and environmental impact, and mechanisms and policies to support knowledge management, research, and innovation development.[2]

4.2.1 The Process of NHA Development

NHA 13 opened space for constituencies to express opinions, feedback, suggestions and information in four steps of the NHA process as follows.

In the first step, ahead of the drafting of the resolution, the discussion points on emerging diseases crisis management and lessons learned from COVID-19 were distributed widely among the constituencies who then shared their views, provided feedback and suggestions in a video-call meeting or submitted their responses via an online form. The discussion points were divided into

[1] For the NHA resolutions in the past, please see https://en.nationalhealth.or.th/nha/

[2] For the detail of the resolution, please see https://en.nationalhealth.or.th/wp-content/uploads/2021/03/2020_NHA13_Agenda-2.2_Health-Crisisi_Resolution.pdf

five sections: COVID-19 and its impacts, the role of the participating organisations or networks on prevention, government response to the pandemic, rehabilitation and recovery. All responses were used as input to draft the technical document and resolution.

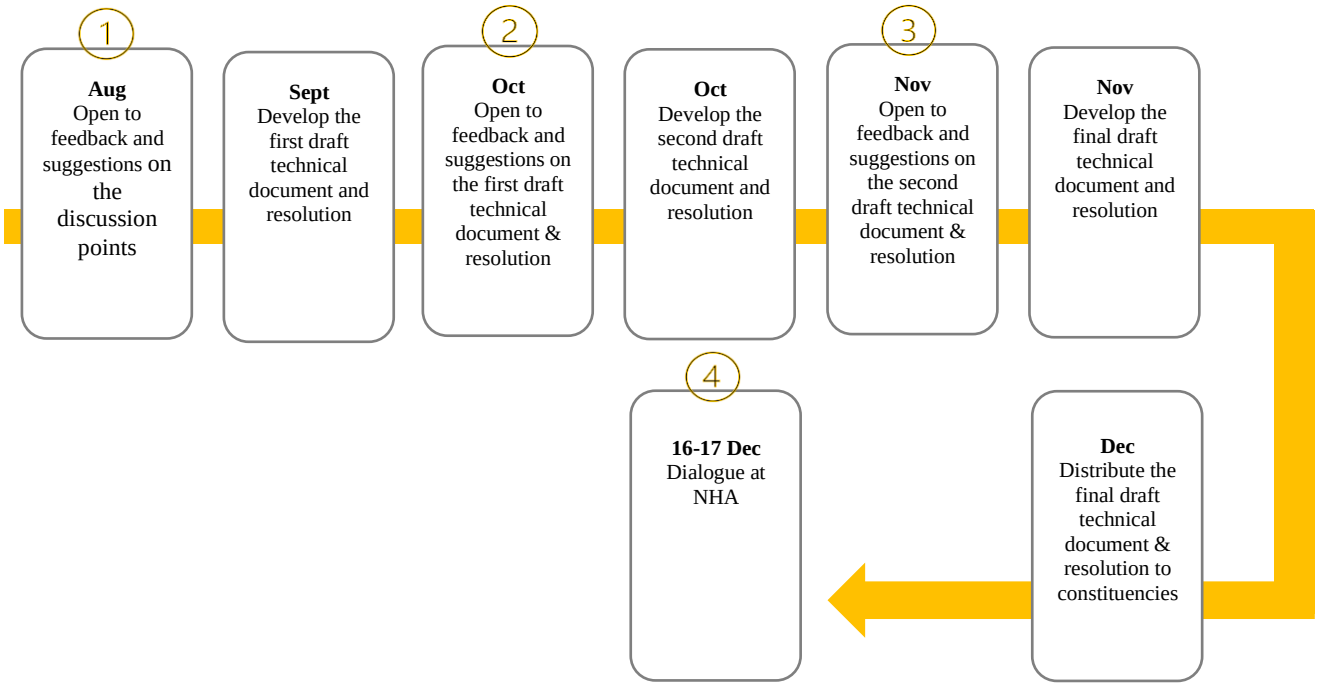
In the second step, after the first draft of the technical document and resolution was made available, key stakeholders were consulted in another online video-call meeting.

In the third step, after completing the second draft of the technical document and resolution, the documents were distributed to the constituencies via email and letters. After receiving feedback and suggestions from the constituencies, the drafting group and the technical subcommittee revised the second draft of the resolution. The revised second draft resolution was submitted to the NHA Organisation Committee for approval and became the final draft of the resolution.

The fourth step was a discussion on the final draft resolution at the NHA. Once everyone agreed, the resolution was adopted on a consensus basis.

The timeline of the public hearings on the resolution on participatory health crisis management for pandemics is shown in figure 4.2.

Figure 4.2 Timeline of the public hearing on the NHA resolution



4.2.2 Constituencies and Participation in the NHA Process

The number of constituencies joining the participatory steps 1-4, as aforementioned, is presented in the table below. They are categorised into five groups: government sector, academia, NGOs or CSOs, Provincial Health Assemblies, and participatory regional health commissions. The number of the constituencies in steps 1-3 show the active constituencies who provided feedback or suggestions to the discussion points and the draft versions of the resolution, while the number of the constituencies in step 4 shows the total constituencies attending the NHA (National Health Commission Office, 2021c, 2021d, 2021e, 2021f). It is noted that the number of the total constituencies attending the online meetings and/or receiving the documents via emails and letters in steps 1 to 3 is not available as the NHCO collected only a list of respondents and their feedback.

Table 4.1 The number of participants attending public hearings and the NHA 13

Participatory Steps	Government agencies from health & non health sector	Academia	NGOs or Civil Society Organisations (CSOs)	Provincial Health Assembly	Participatory Regional Health Commission
1. Discussion points	12	5	2	21	0
2. First draft resolution	6	0	1	0	0
3. Second draft resolution	21	1	0	63	1
4. Final draft resolution at NHA	42	17	43	77	13

Despite the fact that the members of a provincial health assembly are multiple actors in a province, it can be assumed that the voice of the provincial health assembly reflects the voice of people in the province. Therefore, from table 4.1, it can be assumed that the voice of people prevails over the voice of the government sector and that of academia. However, if looking at the composition of the drafting group of this resolution, none of the 16 members are members of an NGO, civil society group or representatives of the provincial health assembly. Unlike the drafting group of the resolution on food security during the crisis, there are five civil society representatives and NGOs out of 17 drafting group members (National Health Commission Office, 2020a, 2020b).

In addition to expressing opinions and giving feedback, suggestions and information, the constituencies could participate in the NHA processes in other ways, for example, by proposing agenda items for the NHA, organising side events, and advocating and implementing the resolutions.

4.2.3 Advocating the NHA Resolution

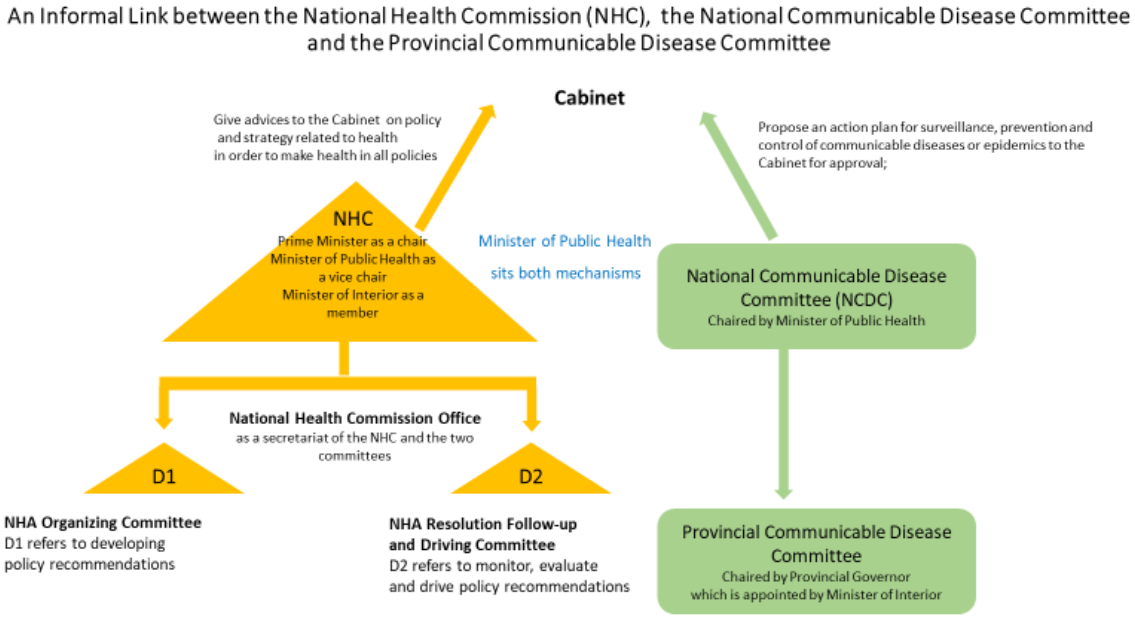
The deliberation-to-policy gap seems to be a limitation of the social participation process. Ensuring the uptake of inputs from the participatory platform to policies and implementations requires additional collaboration (Dheepa, Kock & Rohrer-Herold, 2021). This was a relevant issue for the NHA after the adoption of the resolution. Although the resolution was submitted to the National Health Commission chaired by the prime minister, additional formal and informal policy communication with key stakeholders from the government sector was seen as essential for policy uptake.

In case of the resolution on a participatory health crisis management for pandemics, one of the operative clauses specifies clearly to request the provincial governors, the Provincial Communicable Disease Committee, the Immigration Bureau and relevant agencies, to develop and strengthen local mechanisms by engaging civil society and the public to participate in surveillance, prevention, and control of disease outbreaks at provincial and national borders (National Health Commission Office, 2021g). Therefore, the National Health Commission Office, as the secretariat of the National Health Commission, the NHA Organising Committee and the NHA Resolution Follow-up and Driving Committee, had to advocate and work with at least two involved ministries to mobilise this resolution, particularly the operative clause. First, it contacted the Ministry of Public Health because the public health minister is the chair of the National Communicable Disease Committee. Second came the Ministry of Interior because the chairs of the Provincial Communicable Disease Committee, who are provincial governors, are appointed by the interior minister. In addition, the public health minister and the interior minister are members of the NHC.

This setting up of a formal policy communication channel can be seen as an advantage of multi-sectoral and multi-stakeholder governance.

The figure 4.3 demonstrates the informal link between the National Health Commission, the National Communicable Disease Committee, and the Provincial Communicable Disease Committee. This link connects three key government organisations working on pandemic prevention, control and response namely the Ministry of Public Health, the Ministry of Interior and the National Health Commission Office.

Figure 4.3 An Informal link between the NHC, the NCDC and the Provincial Communicable Disease Committee



In addition to policy communication, it was crucial to have additional strong evidence to convince both ministries that the people have the capacity to support the work of the government on pandemic response. The NHCO chose a community-driven COVID-19 prevention, control and

response model project that was piloted in three slum areas in Bangkok, namely the communities of Klong Toei, Thawi Watthana and Wang Thonglang. The results were presented to the National Health Commission and the National Communicable Disease Committee.

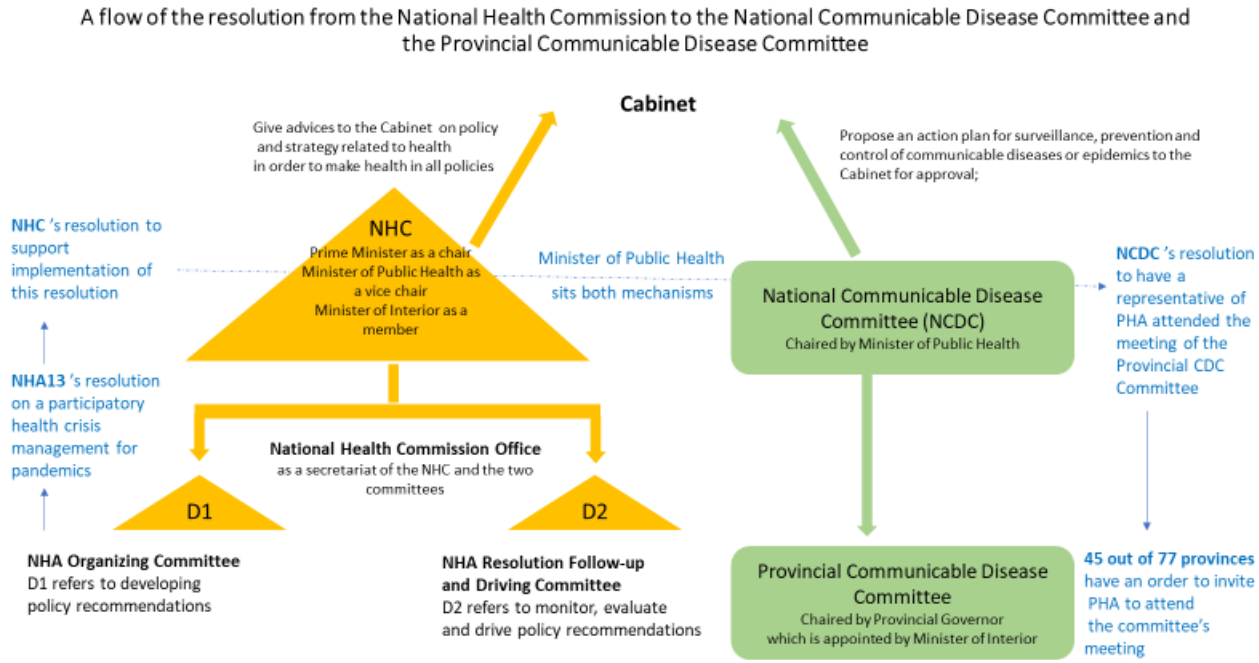
Furthermore, the National Health Commission Office shared data from a survey on the collaboration between local governments and communities in developing and implementing community health charters for COVID-19 prevention, control and response with the Ministry of Interior. In total, 527 local governments have used a community health charter as a social measure to complement government measures (National Health Commission Office, 2021h).

These collective efforts and tangible evidence likely influenced the decision of the National Health Commission and the National Communicable Disease Committee. The National Health Commission passed a resolution dated 11 January 2021 to support the implementation of the National Health Assembly's resolution on participatory health crisis management for pandemics. Further, the National Communicable Disease Committee passed a resolution dated 23 August 2021 to have a representative of the Provincial Health Assembly attend the meeting of the Provincial Communicable Disease Committee (National Health Commission Office, 2021i, Department of Communicable Disease Control, 2021). At present, 45 out of 77 provinces have invited a representative of a Provincial Health Assembly, NGO or CSO to attend the committee's meeting.

Although the representative of the Provincial Health Assemblies is still not considered a permanent member of the Provincial Communicable Disease Committee, having a representative of the people in the decision-making mechanism facilitates a desirable information and communication flow between the government and the people (NP03 interview, 24 January 2020). It is too early to evaluate the results of the decision of the National Communicable Disease Committee in this regard, but it is likely to illustrate the government's acceptance of participatory

governance in pandemic response and its acknowledgment of the capabilities of the people sector in pandemic response.

Figure 4.4 A flow of the resolution from the National Health Commission to the National Communicable Disease Committee and the Provincial Communicable Disease Committee



In conclusion, the evidence of social participation through the National Health Assembly was able to influence the government's response to COVID-19, as reflected in the invitation of PHA representatives to the meetings of the Provincial Communicable Disease Committee in many provinces. However, it must be noted that this success, especially during the crisis, had been built by a long period of cultivating mutual trust between the government and the people sector through multi-sectoral collaboration in different formats.

4.3 NHA's Transformation due to COVID-19

The NHA Organising Committee had attempted to increase the use of digital technology at the NHA before the pandemic. The COVID-19 outbreak stimulated this transformation and led to a wider acceptance of the use of digital technology by the constituencies. The 13th National Health Assembly in 2020 was organised, for the first time, both onsite and online. This transformation helped maintain participation of all sectors while following social distancing rules. It appears that the hybrid meeting format increased several people's access to the assembly. The constituencies from the Provincial Health Assemblies, except those in Bangkok, joined the NHA online. Unlike in the past when representatives of Provincial Health Assemblies travelled to the venue of the NHA, the online meetings enabled more people from the provinces to attend the assembly. Additionally, the NHA was live-streamed on Facebook reaching more than 120,000 viewers in 2020 and 160,00 viewers in 2021. However, the quality of participation at this hybrid assembly has to be further explored.

4.4 Challenges

Due to the unprecedented and acute nature of the COVID-19 pandemic, problem-solving of the situation required rapid decision-making and action. Simply, it needed quick responses from decision makers. However, the format and process of the NHA is rather "rigid" (NHA01 interview, 21 January 2022; Chuengsatiansup, 2012) and has a long process. The NHA is suitable for complex problems that require problem-solving at a systemic level or the social structural level, for example, setting up a mechanism, revising an obsolete law or developing a new law. This can be clearly seen in the operative clauses of the resolution on participatory health crisis management

for pandemics that request a standing body to manage pandemics and revise the Communicable Disease Act, B.E. 2558 (2015).

In addition, public participation in the NHA is still limited. Despite having 1,996 participants attending the NHA onsite and online and 120,000 viewers from the National Health Commission Office's Facebook Live channel, only 192 people as constituencies had the right to adopt the resolution. The total participants of the NHA consist of constituencies, committees, subcommittees, drafting groups, experts, people who register to attend the NHA, observers, media, and National Health Commission Office staff (National Health Commission Office, 2021j). Furthermore, the active engagement of the constituencies is also an issue. While the hybrid meeting format makes the NHA accessible widely, the quality of participation in the hybrid meetings needs to be further studied.

In conclusion, the National Health Assembly as an official and legitimate participatory mechanism enabled multiple actors, especially members of the public, to address health and social determinants of health problems during the COVID-19 pandemic. To a certain extent, this mechanism can influence the governments' response to COVID-19 as seen in many provinces where representatives of the Provincial Health Assembly were invited to attend the meeting of the Provincial Communicable Disease Committee. The success in influencing decisions of the government, especially during the crisis, is based on trust and collaboration between the government and people which has been cultivated for a long time. A link between a participatory mechanism (NHA) and authoritative mechanism (the National Health Commission and the Cabinet) is crucial to convey the voice of the people to policymakers. Additional provided evidence to prove the capacity of the people made policymakers confident to support a participatory governance and to facilitate requests of the people.

5. Provincial Health Assembly (PHA) of Nakhon Pathom and COVID-19

Nakhon Pathom Province was considered a high-risk province during the COVID-19 pandemic for three main reasons. First, Nakhon Pathom was located among the provinces with the highest number of infections in Thailand (Bangkok and Samut Sakhon, as shown in figure 1.). These two areas were prone to the most intense outbreaks in the country, according to the statistics of the Department of Disease Control of the Ministry of Public Health, which showed the country's highest number of new infections on 29 July 2021.

Secondly, the Center for COVID-19 Situation Administration (CCSA) issued Order No. 6/2564, dated 26 June 2021, designating the area as maximum restricted. Nakhon Pathom province became the most strictly controlled area for surveillance and tackling the problems. Furthermore, the Center for Epidemic Management of Coronavirus Disease 2019, Ministry of Interior No. MorTor.0230/Wor. 4295, dated 27 July 2021, issued a policy to enforce healthcare measures for all provinces to facilitate the travel of infected people back to their hometowns to mitigate the high infection numbers in Bangkok.

Figure 5.1 The location of Nakhon Pathom Province

Thirdly, Nakhon Pathom is considered "Bangkok's kitchen" because of its significance as a location of food production and transportation hub of vegetables, fruits, and meat to the capital. This constant commuting of goods and people inevitably worsened the pandemic, putting strain on the public health system and impacting residents' quality of life (PHA07 interview, 23 March 2022).

However, although Nakhon Pathom was a high-risk area, the province had a mechanism to deal with COVID-19. This mechanism, the Community Isolation Complex, resulted from the

participation of many sectors in the province. It was initiated and supported by the Nakhon Pathom Provincial Health Assembly under active cooperation with government agencies in the provincial area. The following section will present the background of the Nakhon Pathom PHA, including the role of the mechanism in supporting and operating the Community Isolation Complex and the problems and obstacles of the Nakhon Pathom PHA in managing COVID-19 in the area. For example, representatives from the Nakhon Pathom PHA are not formally included in the government's decision-making process at the provincial level. Instead, they rely on informal channels and personal relationships to work with the government. However, any changes in staff or relationships may cause a lack of continuity in operation.

5.1 Background of the PHA of Nakhon Pathom

In 2012, the National Health Commission Office (NHCO) accelerated the development of the system and mechanisms for area-based health assembly due to the resolution of the 5th National Health Assembly (2012) on the "Health Assembly Mechanisms and Processes". The resolution called for organising a health assembly based on the principles and concepts of a desirable and systematic health assembly (National Health Commission Office, 2021a). In addition, a review of lessons learned by the NHCO (National Health Commission Office, 2009; Buntian & Orachai, 2010; National Health Commission Office, 2013a) and feedback from local partners pointed out the need to standardize area-based health assemblies. The aforementioned circumstances resulted in the expansion of the NHCO's work from the national-level health assembly to the provincial-level health assembly (National Health Commission Office, 2012b). The Provincial Health Assembly applied and adjusted the process and the format of the National Health Assembly.

Nakhon Pathom Province is the first batch organizing the Provincial Health Assembly. This is because Nakhon Pathom Province has its strength with a social capital. The civil society network in the province has worked on river conservation since 1998. The network also joined in developing and advocating the National Health Act in the early 2000s (National Health Commission Office, 2008). In the beginning, the Nakhon Pathom PHA gave weight to working with civil society networks to develop their capacity in expressing opinions. This led to a better participation and a stronger desire to participate public policy development through the PHA mechanism. Later, the PHA worked closer with the government network bringing about the equal partnership between the civil society and the government sector.

In line with an interview of the Chairman of the Nakhon Pathom Provincial Health Assembly, it was found that:

> *"The Nakhon Pathom Provincial Health Assembly strived to create a connection between the government, academics, and the people. This allowed the government a new perspective that if participation from the people is solid, it will make the work of the government be widely accepted (PHA01 interview, 23 March 2022)".*

The working group of the Nakhon Pathom PHA was later on set up with the objective to develop and drive participatory public policies of Nakhon Pathom through the PHA. In addition to the working group, the advisory group was set up with the members from counsellors from religious organisations, provincial universities, local government, provincial government agencies for the environment, and the provincial chamber of commerce (as shown in figure 5.2). According to the latest Order of the National Health Commission Office No. 69/2560, dated 18 April 2017 on appointment of the working group of the PHA, the multisectoral composition of the working

group was designed to foster collaboration and information exchange between civil society, academics, and the state.

The PHA was also designed to adjust its work according to the situation and needs of the province and complement government agencies' work at the provincial level. More specifically, the PHA was tasked with coordinating, inviting, and supporting the agencies and networks to be joint owners of and utilise the assembly as well as support public policy processes. This was consistent with interviews with health officials in the area, one of whom stated that:

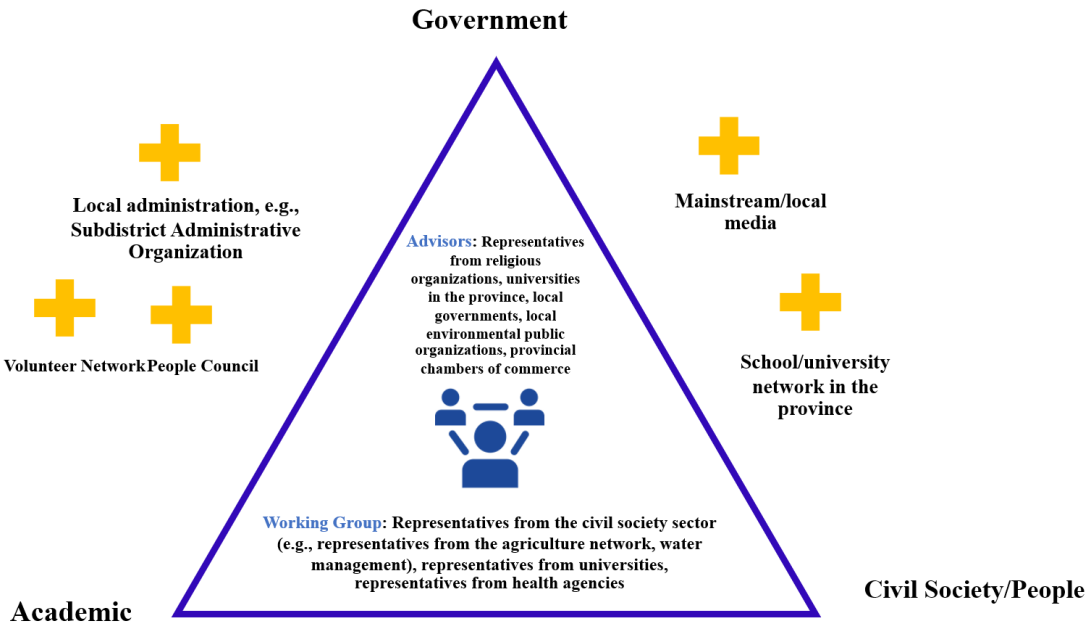
> "*If there is a problem, the government sector can only solve part of it. We will take the matter to discuss at the meeting of the Provincial Health Assembly, which will make the work move faster. For example, the big flooding problem or coping with COVID-19. There would be a discussion between volunteer teams from many agencies, including the private sector, to build collaboration. Some of them are very knowledgeable (PHA04 interview, 23 March 2022)".*

The Nakhon Pathom Provincial Health Assembly has extended its work beyond health issues such as food security and water management. As a result, new commers joined the PHA, for example, collaborations with media organisations, both mainstream media and local media (Thai PBS, Nakhon Pathom News Group), Subdistrict Administrative Organisations (in some subdistricts), community cooperatives, community enterprises, social enterprises for agricultural tourism, primary schools, and the Tha Chin Basin Council (National Health Commission, 2016).

Figure 5.2 shows the structure of the Nakhon Pathom PHA mechanism, consisting of three sectors, namely the government, academics, and civil society. The advisory group and the working group are designed to facilitate collaboration and information exchange among different

stakeholders. The assembly mechanism also focuses on non-health issues by connecting with various networks.

Figure 5.2 The mechanism of the Nakhon Pathom Provincial Health Assembly

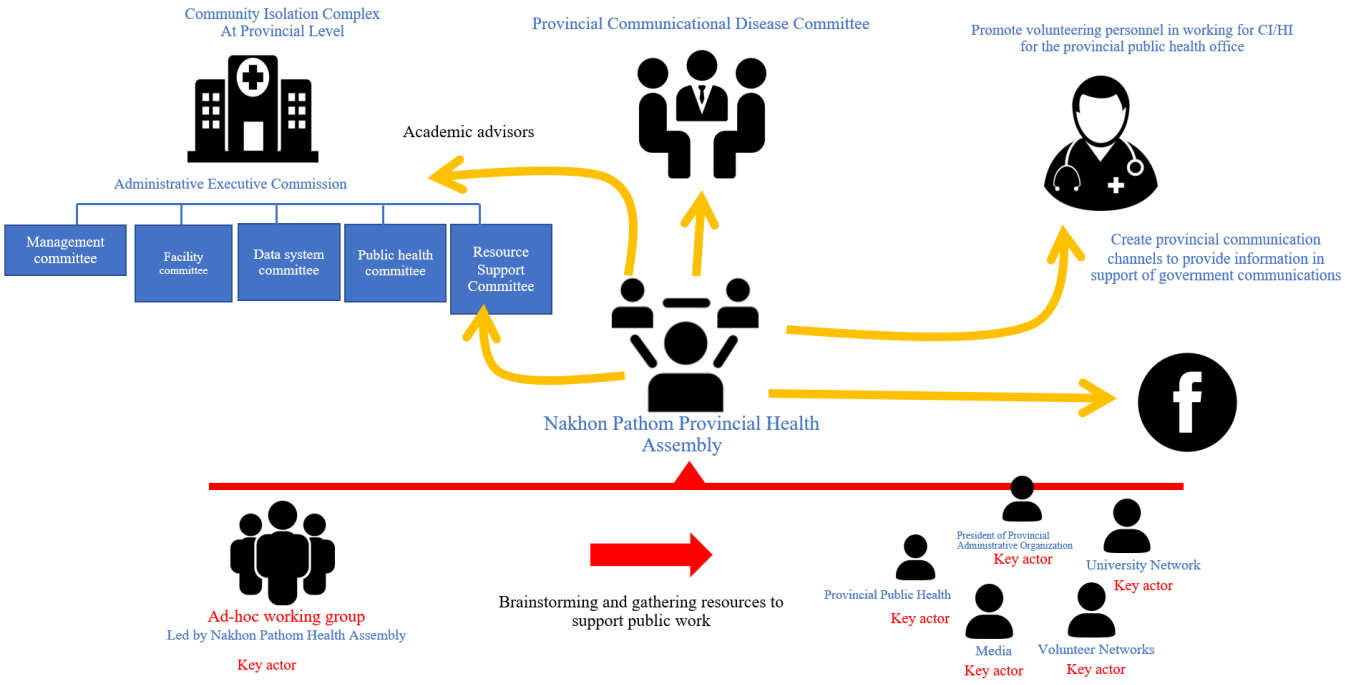


5.2 PHA of Nakhon Pathom in the Time of COVID-19

In response to the COVID-19 crisis, the Nakhon Pathom Provincial Health Assembly established a special working group under the leadership of the Chairman of the Nakhon Pathom PHA working group and representatives from the advisory committee. This ad hoc working group was responsible for liaising with business organisations, educational institutions, volunteer networks, religious organisations, academics, and local politicians in the area to gather opinions and mobilise resources to support the government in solving COVID-19-related problems.

Figure 5.3 shows the solution-finding process for problems related to COVID-19 of the Nakhon Pathom PHA in support of the government's work at the provincial level. The work focused on three crucial issues: (1) establishing the Community Isolation Complex, (2) creating communication channels to support the government's information efforts, and (3) recruiting volunteers for the Community Isolation and Home Isolation programs. As a result of these efforts, a PHA representative was officially invited to attend the meetings of the Provincial Communicable Disease Committee to provide information and suggestions to enhance the government's work.

Figure 5.3 Linkage between the PHA of Nakhon Pathom and COVID-19 solutions



The Chairman and the Secretary of the Nakhon Pathom Provincial Health Assembly considered the spread of the COVID-19 virus as the most crucial issue, affecting people in various ways. Therefore, cooperation from the people and networks was needed to help strengthen the health system within the province. An informal meeting was immediately held within the area to brainstorm ideas and mobilise resources to support the government in addressing the COVID-19

5.2.1 Cooperation between the PHA and the Nakhon Pathom Provincial Office: Jointly Building a Provincial Isolation Centre under the Name of Community Isolation Complex

At a meeting on 22 July 2021 at Nakhon Pathom City Hall with the Communicable Disease Committee of Nakhon Pathom Province headed by Nakhon Pathom Provincial Government, the meeting had the chief executive of the Provincial Administrative Organisation (PAO), the provincial governor, and the head of the government agency of Nakhon Pathom Province attended.

The Nakhon Pathom PHA presented the following information and suggestions from the ad hoc working group meeting: (1) A COVID control strategy on rapid testing and screening, save life first and vaccination as many people as possible; (2) information about the situation of people who have not yet accessed screenings, treatment, and vaccination; and (3) summary of the experience of setting up an Isolation Centre based on multi-sectoral collaboration.

The input from the PHA led to an idea of setting up the Community Isolation Complex at the provincial level, which is a multi-sectoral collaboration and management, aiming to take care of infected people who have not been able to access treatment (PHA02, 04, 06 interviews, 23 March 2022). The meeting also assigned the Nakhon Pathom PHA and the Provincial Public Health Office, along with the provincial universities, to set up a coordinating centre for receiving information and giving advice to infected people. The action of PHA complemeted the mission of public health agencies in the field of public health consultation (Nakhon Pathom Provincial Public Health, 2021).

In addition, the Nakhon Pathom PHA was appointed as a support team for the Community Isolation Complex tasking with mobilising resources, medical equipment, volunteers and workforce for the complex such as screening and patient transportation (as shown in figure 3). The advisors of the Nakhon Pathom PHA, namely the President of Nakhon Pathom Rajabhat University, Provincial Public Health Doctors of Nakhon Pathom Province, and the Chief of the PAO, were appointed as the executive committee members of the Complex. Thus, enabling the exchange of information and support of resources between the government sector and the people (Nakhon Pathom Province, 2021). Afterwards, the Provincial Communicable Disease Committee invited the Nakhon Pathom PHA to attend their meetings with the objective to hear different opinions from the government sector and coordinate potential agencies outside the government

sector (PHA03 interview at Nakhon Pathom Provincial Public Health Office, 2021) (as shown in Figure 5.3).

Despite of having government led isolation centres at all jurisdiction levels, the Community Isolation Complex is unique with a one-stop service including screening, treatment, coordination of vaccination appointments, and provision of Antigen Test Kit (ATK) results for hospital admission, whereas the majority of government led isolation centers provide only treatment. The patients registered to enter the complex via the Thai.Care registration system initiated and supported by the private sector. (PHA06 interview, 23 March 2022). The main difference between the government led isolation center and the community isolation center is the way it is executed. The first one is led by the government solely, while the latter is executed by the collaboration of the government, academics, civil society, and private agencies at the provincial level (Nakhon Pathom province, 2021). From the opening of the Community Isolation Complex on 6 August to 21 September 2021, 221 patients were treated (Nakhon Pathom Provincial Public Health Office, 2022) and approximately 47,000 people were tested by ATK or 1,000 people tested per day (Thai PBS, 2021).

In conclusion, the Community Insolation Complex is consistent with and support of the strategy of the Nakhon Pathom Provincial Office in controlling the COVID-19 pandemic. The complex reduces the burden of isolation centers at the subdistrict level as well as the burden of the hospital (PHA07 interview, 23 March 2022) (Office of the National Health Commission, 2021).

5.2.2 Cooperation between the Provincial Health Assembly and the Mainstream Media: Creating a Communication Channel at the Provincial Level to Support Local Government Information

The Nakhon Pathom PHA joined hands with mainstream media such as Thai Public Boadcasting Service (Thai PBS) and The Reporters, a news online, and local media outlet Nakhon Pathom Newsgroup in setting up a communication relay at the provincial level as a two-way communication channel between the government and supporting agencies in the area. The PHA played a role of connecting and inviting resource persons from government agencies, civil society, acaedemia community and private sector to be speakers to provide information about health services to the people and about the situation assessment of the impact of the pandemic on the local population to the local governments (as shown in figure 3). This was carried out by live broadcasting via Facebook Live on the Facebook pages of The Active (Thai PBS), The Reporters, the National Health Commission Office (NHCO), and YouTube Live on The Active's channel. It was also a space to educate people on how to take care of themselves and gather opinions on solving the pandemic problems (Participatory Public Policy of the Development and Driving Committee, Nakhon Pathom Province, 2021).

Figure 5.4 shows one of the communication channels at the provincial level via the Facebook Page of The Active (Thai PBS). Executives from government agencies at the provincial level, religious organisations, academics, representatives from the Nakhon Pathom PHA, and the media joined the live broadcasts. The objective of the face book live was to provide information to the government, support solution-finding and educate people on infection prevention. More than 1,600 comments were received.

Figure 5.4 A Facebook Live broadcast of the PHA of Nakhon Pathom

5.2.3 Cooperation between the Provincial Health Assembly and Nakhon Pathom Provincial Public Health Office: Providing Personnel for Community Isolation (CI) and Home Isolation (HI)

The Nakhon Pathom PHA coordinated with teachers and students from the Faculty of Nursing at Nakhon Pathom Rajabhat University, Christian University, Mahidol University, and many other universities to be volunteers assisting health care for patients in prisons and those in home isolation. The training for these volunteers was conducted by doctors and nurses under the Thai.Care system. A total number of 500 volunteers, in addition to the village health volunteers, enhanced the public health work in the province (as shown in figure 5.3) during times of high numbers of patients which is around 14,000 patients (PHA03, 04, 06 interviews, 23 March 2022).

5.2.4 Cooperation between the Provincial Health Assembly and the Community Organisations Development Institute (CODI): Disseminating Community Isolation Complex's Model

The NHCO collaborated with the Community Organisations Development Institute (CODI) and strategic partners to organise meetings for provincial health assemblies and community organisation councils from all over the country to disseminate the best practice of the Community Isolation Complex and guide how to set up the Community Isolation Complex with four steps (1) Establish a provincial coordinating centre to fight against COVID-19 which acts as a centre to coordinate and work with the government sector; (2) Establish a fund to mobilise resources based on the model of the Rom-Hai-Jai Fund of Nakhon Pathom province; (3) Mobilise medical and social support for Home Isolation (HI) and Community Isolation (CI) in the area; and (4) Develop management skills for HI and CI in the community to local leaders and volunteers under the mentorship of the health service workers in the area of responsibility (National Health Commission Office, 2021l, Department of Public Relations, 2021).

Conclusion

In conclusion, the mechanisms of social participation at the provincial level through the Nakhon PHA in support of the provincial government helped address problems during the COVID-19 pandemic. The cooperation between the local government, the public, the media, volunteers, academics and private sector in enhancing the provincial government's work is reflected in three primary issues: (1) initiating and implementing the policy to set up Isolation Centres at the provincial level, (2) creating a communication channel to exchange information between the government sector and the people, and (3) recruiting and training volunteers to support Community

Isolation and Home Isolation. In addition, sharing and disseminating the best practice on health emergency preparedness and response to other provinces.

Moreover, it was found that the mechanism of the Nakhon Pathom PHA supported the government's effective handling of the COIVD-19 pandemic. This was partly based on a long-standing collaboration with the government on various issues and during previous crises. As a result, the PHA enabled to arrange meetings with stakeholders including the government sector at short notice without formal commands. Their informal coordination and flexible working style helps proceeding work faster than a bureaucratic working style.

6. Community Health Charter (CHC) of Na Pho Klang and COVID-19

The National Health System Charter, which is specified in the National Health Act, B.E. 2550 (A.D. 2007), sets a framework and guideline to formulate national health strategic policies. It is considered a blueprint by which various sectors joined forces to shape a desirable future for the health system. The Community Health Charter (CHC) was first initiated, found in the National Health System Charter No. 2, B.E. 2559 (A.D. 2016). The section on community health charters in the National Health System Charter emphasises the key principle of community ownership in developing their community well-being . In order to achieve community well-being, engagement of all sectors within the community is inevitable.

The CHC has been promoted and developed mostly in a sub-district level as an example of social participation and public consultation for health policy. This confirmed that the process of public consultation on people's needs and expectations can be implemented both at national and local levels (Putthasri, Mathurapote & Srisookwattana, 2017). During the emergence of COVID-19, the CHC was employed as a tool to build collaboration between the government and the people in coping with COVID-19 and its impacts. The people were motivated and empowered to be active citizens through working with the government sector on CHC. (Phruksa Sinluenam and Korarit Chomnoorak, 2021).

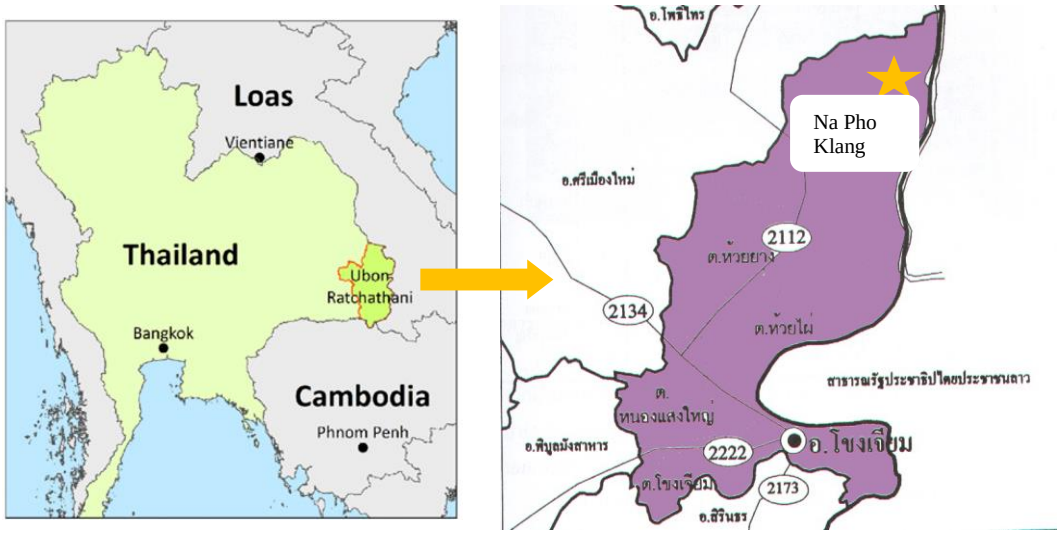
The chapter will explain the background, mechanisms, and roles of the community health charter of Na Pho Klang Subdistrict that was implemented to handle COVID-19 outbreaks. This CHC is regarded as Thailand's first community health charter on the COVID-19 prevention

measures. The chapter will facilitate discussion of problems and obstacles hindering the development and implementation of this health charter.

6.1 Background of the Na Pho Klang Subdistrict Health Charter

Na Pho Klang Subdistrict is located in Khong Chiam District, Ubon Ratchathani Province. This province is in the northeastern region of Thailand (Figure 6.1). The subdistrict has a population of 8,414, consisting of ten villages, 1,963 households, two subdistrict health-promoting hospitals, including the Na Pho Tai Subdistrict Health-Promoting Hospital and Kan Ta Kwian Subdistrict Health-Promoting Hospital, with 119 village health volunteers (Na Pho Tai Subdistrict Health-promoting Hospital, 28 October 2021).

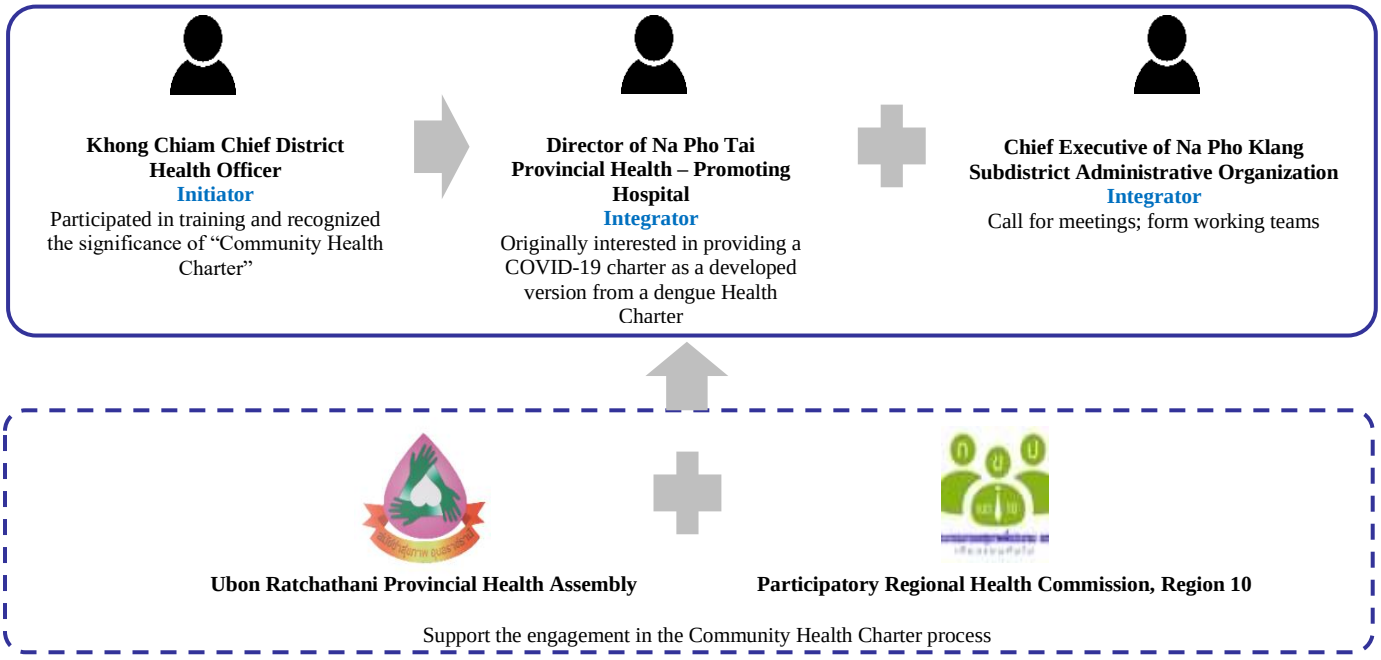
Figure 6.1 The location of Na Pho Klang Subdistrict, Khong Chiam District, Ubon Ratchathani Province



As shown in figure 6.2, the initiator of the Na Pho Klang Health Charter was the Chief of the District Public Health Office of Khong Chiam District. He sent an official letter encouraging the Director of every Subdistrict Health Promoting Hospital and the Head of Community Health Service to develop the CHC on COVID-19 prevention and control. The letter referred to the government letter No. 1132/42, dated 3 March 2020, promoting a CHC against COVID-19 at the subdistrict level. The Vice Chief of District Public Health Office of Khong Chiam district described the health charter in the following way:

> *"The community health charter is a common ground rule. Everyone is aware of it. Everyone works together. Everyone is satisfied and has the chance to participate. Public health work is achieved because diseases are controlled and reduced. People can manage their own health (HC02 interview, 3 March 2022)".*

Figure 6.2 Key actors of the Na Pho Klang Community Health Charter



In addition, the Ubon Ratchathani Provincial Health Assembly[3] and the Participatory Regional Health Commission, Region 10,[4] had organised forums to build an understanding of the CHC and its application to district public health offices since 2017. During the COVID-19 pandemic, the participatory Regional Health Commission, Region 10, coordinated and connected various networks at the provincial and district levels to apply the CHC at the sub-district level to prevent the spreading of COVID-19 in the region. The commission provided training on how to develop the CHC and coaching local leaders to develope the CHC. One of the Participatory Regional Health Commissioners stressed out that *"Social participation should be created at all levels...Any reform cannot succeed because of laws only. The process of participation is a heart of the reform"* (HC01 interview, 2 March 2022).

The executive of the Subdistrict Health-promoting Hospital of Na Pho Tai was interested in developing the CHC on COVID-19 prevention and control after receiving the official letter from the District Public Health Office explaining benefits of the CHC. At first, this sub-district had a plan to develop the CHC on dengue fever prevention and control. But the plan was halted due to COVID-19. When the attempt to develop the CHC was initiated again, the Chief Executive of Na Pho Klang Subdistrict Administrative Organisation (SAO) fully supported. He coordinated and gathered workers and volunteers to join this attempt and used a surveillance and rapid response team (SRRT) which have already had as a working group to start developing the CHC. This SSRT

[3] Gathering of civil society, academics, and government sectors to make public policy issues in the province, which started operating in 1997.

[4] Established according to the regulations of the Prime Minister's Office on the establishment of Participatory Regional Health Commission in 2016 with 45 members per district committee from all sectors to integrate the management of health problems in the area.

was finally renamed to the Na Pho Klang Subdistrict Quality of Life Management Working Group or commonly known as the CHC Working Group. This ad hoc working group worked with no official appointment order.

While thinking to develop the CHC, the outbreak situation in the sub-district was worrying. COVID-19 active cases were found in the subdistrict. Some of them returned home from Bangkok and oversea. According to the staff at local health-promoting hospital, people who came from oversea and stayed quarantine had several demands and did not follow the government measures. In an interview, one of the executives of a health-promoting hospital stated that "*groups that come from overseas have a lot of information…which is a big problem for us. The only thing we can do is to cooperate"* (HC03 interview, 3 March 2022). In addition, some government measures were not applicable to the local area. For example, according to an interview with the Chief of District Health Office of Khong Chiam, there were problems enforcing the mask mandate in the area:

> *"There was a shortage of face masks. And it was illegal not to wear a mask. If anyone was not wearing a surgical or cloth mask, they had to be fined. It is a law. But in practice, it was impossible to enforce the law. That was when we started brainstorming how to keep the people safe"* (HC02 interview, 3 March 2022).

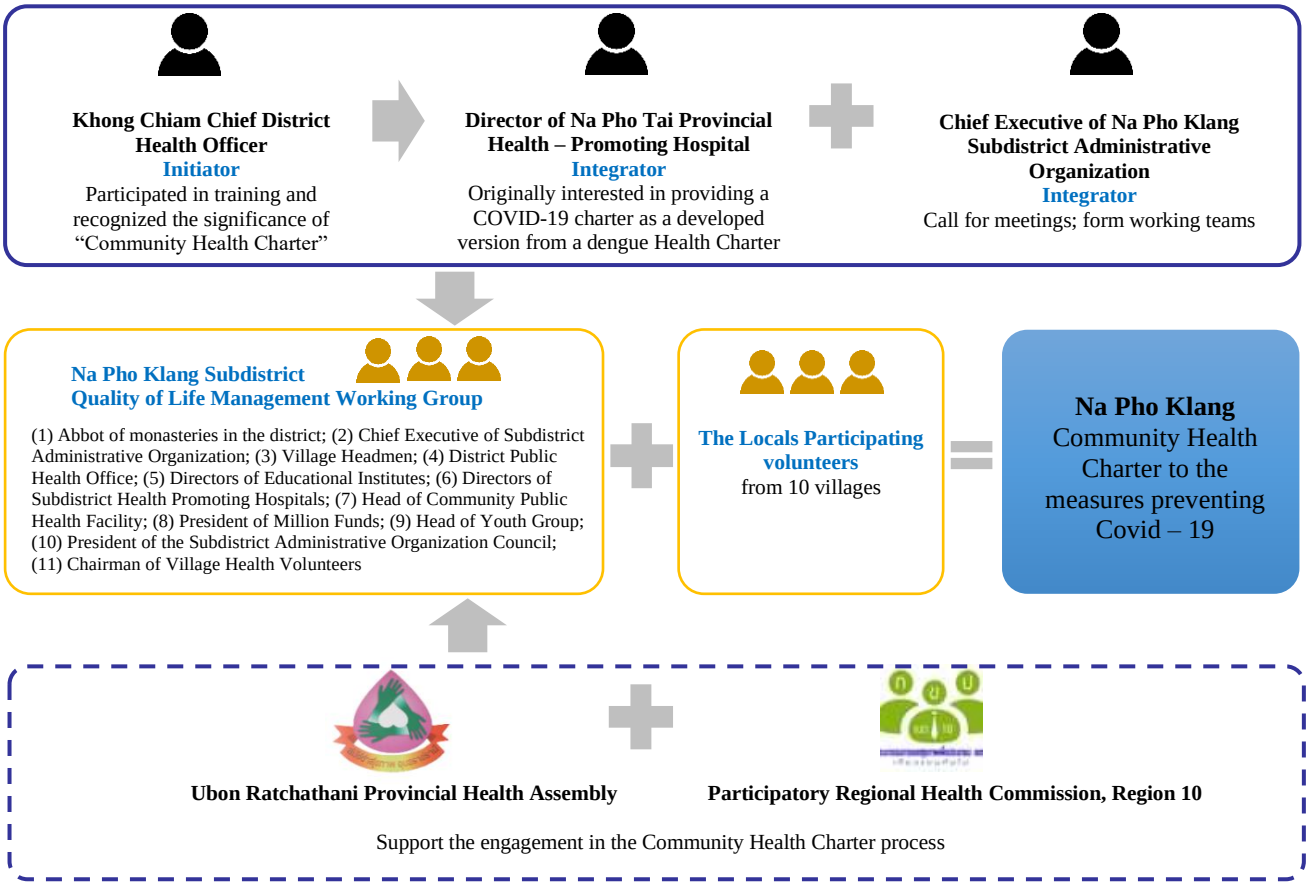
Against the background described above, the Na Pho Klang Health Charter was consequently designed to prevent the spread of COVID-19, keep people safe and reduce the workload of local hospitals.

6.2 The Na Pho Klang Health Charter: Measures to Prevent COVID-19 and Solve the Pandemic related Problems at the Local Level

6.2.1 Uniting all Sectors for Social Participation

The Na Pho Klang Subdistrict Quality of Life Management Working Group was setup and called commonly as the CHC Working Group is a multi-sectoral group including the Abbot Head of Monasteries in the district, the Chief Executive of the Subdistrict Administrative Organisation (SAO), Village Chiefs, District Public Health Officer, Director of Educational Institution, Director of Subdistrict Health-Promoting Hospital, Head of Community Health Service Center (NSO), Chairman of Million-Dollar Fund, President of the Youth Group, Chief Executive of Subdistrict Administrative Organisation Council, and the Chairman of Village Health Volunteers as shown in the figure 6.3.

Figure 6.3 The mechanism of the Na Pho Klang Community Health Charter Working Group



Under the CHC working group at the sub-district level, ten village working groups were formed according to a number of villages in the sub-district. Their mission was to survey the problem and villagers' needs as well as disseminate right information about COVID-19 and the CHC. The common problem found was anxiety about COVID-19. One of the SAO executives of Na Pho Klang expressed the feeling of villagers at that time that *"People were scared, panicked and divided because [the infections] were approaching closer"* (HC05 interview, 3 March 2022). The village working group reported information gained from the survey to the subdistrict CHC Working Group and collectively find solutions and drafted the CHC.

The subdistrict CHC Working Group visited villages and organised the meeting to communicate with and hear opinions from villagers on the CHC and its measures. The village chiefs and the school directors spread information on the CHC through the village loudspeakers, which are commonly found in Thai villages.

The members of the subdistrict CHC working group played different roles in developing and implementing the CHC according to their potential, duty and volunteer spirit as shown in table 6.1.

Table 6.1 The role of cooperation of the Na Pho Klang Community Health Charter Working Group

Cooperation Partners	Roles
Vice Chief of District Public Health Officer	Provide advice to the subdistrict working group, support the work and connect all actors across sectors and levels.

Cooperation Partners	Roles
Abbot of monasteries in the district	Donate food, mattresses and cloth for producing masks for the community isolation program.
Staff from the Subdistrict Health-Promoting Hospital	Prevent and control the spread of COVID-19, collect a variety of public health information as a technical unit.
Chief Executive of Subdistrict Administrative Organisation (SAO)	Connect actors across sectors, prepare the working groups, provide a budget for operations.
Village Health Volunteers (VHV)	Help the Subdistrict Health-Promoting Hospital collect information, buy and deliver food and medicine to patients and quarantined people.
Suppression Inspector	Supervise public orders such as detention and surveillance of illegal gambling at funerals.
Village Chiefs and School Directors	Promote, communicate and build awareness to villagers as well as crate a participation of people in the community.

COVID-19 prevention measures of the CHC adjusted from the central government measures to fit the local context. The CHC measures were first issued on 7 April 2020, covering three categories: Section 1 General, Section 2 Measures, and Section 3 Penalties. Villagers and all

sectors willingly complied with the CHC measures. For example, permission was required when travelling in and out of the Na Pho Klang subdistrict area.

In an interview, the Director of Subdistrict Health-Promoting Hospital shared her opinion on significance of social participation that *"We work as a network engaging villagers, monks, teachers and other actors. ... They spoke for us. This made our work easier. We believe that part of our success is our network"* (HC03 interview, 3 March 2022).

6.2.2 Supporting and Reinforcing Government Measures appropriate for the Local Context

Due to the changes in the COVID-19 situation and the government measures overtime, the working group revised and announced the second edition of the Community Health Charter (CHC) on Prevention and Control of COVID-19, dated 20 October 2021. The revised CHC contained six categories as follows: Section 1 General, Section 2 Promotion, Section 3 Prevention, Section 4 Treatment, Section 5 Rehabilitation, and Section 6 Penalties, as seen in table 6.2.

Table 6.2 Summary of the key points of the Na Pho Klang Community Health Charter.

Section	Key points
Section 1 General	The Office of the Na Pho Klang Subdistrict Administrative is a primarily responsible agent.
Section 2 Promotion	Public health agencies provide information and guidelines to the people to follow.
Section 3 Prevention	▪ General measures according to government regulations such as social distancing and masks wearing. ▪ Specific measures according to the Na Pho Klang CHC, for example, no goods delivery nor any vehicles entering

Section	Key points
	designated areas. No illegal crowdfunding to help the infectious people. ▪ There are forms specific to the district to record information, such as record of entry or application forms of permission for event organisation. ▪ Quarantine of high-risk groups must have a defined, designated area with clear deadlines and public announcement. ▪ Village chiefs can consider village closures without any order from the state or the province. ▪ Permission must be obtained before the organisation of events. Meals for guests must be arranged as one-dish meals or lunch boxes. No gambling and or consuming alcoholic beverages is allowed.
Section 4 Treatment	▪ Community Isolation at the subdistrict level is administered by the SAO. ▪ Home Isolation is overseen by the village chiefs. Village committees to monitor quarantined people and facilitate their convenience.
Section 5 Rehabilitation	Local Quarantine and Home Quarantine

Section	Key points
Section 6 Penalty	▪ Light penalties, i.e., a reduction of the village's financial credit score, community service, recording the offence and keeping the report in the village. ▪ Any repeated offences are reported to the police ▪ Repeated offences must be prosecuted according to the Communicable Diseases Act 2015 or in accordance with the relevant laws and regulations.

It can be said that the strength of the Na Pho Klang CHC lies into three points. Firstly, there is an assigned responsible agent for implementation and monitoring the CHC that is the Na Pho Klang Subdistrict Administrative Organisation. For example, Article 19 under Section 4 on Treatment specifies the SAO to acts as the administrative agency overseeing establishment and operation of Community Isolation Centres at the subdistrict level.

Secondly, the hardworking of village health volunteers who are the forefront of implementing the health charter. They are familiar with the area's context and known in the community. One of them said in an interview about their devotion to the CHC:

> *"The problem was not because of people in the subdistrict, but those who came from other subdistricts. The villagers know the CHC, but not the outsiders such as sellers. We explain the outsiders the CHC and the necessity to respect our CHC. This is for safety and well-being of the locals in the Na Pho Klang subdistrict"* (HC04 interview, 3 March 2022).

Thirdly, it is the tailor-made measures for the local context, while supporting government measures. For example, Section 3 on Prevention has Article 12 stating that the people in the sub-

district must be protected and Article 6 stipulating that drivers and passengers of any vehicles have to wear masks when entering the sub-district. Moreover, vehicles must carry sanitizer, and drivers must sign a specific form for COVID-19 tracing. Further, Section 16 requires event organisers to provide participants with food in single-dish form, lunch boxes, or wrapped in bags, and drinking water must be provided in individual cups or bottles. Additionally, there were a variety of forms developed for the implementation of the CHC, for example, a form for permit to travel for a business person, a form for ordinary people, a form for government officers who are not working in this subdistrict and that of for government officers residing in the district, a form for shopkeepers, sellers at markets, a form for permit to organize events. These forms are useful for tracing and control COVID-19. And the people in the subdistrict well comply with. The forms are still in use as common practice for both people within the subdistrict and outsiders.

As a result of everyone's compliance to the Na Pho Klang CHC, the death rate from COVID-19 in Na Pho Klang subdistrict remained zero as of 27 October 2021 (Na Pho Tai Subdistrict Health-Promoting Hospital, 28 October 2021). There were also no large infection clusters in the area.

6.2.3 The Expansion of Thailand's First Community Health Charter Model to Fight COVID-19 to other Areas.

The establishment of the Na Pho Klang Health Charter and its success in fostering participation in the fight against COVID-19 and supporting the government's measures on the subdistrict level was reported by the media, which helped promote the model. In addition, the working group presented the process of developing the CHC at the monthly meeting of the district health and wellbeing board. As a result, the model was disseminated to other subdistricts, districts,

and provinces in Region 10. Subsequently, the CHC was developed in eleven districts and 58 subdistricts (Civil Society Foundation, Ubon Ratchathani Province, 2022). However, due to each area's different context, some adaptations still needed to be made.

One of the executives of Na Pho Klang SAO discussed the results of the CHC's implementation:

> *"After presenting the health charter at the district level, provincial level, and regional level, eventually, we received an award from the Minister of Public Health, which we're very proud of. However, the important thing is that people in Na Pho Klang understand the health charter thoroughly and learn together to join in problem-solving in the area. This does not end with the COVID-19 issue, but this can be further developed into other problems in the future"* (HC07 interview, 3 March 2022).

On 15 September 2021, Taweesin Visanuyothin, M.D., spokesman for the Center for COVID-19 Situation Administration (CCSA), as the inspector general of the Ministry of Public Health in Health Region 10 and the member of Participatory Regional Health Commission, Region10, visited Na Pho Klang to witness the implementation of the CHC on measures in COVID-19 prevention. He then informed the Ministry of Public Health leading to an interview of Kiattiphum Wongrajit, M.D., permanent secretary of the Ministry of Public Health on 20 September 2021. He praised Na Pho Klang Subdistrict for the CHC initiative and engagement of all sectors in the area to find preventive measures against the pandemic and solutions to various problems. He emphasised that *"This CHC could be the model for other areas to study and apply in practice."* The Na Pho Klang Health Charter was also regarded as *"Thailand's first subdistrict health charter model in fighting against COVID-19"* as reported in the media.

6.3 Challenges

The challenges and obstacles in developing and implementing the CHC can be concluded as follows:

(1) The Na Pho Klang Subdistrict health charter on COVID-19 prevention and control was a social contract among the people in the Na Pho Klang subdistrict, which was not legally enforceable. Therefore, when the government eased the COVID-19 measures according to the situation, but the community health charter working group still remained the community measures. Some people did not comply with the community health charter, as they referred to the government measures.

(2) All people in Na Pho Klang must help communicate and publicise the community health charter of COVID-19 prevention and control to people from different areas to raise awareness and comply with the charter, which was an agreement on the co-existence of the community. Failure to do so might lead to spreading COVID-19 in the community by outsiders.

Because of all these challenging factors, the process of developing the community health charter is as important as implementing the community health charter. The developing process required participation of community stakeholders especially villagers to think, do, and make decision together. In addition, a review process was also needed to update the progress of implementation and keep up with the situation. The community health charter process was a the starting point to activate citizenship and build a sense of ownership in the subdistrict.

In conclusion, a social participation mechanism through the Na Pho Klang Subdistrict Health Charter demonstrated the power of collaboration between the public and the government sectors in responding, preventing and control the COVID-19. The Na Pho Klang Subdistrict Health Charter could reinforce the government measures, while conform to the local culture and context,

leading to the expansion of the model of the community health charters against COVID-19 to other areas in Thailand.

7. Discussion and Conclusion

This final section critically discusses the social participation mechanisms and participatory policies investigated in the previous chapters. The chapter then provides some recommendations on the development of the social participation mechanisms and ends with some concluding remarks.

7.1 NHA, PHA, and CHC as Social Participation Mechanisms

NHA, PHA, and CHC as social participation mechanisms act as bridges between the government and the people, enabling the development of participatory healthy public policy to address social determinants of health. These participatory mechanisms have redefined 'health', expanding the concept to include four interrelated dimensions: physical, mental, spiritual and social (Chokevivat, 2009). As a result, health has become about well-being which is the business of everyone. In effect, these participatory mechanisms do not only engage actors from the government and health sector but also the non-governmental and non-health sector in developing participatory policies and activities. In other words, these mechanisms can be seen as a coordinating body promoting a cross-sectoral collaboration between different actors at different levels.

At the centre of the participatory mechanisms lies the policy advocacy concept of 'tri-power strategy' or 'tri-power that moves the mountain' (Wasi 2000). The concept suggests that collaboration between academics, civil society and authorities is necessary to achieve social change or solve difficult social and health problems (symbolised as the immovable 'mountain' mentioned in the introduction).

As participatory mechanisms, NHA, PHA, and CHC also opened space for civil society involvement and connected civil society actors to the government. They helped activate civil

society engagement at different levels in the country by giving them public spaces and encouraging them to use their voice. In this sense, they encouraged civil society actors to speak out and use their agency in response to COVID-19. They raised people's self-awareness and responsibility over the crisis, which led to the development of participatory policies and measures in dealing with COVID-19, which belong to civil society and the communities. Civil society actors at different levels have become agents of their own COVID-19 responses and can contribute to different levels of government responses. NHA, PHA, and CHC thus facilitated a space where civil society actors feel empowered to act and speak.

In effect, the operation of these participatory mechanisms can be seen in table 7.1.

Table 7.1 Inclusiveness, intensity, and influence of NHA, PHA, and CHC working group

	Inclusiveness	**Intensity**	**Influence**
NHA	*Professional stakeholders* - NHA opens to constituencies, inviting representatives from different policy sectors. It portrays mini-publics focusing on professional stakeholders such as technocrats, academics, and civil society actors.	*Deliberate and negotiate* - Participants come to deliberate and discuss common issues to produce policy solutions, which are then proposed to the government.	*Advise and consult* - NHA provides input, the resolution or the policy framework, to officials who preserve authority and power but commit themselves to listening to the participatory mechanism.

PHA	*Lay stakeholders* - PHA opens to lay stakeholders in provincial areas. It is organised by a working committee consisting of actors from different backgrounds, albeit often occupied by civil society. - PHA is also an established organisation or mechanism that functions as a coordinating body in provinces.	*Aggregation and bargaining* - PHA aggregates people's needs and preferences into a choice and action overview. PHA then advances the preferences using several means.	*Co-governance* - PHA co-produces the CI complex with officials from the provincial government.
CHC working group	*Expert administrator* - CHC working group is an established network derived from public agents and a few lay stakeholders in local areas appointed by the local government. It is largely a working group of provincial	*Deploy technique and expertise* - The working group decides and advances its agenda through the technical expertise of the members whose training and professional	*Direct authority* - The working group, as a participatory body, exercises direct authority over public decisions or resources on COVID-19 responses in the local area.

	and local government officers.	specialisation suits them to solving the problem.	

7.2 The Contribution of the Social Participation Mechanisms to Governmental Response to COVID-19

NHA, PHA, and CHC were not only empowering civil society, but also contributing to the Thai governmental response to COVID-19 in three important ways: decision-making, information and communication, and implementation. The tables 7.2, 7.3, 7.4 show how the participatory mechanisms have contributed to government responses.

Table 7.2 The contribution of NHA, PHA, and CHC to government decision-making

Mechanisms	**Contribution to government decision-making**
NHA	The participatory mechanism of NHA supplemented the formal CCSA and government's policy development mechanisms to deal with COVID-19. It also highlighted actors' voices from different sectors. In addition, the NHA 13 resolution in 2020 on participatory health crisis management for pandemics complements the central government to prepare for potential future pandemics by encouraging multi-sectoral collaboration and integrated health management, which can bring about active participation from all sectors in order to have a well-defined decision-making system for pandemics.

PHA	The participatory mechanism of PHA complements the way the provincial government decides policy in dealing with COVID-19 by jointly establishing and managing the CI complex and one-stop service of the province.
CHC	Despite being informally founded, CHC working groups supplemented the decisions of the local government in dealing with COVID-19 as an officially dedicated mechanism to respond to the pandemic. CHC, as established by a joint working group between local government officers and people in the local area, is then a result of collaborative action which makes decisions based on shared interests and goals. CHC is an excellent example of not only how social participation mechanisms can contribute to government responses but also how collaborative decision-making between the government and people happens at the local level.

Table 7.3 The contribution of NHA, PHA, and CHC to government information and communication

Mechanisms	**Contribution to government information and communication**
NHA	The participatory mechanism of NHA offers a communicative platform that allows multiple actors and the wider public to engage in dialogues and discussions on COVID-19 problems and solutions. In this sense, NHA is not a one-way communication where authorities solely inform people about policies and measures. Instead, it is a mechanism encouraging people to deliberate and devise solutions based on multiple sources of information and different opinions, experiences, and interests.

	The NHA 13 resolution in 2020 on participatory health crisis management for pandemics recognises that COVID-19 is not merely a health crisis but a 'public crisis' involving non-health dimensions. In this sense, it suggests the comprehension of multiple dimensions of COVID-19, which is broader than the information provided by the central government. In specific, the resolution complements the government to encourage relevant government organisations to manage the communication, public relations, and information system, which will result in accurate, speedy, and timely communication.
PHA	Using Facebook Live, PHA provided an interactive communication channel to inform people about the COVID-19 problems and how to prevent infection while allowing people to give comments and ask questions. This supplements a communication channel and types of information provided by the provincial government and the Provincial Public Health Office.
CHC	CHC can be seen as a source of information and a way of communication for communities developed by communities themselves. Locally owned, it provides bottom-up, clear, and contextualised information regarding COVID-19 and how to deal with it at the community level. CHC clearly complements how the local government communicates with people.

Table 7.4 The contribution of NHA, PHA, and CHC to government implementation

Mechanisms	**Contribution to government implementation**
NHA	The NHA 13 resolution in 2020 on participatory health crisis management for pandemics complements the government at all levels by encouraging the

	strategic investment in health workforce and infrastructure to manage the crisis, from surveillance to prevention and treatment. As it acknowledges multiple dimensions of the crisis, the resolution promotes the implementation of government policies and measures focused on mitigating health, economic, social, and environmental impact during and after the crisis. In addition, the implementation of the resolution requires multi-sectoral actions through the coordination among government departments, autonomous public organisations and civil societies.
PHA	PHA co-produces CI complex and one-stop service at the provincial level with the provincial government. This model of CI establishes resource sharing among members, which can be considered an effective way to COVID-19 prevention, control and treatment. Specifically, by coproducing the CI complex, PHA complements a Provincial Public Health Office on active case finding (by using ATKs) and training volunteers to perform like village health volunteers due to the lack of frontline health workers. This proves a good example of co-production, which fulfils the lack of resources of the provincial government.
CHC	The CHC working group is not only a decision-making unit but also a fast and flexible implementation unit at the local level. Its members can effectively react to the problems as they have known the area very well. As aforementioned, the working group does not only show the contribution of participatory mechanisms to government responses but also the practical collaboration between the local government and people to implement policies and measures.

	Moreover, CHC, as a community-owned product based on collaboration, supplements the local government on encourage communities to deal with the crisis. Specifically, CHC helps guide communities to deal with COVID-19 in terms of response, prevention and preparedness. Local people can consult with CHC and respond to the crisis by themselves first. This helps the local government to implement COVID-19 policies and measures at the local level more effectively and efficiently.

Accordingly, it is possible to see that NHA, PHA, and CHC largely supplement the government response to COVID-19. The mechanisms can be considered as an extra or value-added element of the government's formal policy. In effect, many parts of the participatory policies are not mandatory. Given the highly centralised regime of the Thai government, at best, the social participation mechanisms have functioned as alternatives to the formal policy response to COVID-19 of the government. They provide policy options which are derived from the participatory processes. Hence, social participation mechanisms might not help the government to control the number of COVID-19 cases much, but they are significantly concerned more with how to cope with multiple dimensions of COVID-19, which are not confined only to health but how to encourage people to voice and have control over their lives and communities.

The institutionalisation of the participatory mechanisms is not without challenges. Local mechanisms such as PHA and CHC contribute to government responses and create a multi-sectoral collaboration that is more effective than NHA, the national social participation mechanism. This is partly because they have different levels of formality. NHA is a rather fixed process, highly official, issue-based with specialised, fragmented stakeholders. The formality of the mechanism

prevents the coordination from happening freely in practice. NHA is also arguably slower at responding to emergencies but better at developing plans and policies. In contrast, PHA and CHC are area-based, holistic, and powered by strong social networks. They can connect relevant actors in a short period of time with less formality. As a result, they are relatively fast and flexible at responding to emergencies but have limited authority to develop plans and policies.

In addition, NHA resolutions and CHCs are not legally binding. The NHA cannot implement resolutions by itself. Each resolution is just a policy framework consisting of a list of solutions and suggestions, mainly for government departments, which has no authoritative power to enforce the implementation of the resolution. Likewise, CHCs merely provide community guidelines. The implementation of NHA resolutions and CHCs are thus heavily voluntary. It is possible to argue that the NHA and CHC as social participation mechanisms are largely alternatives to government policy. This is different from the CI complex (a product of PHA), which is implemented and enforced by the provincial government.

Even so, NHA resolutions and CHC policies can yield results. Firstly, they are derived from the process of public participation and deliberation. Hence, when the national and local governments accept the resolutions, policies and measures, they will likely be deemed socially relevant and legitimate. Secondly, many suggestions for the resolution and the CHC already suit the government as representatives of relevant government organisations that have been involved with the development process of the resolution and the CHC. The resolution and the CHC are thus not baseless and unimplementable, but governmentally and politically relevant with practical insights.

Finally, the PHA is, intended or not, also an implementation mechanism. It can implement participatory policies and measures by itself, albeit led by the government sector, as it is better equipped to connect with the provincial government.

7.3 Recommendations on the Development of Social Participation Mechanisms in Response to COVID-19

This section provides key points which can be considered as lessons and recommendations for other societies regarding the development of social participation mechanisms in response to COVID-19**.**

Although social participation is a universal concept, its applications are contextual. To develop social participation mechanisms in a highly centralised regime, advocates should be critical pragmatists who realistically aim to cultivate public participation and nurture the mechanisms by focusing on the restructuring of communication between relevant actors and stakeholders with divergent, and many times conflicting, interests and asymmetrical relationship in terms of power and influence. In practice, the government is undeniably the first among others. Trying to connect the social participation mechanisms as an alternative policy option to supplement and complement the government mechanisms is a strategy. In other words, coming up with ways to encourage networks and hierarchies to function in concert is suggested.

Social participation mechanisms contribute to governmental responses to COVID-19 when they are designed to coordinate with different levels of government. The Thai cases show that having different social participation mechanisms to address and connect with each level of governmental mechanisms (i.e. the central, the provincial, and the local) allows the participatory

mechanisms to operate as a policy option which can supplement and/or complement the governmental response.

Social participation mechanisms *per se* do not guarantee the government uptake of the mechanisms, even though there are links between the social participation mechanisms and authoritative mechanisms of the government. Therefore, there is a need for a key agent to coordinate the links and mobilise the participatory mechanisms. In Thailand, the NHCO has positioned itself as the key agent, the mediating body, focusing on coordinating social participation mechanisms at different levels and trying to connect them with the government. In other words, the three participatory mechanisms have been made possible due to the role of the NHCO.

The Thai case emphasises that to create enabling policy and governance for the development of the participatory mechanisms, multi-sectoral actions are necessary. One of the famous approaches to multi-sectoral actions for health in Thailand is known as "tri-power strategy" (Wasi, 2000; Rajan et al., 2017), a policy advocacy strategy which actively involves a partnership between the public sector, the people/non-government sector, and the knowledge sector, which can help increase the legitimacy and the government uptake of the participatory mechanisms. Through multi-sectoral engagement, the participatory mechanisms are consequential.

Focusing on the inclusiveness, intensity, and influence of the social participation mechanisms can help avoid romanticising the participatory mechanisms and instead recognize the benefits and the limits of the mechanisms. For example, social participation mechanisms at the national and local levels have different advantages. The national social participation mechanism, NHA, is effective in "planning" emergency preparedness. This task is more of a decision-making process. However, the national mechanism is rather formal and time-consuming. As a result, it tends to be delayed in responding to emergencies. The government and the NHCO thus should

develop the NHA model to be more flexible and inclusive, which can become the national participatory policy development platform where key stakeholders can actively participate. On the contrary, local social participation mechanisms, PHA and CHC, are effective in "responding" to emergencies. They are area-based, quick and flexible, which suit the implementation level. For this, the government and the NHCO should focus more on resource support at the local levels to enhance the implementation of the mechanisms.

7.4 Conclusion

This section concludes the study by answering research questions as follows.

Q1: What NHCO's social participation mechanisms were used to engage people in COVID-19 responses?

This study found three important social participation mechanisms that the NHCO initiated and helped develop: NHA, PHA, and CHC. The idea and the operation of the mechanisms already existed before the start of the pandemic in 2019. However, when the COVID-19 crisis emerged, these participatory mechanisms started to engage people at different levels to respond to COVID-19.

Q2: In what ways did the mechanisms operate, and engage and empower people in response to the COVID-19 crisis?

As a participatory platform to develop policy suggestions, NHA had a dedicated resolution for pandemic management in 2020. This resolution mainly aimed to prepare policy and administrative aspects of the government to deal with COVID-19 and future public crises. The mechanism of NHA involved relevant actors across the policy sector to discuss and create common

policy suggestions for the government to implement, while allowing the participants to voice their concerns and develop potential solutions together.

PHA is a participatory platform to develop policy suggestions at a smaller scale, the provincial level. Apart from policy development, it can also take action and implement policies because PHA is a joint coordinating body consisting of representatives from the provincial government and civil society organisations. For example, to deal with COVID-19, the PHA of Nakhon Pathom Province helped the provincial government to establish and run the CI complex and one-stop service for preventing, controlling and treating COVID-19 cases in the area.

The CHC of Na Pho Klang is a result of a working group consisting of local government officers and people in the local area. Developed in a bottom-up manner, CHC is a community-owned guideline for COVID-19 response, prevention and preparedness for communities. It allows people in the community to consult with the guideline, which helps the local government to deal with the crisis more effectively and efficiently.

Q3: What challenges did the mechanisms face when they were institutionalised and operationalized to address the COVID-19 pandemic?

The three social participation mechanisms faced challenges when they were institutionalised and operationalised. Due to the non-mandatory nature of NHA resolutions, it is challenging to advocate for the government to implement the resolution, albeit the resolution provided valuable insights. To institutionalise the NHA resolution is thus a matter of the government's voluntary agreement. The process of NHA is also formal which makes it hard to respond flexibly to emergencies.

The PHA of Nakhon Pathom collaborated well with the provincial government and coproduced the CI complex. However, since the governmental sector leads it, the creation and

implementation of the participatory policy are heavily dependent on the provincial government. Although helping initiate the CI complex, civil society actors mainly played a supportive role. Convincing the government to act with civil society like it happened in Nakhon Pathom is an exception rather than a norm.

Although CHC is a community-owned mechanism, it is developed by the leadership of the local government. The CHC of Na Pho Klang is well institutionalised as it has been promoted by the government and became a lesson-learned for other local governments. However, it is not mandatory, and people do not necessarily comply with the CHC.

Q4: In what ways are the mechanisms related and contributed to the government's response to COVID-19?

The three participatory mechanisms are alternatives to governmental responses to COVID-19. They provided policy options based on social participation, people’s voices and agency. They either supplement or complement government responses. If taken seriously, the government can benefit from participatory mechanisms. COVID-19 will not be treated just as a health problem with the aim to control the number of cases, but a serious crisis involving social, cultural, economic, and other dimensions with the aim to build a healthy and well-being society. In this way, COVID-19 will be addressed more inclusively and sustainably.

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Appendix

A. Lists of interview participants

Code	Description	Interview date
NHA01	- NHA Resolution Follow-up Committee - Director-General of Medical Services Department, Ministry of Public Health (MoPH)	25 January 2022
NHA02	- NHA Organising Committee 2020-2022	25 January 2022
NHA03	- NHA Organising Committee 2022-2023 - Former Permanent- Secretary of Ministry of Justice	26 January 2022
NHA04	- NHA Organising Committee (2020-2022) - Chair of the Radio and Media Association for Children and Youth	27 January 2022
HC01	- Member of Provincial Health Assembly of Ubon Ratchathani Province - Chairman of Participatory Regional Health Commission for Public (Region 10)	2 March 2022
HC02	-Vice Chief of District Public Health Office at Khong Chiam District, Ubon Ratchathani Province	3 March 2022
HC03	-Director of the Na Pho Tai Subdistrict Promoting Hospital	3 March 2022
HC04	- Chair of Village Health Volunteer	3 March 2022

HC05	-Vice Chief Executive Na Pho Klang Subdistrict Administrative Organisation (SAO)	3 March 2022
HC06	- Community Developer of Na Pho Klang Subdistrict Administrative Organisation (SAO)	3 March 2022
HC07	- Chief Executive Na Pho Klang Subdistrict Administrative Organisation (SAO)	3 March 2022
PHA01	- President of Provincial Health Assembly of Nakhon Pathom Province - Former Vice Chief of Provincial Public Health of Nakhon Pathom Province	23 March 2022
PHA02	- Lecturer from Nakhon Pathom Rajabhat University - Secretary of Nakhon Pathom Provincial Health Assembly Pun Sook Foundation Committee	23 March 2022
PHA03	- Director of Communicable Disease Section, Provincial Public Health of Nakhon Pathom Province - Assistance Secretary of Communicable Disease Provincial Committee	23 March 2022
PHA04	- Director of Strategy and Plan section, Provincial Public Health of Nakhon Pathom Province (Special Task on taking care of Community Isolation Complex) -Working group member of Nakhon Pathom Provincial Health Assembly	23 March 2022

PHA05	- Assistant Director of Quality Standards Joseph Uppatham School, Sampran District, Nakhon Pathom Province - Joint committee for coordinating the Catholic Church of Bangkok for taking care of Community Isolation Complex	23 March 2022
PHA06	- Rom Hai Jai Fund - National Health Commission Officer Officer, Thailand	23 March 2022
PHA07	- Chief Executive of Nakhon Pathom Provincial Administrative Organisation (PAO)	23 March 2022
NP02	- Deputy Secretary-General of National Health Commission in charge of COVID-19 tasks	1 April 2022
NP03	- Social and health Institute, Ministry of Public Health	25 January 2022
NP04	- Senator	26 January 2022

B. Interview guidelines

1. How have you been involved with the social participation mechanism(s) (NHA, PHA, and/or CHC)?

2. What kind of policy and measure that the participatory mechanism(s) have you been involved with in dealing with COVID-19?

3. What are the key outputs and outcomes of the participatory mechanism(s) you have promoted in dealing with the crisis?

4. Are the participatory mechanism(s) you have advocated integrated into the governmental response to COVID-19? If they are, how do they contribute to the government mechanism?

5. What are the key factors driving the success of the participatory mechanisms?

6. What kind of challenges or barriers that you found with the participatory mechanisms?

7. In your view, what is the role of the NHCO in dealing with COVID-19?

8. How does social participation in general contribute to the governmental response to COVID-19?

C. Certificate of MUSSIRB Approval

Certificate of MUSSIRB Approval

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Certificate of Approval No.:	2022/009.2401
MUSSIRB No.:	2022/015 (B2)
Title of Project:	SOCIAL PARTICIPATION IN THAILAND GOVERNMENT' RESPONSE TO COVID-19
Principal Investigator:	LECT. DR. THEERAPAT UNGSUCHAVAL
Co-Investigator:	DR. WEERASAK PUTTHASRI
	MS. NANOOT MATHURAPOTE
	MS. PHRUKSA SINLUENAM
	MS. KHANITTA SAEIEW
	MS. KOTCHAMON SUKYOYOT
Name of Institution:	FACULTY OF SOCIAL SCIENCES AND HUMANITIES
Approval includes:	1) MUSSIRB Submission Form version received date 19 January 2022
	2) Participant Information Sheet version date 28 December 2021
	3) Informed Consent Form version date 28 December 2021

The Committee for Research Ethics (Social Sciences) is in full compliance with International Guidelines of Human Research Protection such as Declaration of Helsinki, The Belmont Report, and CIOMS Guidelines.

Date of Approval:	24 January 2022
Date of Expiration:	23 January 2023

(Assoc. Prof. Pichet Kalamkasait)
Chairman

(Asst. Prof. Dr. Porntida Visaetsilapanonta)
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