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ORIGINAL ARTICLE

Civil societies as the providers in area-based health promotion services under the universal health coverage, Thailand

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ABSTRACT

Thailand's National Health Security Act promoted a participatory process of civil society organizations (CSOs) by granting funds to provide health promotion and disease prevention (P&P) services in the community. This qualitative research aimed to elaborate CSOs' participating roles and obstacles in providing P&P services and gave recommendations to improve the CSOs' roles. The research methods included documentary research, in-depth interview, and focus group discussions. The study revealed that in 2020, twenty-one CSOs received a budget for a total value of 9.1 million baht, which was 3.8% of the total area-based fund. Moreover, 1,724 million baht, or 36.18% of the total community-based fund, was granted to CSOs under 75,698 community-based projects. As a result, people gained more access to the services, especially those whose regular service providers were unable to provide. However, it was found that the area-based budget was allocated for CSOs in a very small proportion. This was due to the issues in attitudes and mistrust in CSOs' capabilities and the lack of clear criteria for budget approval. Therefore, it was a challenge to earnestly promote the participation of civil society in P&P activities in all the areas of Thailand.

Key words: civil society participation, health promotion and disease prevention, area-based, access to services

INTRODUCTION

Thailand has been well recognized in the world community for its achievements and firm intentions in introducing and maintaining the Universal Health Coverage (UHC) since 2002 although the country is still considered a "developing country".[1] UHC was one of the three health insurance that covered the rest of Thai citizens who were not covered by the other two schemes including the Civil Servant Medical Benefit Scheme (CSMBS) and the Social Security Scheme (SSS). The UHC provides comprehensive benefits packages that cover curative services, health promotion and disease prevention services, and rehabilitation services to

assure the people to access their needed care without financial barriers. Thailand's success stories about UHC have been told to the world both in terms of publications and recognitions that Thailand was one of the leaders of the UHC initiated countries.[2-4] The successful launch of the UHC benefitted from the convergence of three factors: political commitment, technical expertise, and civil society engagement.[5]

Civil society organizations (CSOs), defined by the United Nation, were non-profit, voluntary, and task-oriented citizens' groups run by people with a common interest.[6] Before 2002, to access needed care, people were required to pay for the services. This was considered a barrier for the poor and some disadvantaged groups. Therefore, Thai CSOs have participated in Universal Health Coverage since 1998 to make a better health care system accessible to all.[7]In 1999, the CSOs collected more than 50,000 supporters to propose the National Health Security Act based on the Thai Constitution, and they were appointed representatives in the Act Drafting Committee in Thai Parliament. This was the first law in Thailand the CSOs participated in the process. After the Act was enacted in 2002, the CSOs were selected as the National Health Security Committee to promote people's participation. According to the National Health Security Act, Section 13, five civil society representatives were selected from the CSOs to work with nine target population, including children and youth, elderly, women, disabilities, chronic patients, formal and informal workers, minorities, farmers, and slum dwellers.[8] Although the CSOs' qualification was not required by law to be officially governmental registered organizations, they had to present their previous performances with these target groups. The CSOs and community representatives as National Health Security Board members played a role to protect the UHC system against political manipulation and dominance by any particular interest group(s).[9] Furthermore, the CSOs in Thailand also incorporated the new benefits packages, such as antiretroviral drugs, renal replacement therapy, and health coverage for non-Thai citizens.[10]

Although the problems of essential health service access decreased since the law passed in 2002, the access to some services was still low due to several factors, namely limited budget, inadequate health personnel, and inability to access among the target population. Access to health promotion and disease prevention, or P&P services did not reach their goals although Thailand had invested a higher budget for the services under the basic health packages than that of many other middle-income countries.[11] The National Health Security Office (NHSO) reported that the P&P services access was still low. According to the P&P service performance report in 2019, vaccination coverage in 0-5-year-old children was only 60-70% of the target population. Only 76.08 percent of the newborns were screened for hypothyroidism. The screening for chronic diseases in people aged 35 years and older (e.g., diabetes, hypertension) was performed in only 40-46 percent of the target population.[12] Even though the statistics of such services were relatively low, the poor quality of routinely collected data, fragmented health insurance schemes, and undisclosed statistics of the services provided in the private sectors could be problems. Another was that the service budget which was set based on the service providers' capacity did not cover all needed target groups.[13] Therefore, relying on healthcare providers could cause inaccessible services.

Due to the concern of increasing cost from curative care with lower health outcomes, the National Health Security Committee had the policy to invest more budget for P&P services to a proportion of at least 20 percent of the total budget while the current budget accounted for only 12.6 percent in 2019.[14] Although P&P services were included in the benefit packages under the UHC, the governmental budget was allocated to provide those services to all Thai citizens. NHSO organized a budget service structure for P&P services, which was divided into five areas as shown in Figure 1.[15]

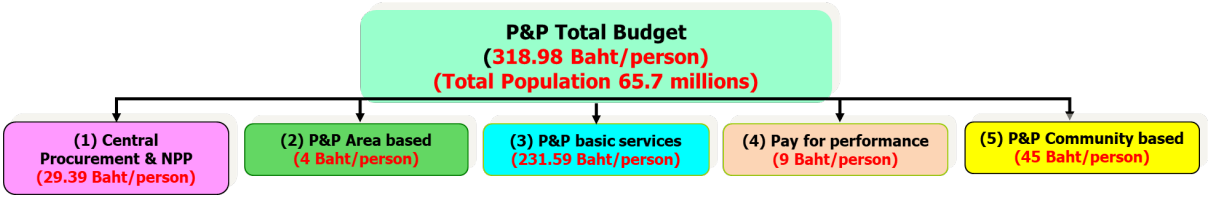

Figure 1 Budget structure for health promotion and disease prevention in 2019

The first area was the P&P national priority program and the central procurement budget, which was a national supply of vaccines, drugs, and medical equipment. A budget of 29.39 baht/person/year was allocated to this program. Secondly, a P&P area-based budget (PPA) was allocated 4 baht/person/year to support a project-based manner of solving regional health problems. Thirdly, a P&P basic service budget was allocated to the hospitals to provide basic P&P services, of which 231.59 baht/person/year was allocated. Fourthly, the performance budget was paid based on the quality of service performance, of which 9 baht/person/year was allocated. Lastly, a P&P community-based budget (PPC) acquired an allocation of 45 baht/person/year. The budget was allocated to the local governments at the sub-district level for the Tambon Health Insurance Funds, where the local governments must be co-funding in the proportion of 30-50% of the budget received from the NHSO, depending on the size of the Local Administration Organization. This fund was allocated to the organizations wishing to do activities to promote health and prevent disease in the community, where the organization requesting support can be an academic organization, hospital, private organization, or civil society organization. The budgets in the PPA and PPC categories can be legitimately allocated as financial support for CSOs to provide P&P services to the people in an area.[16] It was; therefore, a challenge for CSOs to expand the role of providing P&P services through those funds. This study aimed to define the role of CSOs in health promotion and disease prevention activities at area-based and community-based levels, to analyze problems as well as obstacles in the implementation, and to make recommendations for improving health promotion activities of the civil society sector in the future. Such roles would be beneficial for other countries to empower their people to have more engagement in improving access to UHC.

METHODOLOGY

This research was qualitative. The data were collected during February-May

2020 by using three research methods as follows:

1) Documentary research: The documents studied in this research were both published and unpublished (gray literature) in English and Thai relevant to the health promotion action policy of Thailand and the CSO's roles in providing P&P services. These included annual reports of the NHSO, the NHSO's performance evaluation research reports, the NHSO's health promotion performance reports, and the civil society sector's report. The statistics of health promotion and disease prevention budgeting were derived from the NHSO database. This presented the budget allocated to civil societies at the local levels, including regional and community levels.

2) In-depth interviews: The seven representatives of the CSOs from 6 regions undertaking the health promotion activities in 7 projects (from the total of 20 projects in 2019) granted at the regional and community levels were interviewed. The interview results about the service models and the obstacles in providing the services were summarized.

3) Focus group discussion: The focus group discussion was conducted among nine key experts from the CSOs and government agencies to suggest approaches for building civil society's capacity towards future health promotion activities.

Data analysis

The qualitative data gained from the interviews and the focus group discussions were analyzed by a thematic analysis method. The allocation of health promotion and disease prevention budget from NHSO Fund was calculated so that the budget given to civil societies and other stakeholders were presented in numbers and percentages.

Ethics submission

This research obtained a certificate of exemption from the Office of the Human Research Ethics Commission, Payap University, COE No. 62/001, dated November 4th, 2019.

RESULTS

1. Budget allocation to civil society organizations under the National Health Security System

As for the PPA and PPC budget allocated to civil society sector organizations based on statistical data of the Local Health Security Fund and NHSO in 2019 and 2020, it was found that the PPC budget was allocated maximally to civil society organizations at 39.36 percent or 1650.94 million baht in 2019 and 36.18 percent or 1,724.07 million baht in 2020[16] (Table 1). However, there was a very small proportion of the PPA budget allocated to the civil society sector. In 2020, only 22 projects were allocated to civil society sector organizations at 9.1 million baht or only 3.8 percent of the PPA budget (Table 2).

Table 1 Summary of the number of projects and budgets funded by the Local Health Security Fund (PPC) for the fiscal year 2019-2020.

Fiscal Year	Public Organization		Civil society organization		Others*		Total	
	Total number of projects	The total budget allocated (Million Baht)	Total number of projects	The total budget allocated (Million Baht)	Total number of projects	The total budget allocated (Million Baht)	Total number of projects	Total PPC budget (Million Baht)
2019	45778	1454.31	73785	1650.94	40100	1089.58	159663	4194.83
(Percent)	28.7	34.7	46.2	39.36	25.1	25.97	100	100
2020	45264	1508.35	75698	1724.07	44085	1532.5	165047	4764.92
(Percent)	27.4	31.66	45.9	36.18	26.7	32.16	100	100

*Note: * The others included 1) budget provided to the organizations working with Community Care Center for children, the elderly, and the disabled, 2) administrative cost of PPC funds, and 3) epidemic and disaster management budget.*

Table 2 Summary of the number of projects and budgets funded by the Area-based Health Security Fund (PPA) for the fiscal year 2019-2020.

Fiscal Year	Public Organization		Civil society Organization		Other private organization		Total	
	Total number of projects	The total budget allocated (Million Baht)	Total number of projects	The total budget allocated (Million Baht)	Total number of projects	The total budget allocated (Million Baht)	Total number of projects	The total budget allocated (Million Baht)
2020	144	198.43	24	8.42	22	15.28	190	222.13
(Percent)	75.8	89.3	12.6	3.8	11.6	6.9	100	100
2020	124	217.5	22	9.1	15	15.9	161	242.5
(Percent)	77	89.7	13.7	3.8	9.3	6.6	100	100

Note: 1) Public organizations included public hospitals, Provincial Health Office, and Regional Health Security Office and
2) Other private organizations included private hospitals, private associations, and foundations.

2. Service Models of Civil Society Sector for P&P services

The P&P service model of the civil society sector was more proactive than that of the regular service providers. From the in-depth interview, it was found that the civil society sectors in different areas had different service models and identities. All of them focused on the proactive service process to educate people on health and its

risk factors and to raise awareness on health promotion and disease prevention. As a result, they had the potential to take care of themselves. On the other hand, the regular service providers focused more on passive service activities within the service units, such as vaccination services, oral and dental health checking, etc.

The projects in the civil society sector in Region 12, for example, were supported by the PPA budget. They used proactive activities to reach target groups in the community and raised awareness among parents whose children did not receive the scheduled vaccination services. This was also a health problem in the Muslim community where basic essential vaccination coverage was not complete. The other project focused on the target groups who were at risk of cardiovascular disease. It used a screening method (Cardiovascular Disease Risk Assessment) to make the screened person aware of their risks and intend to change dietary and exercise habits. In Region 5, a project focused on the assessment of growth and nutritional status and the activities to increase health literacy about junk food among school children. The project actors also worked with the school administrative bodies to eliminate junk food in schools and nearby. The project examples funded by the PPA were shown in Table 3.

Table 3 The examples of civil society projects receiving budgets from the PPA Fund in 2019

Region No.	Project Number and Titles
1	Education Service and Advice on Reproductive Health, and Prevention of Adolescent Pregnancy, Unwanted Pregnancy, and Sexually Transmitted Diseases in six provinces including Phayao Province, Phrae Province, Chiang Rai Province, Lamphun Province, Nan Province, and Lampang Province.
4	Enhancing the Quality of Life before Aging/of Elderly People with Good Physical and Mental Health.
5	Growth and Nutritional Status Assessment Service for Older Children and Adolescents in Region 5 Ratchaburi.
9	1. Reducing Non-communicable Diseases Risk Factors among Monks.
	2. Health Promotion and Adolescent Pregnancy Prevention.
	3. Health Promotion and Non-Communicable Diseases (NCDs) Prevention in the Population at Risk of Working Age (29-59 Years) in Nakornchaiburin District.
10	Consultation Service and HIV/Sexually Transmitted Disease Infection Screening Services for People at Risk with Age 25-59 Years.
12	1. Community Outreach Program to Increase Access to Vaccination Services for Disadvantaged 0-5 years-old Children in 5 Southern Border Provinces.
	2. Consultation Service, Advice, and Behavior Changing Guiding for Reducing Cardiovascular and Heart Disease Risk in Community Leaders in 7 provinces.

3. Lessons learned from health promotion implementation of civil society sectors at the community and regional levels

The in-depth interview results from seven representatives of the civil society sector, the result analysis of the focus group discussion among nine experts, and the assessment outcomes of health promotion activities at the local area of NHSO disclosed important information as follows.

3.1 The importance of P&P services in civil societies' and residents' perspectives.

The principle saying that "People own their health. Health is not only the duty of medical personnel" encouraged the CSOs to involve in developing P&P education programs at the community and regional levels to raise health knowledge and awareness within the community. One interviewee commented that:

"We believe in the principle that people have to own their health. If people do not know about health, even just about cardiovascular disease, how do people go about managing their health? If people still believe that people's health only depends on doctors, the illness will never be cured. On the other hand, if the people own their health and become able to manage themselves, analyze their health, take care of their health, and take care of people in the community, then the outlook for serious illness is likely to decrease."

The representative of the civil society sector 1

The P&P activities of local people organizations possessed strengths. Firstly, the services were easily accessed because they proactively reached the communities while those of the regular providers were at hospitals. Secondly, they trusted the responsible persons in the communities who tried to understand them. Thirdly, they performed activities that could build a network among new people and generation in the community in solving health problems that could persist. Most importantly, the service model making people aware of their health problems contributed to the behavior changes that improved their health.

3.2 The level of civil societies' participation and influencing factors.

Although civil societies provided P&P services supported by both PPA and PPC budgets, they took part in PPA much less than in PPC. The civil societies' representatives reflected that civil society organizations had proposed a very small project proportion for regional area-based budget compared to that of other organizations. The civil society sector indicated the main problems of participating in P&P services at the regional area-based level as follows.

1. The committees approving the budget had negative attitudes and had no confidence in the civil society's capability to work in P&P services. It was found that the civil society sector often questioned the expertise of public health operations. They also thought that the mission belonged to service providers, not the civil society sector. One participant of the focus group discussion commented that:

"The service department always says 'How are people going to make people have access to vaccines? I don't understand. How can people do this? Are you going to get him vaccinated? You are not a doctor.' They believe blindly that this is only a matter of doctors or medical staff, and the public cannot do it. Then, such ideas are passed on to all relevant organizations, including NHSO at both the central and regional offices. When we gave a project presentation, the committee would ask a lot of questions about civil society projects while they rarely asked about the project of the regular service providers. However, when we gave them an explanation, they

clearly understood and could figure out how we would do it. Therefore, they supported the project but still did not trust us."

The representative of the civil society sector 2

2. Service providers lacked understanding and did not accept the civil society sector's service models in P&P services. It was found that the service models of the civil society sector emphasized more on the creation of a learning process to raise the public awareness of changes in health behavior. This was different from the government service models that emphasized specific conventional service models. One interviewee commented that:

"I heard that the service provider said "I cannot accept it. They brought the bounty to provide training. It must be used for providing services." The civil society activities looked like this because the project was a matter of organizing the learning process, training to develop potential, and building knowledge and understanding to achieve behavior change. It is not that we are going to draw peoples' blood. The service providers said that it was a waste. They felt that when civil societies received the budget and used them to organize training, it was not certain whether people would get the benefit or not."

The representative of the civil society sector 3

3. The budget competitiveness and delayed budget management of NHSO were the other factors. The civil society sector thought that allowing a wide variety of organizations to propose a wide range of programs to request health promotion budgets was one of the obstacles limiting the participation opportunity of the civil society sector. These organizations were able to obtain support from many other sources of funding. Besides, the civil society sector experienced delays in budget management and project evaluations made by NHSO that caused the inadequate cash flow to provide the services. One interviewee commented that:

"This fund is available for service providers, academic organizations, and civil societies. Many groups can propose projects. If your project is not interesting or is not eye-catching, the opportunity for the civil society sector to access funds is quite little. Also, when many projects ask for a budget, the budget will be divided into many small portions for every project. That caused some projects at the regional level could not obtain sufficient budget to implement. Also, some projects can be reimbursed only for certain activities, and so the project with good creative activities cannot be implemented."

The representative of the civil society sector 4

Also, other policy-level factors made civil society organizations involve less in the provision of P&P services. Firstly, the regional level administrators and project managers lacked concepts about people participating in the health system. This caused fund managers not to give priority to grant to the civil society sector. Secondly, the scope of P&P services was limited to only health needs determined by the Ministry of Public Health. The civil society sector thought that the project scope should cover the health needs based on the perspective of the community.

DISCUSSION

The concept of providing P&P services in Thailand has developed continuously. It originally focused on providing passive services by regular service providers and developed the process of strengthening and supporting the community to participate.[17] Such concept

was in line with three of the five action areas of the Ottawa Charter for Health Promotion, namely 1) building strong communities as a driving mechanism for effective health promotion, 2) developing personal skills through providing information, strengthening health knowledge, developing life skills, and promoting people to control their health and environment and to make choices on a positive effect on their health, and 3) transforming the health service system into the role of all sectors, including individuals, communities, health service providers, and government sectors, which all sectors worked together to bring the health service system to well-being.[18]

Thai civil society organizations were supported to provide P&P services in a broader range of services than CSOs in several countries providing mostly HIV/AIDS services.[19,20] In Thailand, the service scope could be any kinds of P&P services that were suitable for the target groups of all ages and had to respond to the people's health needs. On the contrary, other countries focused more on HIV/aids services.

According to the stipulation, sources of a budget for health promotion and disease prevention activities in Thailand were the state budget from the National Health Security Office, and the Thai Health Promotion Foundation. These offices could legitimately grant a budget requested by civil society organizations to do health promotion and disease prevention activities.[11] On the other hand, most budgets from the Ministry of Public Health were allocated to government service units. The budget from the Ministry of Public Health was used in the National Public Health Program while NHSO's budget was used for the provision of P&P services to individuals and families. NHSO's budgets were allocated to the P&P area-based budget and the P&P community-based budget according to Section 47 of NHSA. This enabled local government organizations to participate in the implementation and management of the health security system at a local level.[8] The Thai Health Promotion Foundation supported the budget for various agencies, including civil society organizations, to develop programs aiming at changing health behavior as a pilot project (Model Development), which was not a normal service arrangement.

Therefore, this legal requirement was a supporting factor for the civil society organizations to participate in health promotion and disease prevention activities at the regional and community levels. However, in practice, it was found that civil society organizations received a relatively low percentage of funding for health promotion and disease prevention activities in the community, compared to the budget support to regular service providers, especially budget allocation in the PPA category.

There was a major deterrent to the civil society sector's budget allocation compared to other funded organizations. This factor was caused by the committee having the authority to decide the budget, namely, executives and project managers under NHSO at the regional level. They lacked confidence in the ability or capability of civil society organizations to carry out P&P services. They also lacked the understanding and acceptance of the different service models provided by the civil society sector. They did not pay any attention to the principle of civil society participation in the health system in that they should be real partners, not just an add on the concept.[7] This was in line with the study result of Yupadee Sirisinsuk.[21] She found that the committees approving budgets at a regional level were service providers and public sector representatives who did not believe in the capability of civil

society organizations to manage the project. This affected the decision not to support the budget to the civil society organizations.

Also, there was a problem with budget competition among several sectors seeking support. Communication and close collaboration between CSOs and the committee approving projects could create mutual understanding to increase civil society organizations' participation.[22]

This study characterized civil society organizations' involvement as service providers. It was different from the participation model of the research in the past. For example, the research looking at the participation as a recipient of services increased access to services.[23,24] Another was that the government or service units drew the participation of people or communities to serve as a liaison, a link, or an intermediary between health/social services and the communities to make the services more efficient or facilitate public access to services.[25,26]

The proactive P&P service model civil society organizations provided to people under the P&P Area-based or P&P Community-based budget made them aware of their health problems. It contributed to health caring and behavior changes to improve their health. This was in line with the research comparing the proactive service model with the traditional passive service. It was found that the former gave better results in improving health behavior.[27]

CONCLUSION

To achieve a new form of health promotion based on the principles of the Ottawa Charter for Health Promotion, it is a challenge for public sectors and civil society to actively build civil society's participation in health promotion and disease prevention in this area. The committee approving the budget and the National Health Security Office's administrators need to change their thoughts and attitudes to recognize and be confident in the importance of collaboration with the civil society sectors in health promotion and disease prevention.

Also, they should recognize the main principle that health promotion and disease prevention is not only for the healthcare personnel, but is a matter that all people should do together. If the budget to support health promotion and disease prevention activities is adequately allocated for the civil society sector, it will reduce budget constraints and encourage participation. Moreover, they should pay attention to the process of developing the capacity of people's networks to participate in the provision of health promotion and disease prevention services by civil society organizations with higher efficiency. Lastly, the civil society organizations in areas need to develop the potential of the new generation of civil society organizations in both the development of proactive service skills, the supervision, and monitoring of service quality skills.

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REFERENCES

1. The Guardian. What Thailand can teach the world about universal healthcare [Internet]. [Cited 2020 May 25]. Available from: https://www.theguardian.com/health-revolution/2016/may/24/thailand-universal-healthcare-ucs-patients-government-political
2. Tangcharoensathien V, Suphanchaimat R, Thammatacharee N, Patcharanarumol W. Thailand's Universal Health Coverage Scheme. Econ Polit Wkly. 2012; 47(8):53-57.
3. The United Nations. UN HIGH-LEVEL MEETING ON UHC [Internet]. [Cited 2020 May 25]. Available from: http://universalhealthcoverageday.org/un-high-level-meeting-on-uhc/
4. Tangcharoensathien V, Limwattananon S, Patcharanarumol W, Thammatacharee J, Jongudomsuk P, Sirilak S. Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. Health Policy Plan. 2015; 30:1152–1161.
5. IOL Social Protection Department. Thailand: Universal Health-care Coverage Scheme [Internet]. [Cited 2021 February 3]. Available from: https://www.social-protection.org/RessourcePDF.action
6. The United Nations. The Civil Society Unit. Who are we [Internet]. [Cited 2021 February 2]. Available from: https://www.un.org/en/civil-society/page/about-us
7. Alfers L, Lund F. Four Lessons from Thailand's Participatory Process in Gaining Universal Health Coverage [Internet]. [Cited 2021 February 3]. Available from: https://www.wiego.org/blog/four-lessons-thailand%E2%80%99s-participatory-process-gaining-universal-health-coverage
8. National Health Security Office. National Health Security Act 2002. Thai government gazette No.119 Section 116A (November 18, 2002). (in Thai).
9. McManus J. Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010). Nonthaburi: Health Insurance System Research Office; 2012.
10. Tangcharoensathien V, Witthayapipopsakul W, Panichkriangkrai W, Patcharanarumol W, Mills A. Health systems development in Thailand: a solid platform for the successful implementation of universal health coverage. Lancet. 2018; 391: 1205–1223.
11. Watabe A, Wongwatanakul W, Thamarangsi T, Prakongsai P, Yuasa M. Analysis of health promotion and prevention financing mechanisms in Thailand. Health Promot Int. 2017; 32(4): 702–710. doi: 10.1093/heapro/daw010.
12. National Health Security Office. National Health Security Office Database: Health promotion and disease prevention service performance information 2019.
13. Aljunid SM, Srithamrongsawat S, Chen W, Jin Bae S, Pwe RF. Health-Care Data Collecting, Sharing, and Using in Thailand, China Mainland, South Korea, Taiwan, Japan, and Malaysia. Value Health. 2012; 15(1 Suppl): s132-s138.
14. National Health Security Office. National Health Security Board's Resolution. Number 7:2553 (July 12, 2010). (in Thai)

15. National Health Security Office. Manual for National Health Security Fund Management, 2019. Nonthaburi: Sahamitr Printing and Publishing Company Limited 2019. (in Thai).
16. National Council for Peace and Order, Number 37:2559. The necessary expenditure for support and promote health service providing and other expenditures under the National Health Security System. Thai government gazette. Number 133 Special Section 150 d, p30 (July 5, 2016). (in Thai)
17. Archananuparp S. Health Promotion: Concepts, principles, and lessons learned in Thailand. Bangkok: Moh-Chao-Ban Publishing House 2007. (in Thai).
18. Aunpromee S. The critical development of Health Promotion. Nonthaburi: Academic Welfare Project, Praboromarajchanok Institute, Ministry of Public Health 2013. (in Thai).
19. Eurasian Harm Reduction Network. CONTRACTING PUBLIC HEALTH-CARE AND SOCIAL SERVICES TO CSOs: framework, opportunities, lessons learned [Internet]. [Cited 2020 December 3]. Available from: https://harmreductioneurasia.org/wp-content/uploads/2019/03/Bulgaria-NGO-funding-mechanisms-analysis.pdf
20. The World Bank. ENGAGING WITH CIVIL SOCIETY IN THE HEALTH SECTOR IN INDONESIA [Internet]. [Cited 2020 December 5]. Available from:http://documents1.worldbank.org/curated/en/637901568357782768/pdf/Engaging-with-Civil-Society-in-the-Health-Sector-in-Indonesia.pdf
21. Sirisinsuk Y. Lesson learned from people participation in managing Regional Health Preventive and Promotion Budget. Bangkok: National Health Security Office 2019. (in Thai).
22. Seddoh JE. Stakeholder perception on factors influencing NGO collaboration with the government in family health education in the Tema Metropolis of the Greater Accra Region of Ghana. Global Journal of Political Science and Administration 2016; 4(3):20-33.
23. Brunner-Ziegler S, Rieder A, Stein KV, Koppensteiner R, Hoffmann K, Dorner TE. Predictors of participation in preventive health examinations in Austria. BMC Public Health. 2013; 13: 1138. doi:org/10.1186/1471-2458-13-1138.
24. Chien SY, Chuang MC, Chen IP, Yu PH. Primary drivers of willingness to continue to participate in community-based health screening for chronic diseases. Int. J. Environ. Res. Public Health. 2019;16:1645. doi: 10.3390/ijerph16091645
25. World Health Organization. 2008. Community involvement in tuberculosis care and prevention towards partnerships for health [Internet]. [Cited 2020 December 13]. Available from: https://apps.who.int/iris/bitstream/handle/10665/43842/9789241596404_eng.pdf;jsessionid=881351E1F6879ACECA8FA3DB5633796A?sequence=1
26. Sharma N, Harris E, Lloyd J, Mistry SK, Harris M. Community health workers involvement in preventative care in primary healthcare: a systematic scoping review. BMJ Open. 2019;9: e031666. doi: 10.1136/bmjopen-2019-031666
27. Hankin JR. FAS Prevention Strategies: Passive and Active Measures. Alcohol health and research world 1994;18(1): 62–66.