ASSESSING COMMUNITY PARTICIPATION IN HEALTH PROMOTION PROGRAMS; A CASE STUDY OF MALDIVES.

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THE THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSPHY

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ABSTRACT

This study assessed the participation of Maldives community in health promotion programme, namely, decision making, implementation, benefit sharing and evaluation. This study, which was conducted in the Maldives, also examined the factors associated with participation in health promotion programme. Adopting the survey method, the pre-tested interview schedule was administered to the random sample of 1,070 respondents from 3 selected atolls. The survey adopted a self-report technique. Multi-stage cluster sampling techniques were used to select the respondent for this study. The total geographical area was divided into 7 provinces and 3 provinces from Upper North, North Central and Upper South were taken for this study. The response rate of the survey was 86% (n=923). Data gathered from the survey was supported with secondary data gained from the office records and library research. All data were analyzed using the Statistical Package for the Social Sciences (SPSS).

The Maldives community who involved in this study was heterogeneous in terms of their socio-demographic attributes and participated in health promotion programme through political party. By and large, the level of participation measured along four clusters of factors, was occasionally and uncertain. High level of participation prevailed only among a small proportion of Maldives community. The notion of 'uncertain' may itself is ultimate barriers to participation. In this appeal the participation of rural community groups may be significantly difference from participation of mainstream community members in terms of motivation, constraints and strategies which are necessary to make it meaningful and effective. The chi-square analysis shows that structural, operational and community factors are significantly association with the level of community participation. In relation to the interest of study findings the government needs to reconsider in modifying the current

practice, and a number of practical recommendations for strengthening community participation in health promotion can be explored by implementation of the proposed "*Community –based intervention on health promotion module"*.

ABSTRAK

Kajian ini meneliti penyertaan masyarakat Maldives dalam program promosi kesihatan, iaitu dalam membuat keputusan, melaksana rancangan, berkongsi manfaat dan menilai aktiviti promosi kesihatan. Kajian yang dijalankan di kepulauan Maldives ini juga bertujuan untuk mengenal pasti faktor-faktor yang berkaitan dengan penyertaan masyarakat Maldives dalam aktiviti promosi kesihatan. Kaedah tinjauan telah digunakan. Borang soalselidik yang telah diuji telah diedarkan secara rawak kepada 1070 orang responden di tiga kepulauan yang telah dipilih. Tinjauan ini menggunakan teknik "self-report". Kaedah persampelan Multi-stage telah digunakan untuk memilih responden kajian ini. Kawasan geografi kepulauan Maldive telah dibahagikan kepada 7 wilayah dan 3 wilayah dari Hulu Utara, Utara Tengah dan Atas Selatan telah dipilih sebagai lokasi kajian ini. Kadar maklubalas terhadap borang soalselidik yang diedarkan ialah sebanyak 86% (n = 923). Maklumat juga diperoleh melalui rekod pejabat dan kajian perpustakaan. Maklumat dianalisis dengan komputer menggunakan Pakej Statistik untuk Sains Sosial (SPSS).

Masyarakat Maldive yang terlibat dalam kajian ini adalah tidak seragam dari segi ciri-ciri sosio-demografi. Mereka terlibat dalam program promosi kesihatan melalui penyertaan dalam parti politik. Secara keseluruhannya tahap penyertaan masyarakat yang diukur berdasarkan empat set faktor adalah sekali sekala dan tidak menentu. Tahap penyertaan yang tinggi berlaku hanya dalam kalangan sebilangan kecil responden sahaja. Jawapan 'tidak menentu' itu sendiri boleh sendiri merupakan halangan utama kepada penyertaan mereka dalam aktiviti promosi kesihatan. Penemuan ini menggambarkan perbezaan tahap penyertaan masyarakat luar bandar mungkin berbeza dengan masyarakat arus perdana disebabkan oleh motivasi, kekangan dan strategi yang lebih bermakna dan berkesan. Analisis Ujian Khi Kuasa

Dua menunjukkan faktor struktur, operasi dan komuniti mempunyai hubungan yang signifikan dengan tahap penglibatan komuniti. Kajian ini mencadangkan kepada kerajaan. Oleh itu kajian ini memberi cadangan agar kerajaan memperbaiki amalan promosi kesihatan melalui pelaksanaan modul "*Community–based health promotion program"*.

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Asma Ibrahim Sulaiman

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CHAPTER ONE

BACKGROUND OF THE STUDY

1.1 INTRODUCTION

Since the mid-1970s, community-based approaches to health promotion and disease prevention have become increasingly common. Community participation was said to be important because the origins of disease lie outside the health sector (Jewkes & Murcott, 1998), fatalistic attitude of communities as one of the obstacles to health (MacCormack, 1983), the acknowledgment of community participation as a socially-economically effective approach in changing people's attitude (Jewkes & Murcott, 1998) and addressing health problems (Jewkes & Murcott, 1998; Guldan, 1996). Other rationales for pursuing community participation include promoting positive health behavioral change, improving service delivery, mobilizing human, financial and other resources for health services, and as an effective means of empowering a community (Woelk, 1992).

Health promotion was defined in 1986 at the first international health promotion conference in the Ottawa Charter as the process of enabling people to increase control over, and to improve their health and its determinants (WHO, 1986). Any individual must be able to identify and to realize their targets, to satisfy needs, and to change or cope with the environment to reach a state of complete physical, mental and social well-being (WHO, 2002). Health is seen as a resource for everyday life. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the

health sector, but goes beyond healthy life-styles to all well-being (WHO, 2002). Health promotion is to modify human behavior that is prone to resist diseases or injury by eliminating exposures to harmful diseases. In developing countries, health education directed towards these goals remains a fundamental tool in the promotion of health and prevention of disease (Nutbeam, 2000).

Community and individual involvement and self-reliance are very important to achieve health for all (WHO, 2002). Community participation is one of the domains of community capacity building. It is one of the mechanisms to empower people to take part in community development. Community participation is an essential part of community development and one of the factors in the community capacity building process, which allows involvement of people in the different stages of decision making. It is not only valuable in identifying needs, assessing assets and agreeing on shared vision. It can also contribute greatly to generating tangible ideas and plans for action. Once people are actively involved in assembling the building blocks, a commitment to involving them in putting these together can add greatly to the quality, sustainability and sense of ownership of the overall planning process (WHO, 2002).

Community participation has been practiced in many different ways for many years not only within health but more broadly within other fields of social practice and development. It is recognized as a key success factor in improving collaborative approaches to health and sustainability planning (Nutbeam, 1998). Involving communities in decisions making will lead to better decisions being made, which are more appropriate and more sustainable because they are owned by the people themselves (WHO, 2002). Participation is an empowerment tool through which local communities take responsibility for diagnosing and working to solve their own health

and development problems (Morgan, 2001). Public health experts, such as Baum et al., (2000) suggested the importance of community participation as a successful health promotion activity. Due to this importance, a study which emphasizes on community participation in health promotion programs is indeed in need.

1.2 PROBLEM STATEMENTS

Historically, Maldives community perceived health promotion as oriented health services activities that are largely lies outside conventional treatment. Health promotion is a high priority agenda in Maldives government policies. The Ministry of Health and Family is responsible for delivery of health services. Other than the ministry, many different agencies, groups and individuals are involved in health promotion activities in Maldives.

The major barrier facing health promotion programs in Maldives is the lack of leadership in health care and comprehensive planning for health. Inadequate incidence and prevalence rates for several risk factors made the establishment of baseline data useful in local decision making impossible. Additional barriers include the lack of technical and support services for local communities, a shortage of health care professionals especially in rural areas, people's awareness on issues pertaining to health, and a culture of self-reliance that can inhibit the use of formal services systems (WHO, 2007a).

The Ministry of Health and Gender, of Maldives has accepted and implemented the concept of people participation in health development since the world embraced Primary Health Care as the key strategy to achieve health for all.

Community development program relies mainly on one's community member's participation. Many challenges rise, in particular difficulties to draw community members participation; albeit of the present health policy embraces community participation in Maldives (Manifesto, 2009).

In order to consider the status and level of participation in various activities in health promotion, one needs to specify who participates in program. The term "participation" is very broad and refined according to relevant characteristics. In most community development initiatives, participants of the programs are classified to four groups based on their socio-economic background and responsibilities they perform in the development activities. The groups are local residents, local leaders, government personnel/professional and foreign personnel.

Local residents are the informal group of people who reside in the project area. They are referred to as local people who have minimum information about ongoing projects in the community. However, they are willing to provide any vocational assistance. Their participation tends to be limited and absent in all stages. The opportunities for citizens to participate in health planning has been hindered or blocked due to resistance from the state and from professionals, excluding citizens from making decisions and shaping policy about their own lives. They are disempowered to participate in from most development programs. Empowerment is very important if any changes to be made in the lives of the people of Maldives are to be sustained and meaningful. In most events, empowerment occurs at the micro level such as in the stage of self-esteem development and increased control over one's life and at macro level, in the stage of social development action and political power enhancement (Pardasani, 2006). Local leaders like large land holders, voluntary association leaders, major traders and local professionals like lawyers and religious

leaders do participate as a catalyst. They participate passively by providing financial assistance or funding for programs implementation.

Government sectors such as education, environment, transport, agriculture, housing, social security, sports and media play constricted role in health promotion. These sectors participate in the celebration of world notable days such as World Health Day, Earth day Environment Day etc. The government recognizes that the community organizations and NGOs are useful partners in the development of the country.

With assistance of the United Nation (UN), there is an initiative to enhance coordination of Non-Governmental Organization (NGO) activities and to facilitate their collaboration with government. The NGO sector in the Maldives is small, but growing. These organizations often evolve in response to community needs. The community organizations such as WARD Committees, Atoll Development Committees (ADC), Island Women's Development Committees (IWC), Island Development Committees (IDC), Health Task Forces (HTF), Parent-Teacher Associations (PTA), Youth Clubs and Girl Guide exist at various levels with varying functions. These organizations work together with several community groups in areas relating to health.

Private stakeholders in health promotion include private hospitals and clinics, pharmacies, gyms and sports centers, cafes and restaurants, food shops and markets, and newspapers, magazines and media. Most of the private stakeholders participate actively in celebration of world notable days like "World Health Day", "No Smoking Day" and "Earth Day".

One of the leading challenges in Maldives is establishing working partnerships between the government, national and international NGOs, aid programs and the communities (Pardasani, 2006). There are several NGOs registered throughout countrywide under designation of “clubs” or “associations”. Among others, well-recognized local NGOs with proactive role in health include the Society for Health Education, which concentrating on health and family welfare issues, Care Society and Diabetic and Cancer Society; as well as the Manfaa Center on Aging. However, lack of coordination has resulted in duplication or blurring roles and activities between NGOs and the government (WHO, 2007b).

International organization Of the UN agencies, United Nation Development Program (UNDP), United Nation Fund for Family Activities (UNFPA), United Nation International Children’s Emergency Fund (UNICEF) and World Health organization (WHO) are represented in the Maldives and have specific projects with the Government. International NGOs, such as Japan Overseas Cooperation (JOC) and Voluntary Services Overseas (VSO), also work in the country. The UNICEF and WHO for instance are supporting the Ministry Of Health (MOH) in strengthening the health information system (HIS) and participating actively in the new integrated community development projects, as well as coordinating and providing support in the introduction of new vaccines, essential drugs and assisting government in the area of food safety and water and sanitation programs. Most of the organizations conduct health promotion activities directly or indirectly (i.e., support health promotion through financial and/or technical assistance).

Ideally, true or active participation means that members of a community should be knowledgeable about their own health problems; before capable of identifying solutions for the problems. All sectors and sections/ groups of community need to work hand in hand in promoting health. Government or related agencies should be able to identify which segment of community plays an active participation; as well as which segments of the community do not participate or poorly participate. The information is important in assisting the government to empower the inactive groups. In related to the matter, the initial question that I want to seek response from this study is *who are participating in health promotion activities in Maldives?*

Kummeling (1999, cited in Heritage & Dooris, 2009) mentioned that achieving high-level participation is not always possible. Different political, social, economical and organizational context may create different conditions, and thus offering different opportunities and constraints. Generally, Maldivian participates only if their community is experiencing pandemic disease. In most advocates' initiatives for change, community volunteers mostly organize sports and recreational activities rather than public health programs. Local leaders' participation is limited to certain level due to government policy. Limitation is stated because of the limited power given in accordance with the Constitution, Act on Decentralization of the Administrative Divisions of the Maldives. The act is not clearly identifying the boundary of the councils and government. (Act no. 9/2011)

No study about types of Maldivians participation in health promotion programs has ever been conducted. Hence, no available information about community participation in health promotion of the country can be referred to. This status quo

provokes me to find answers for this question: *what are the types of community participation in health promotion programs in Maldives?*

Although community participation is recognized as a success factor underlying healthy and sustainable planning and programs, achieving participation can be a major challenge. There are potential barriers to community participation such as economical, social, cultural, attitudinal and motivational, which hinder participation even with an existing policy on participation in any country. The reason behind this is due to lack of collaboration between community health workers and volunteers, inter-sectoral coordination and lack of effective referral support system in the country.

At the structural level there is lack of professional support and commitment to community health and participation in Maldives. Lack of expert skills, local human resources, resources dedication to support participation policies and an appropriate health care structure are the responsible factors that affect local involvement (Manifesto, 2009).

At the operational level, lack of adequate communication facilities and coordination between islands are the major challenge to improve quality of life of the inhabitants. At this stage, involving community in health planning, namely political will and bureaucratic and political support, are aligned with that of community participation, coordination, collaboration, communication and administrative support are the main barrier in the country (Razee, 1985).

Community stakeholders; whether they are from local community or local non-government support agencies needs to have certain strengths to increase the likelihood of sustainable community participation. They also need a commitment to trust the process, leaders and participants who involved in the program. Willingness of the community overlaps within organization and citizen due to their character and reliability. These limitations in turn affect the commitment within the organizations of the health care system; as well as commitment within the community.

The above mentioned barriers have been observed in health sector and as a result communities are being de-motivated and thereby influence their participation. The Maldivians are considered as a receiver rather than a giver. Communities are de-motivated by not giving authority and autonomy to initiate or implement any of health promotion activity. These are hurdles for them to participate. This, then leads me to explore more about *why Maldivian cannot fully participate in health promotion programs?*

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process are the empowerment of communities, their ownership and control of their own activities and destinies (WHO, 1986). In theory and practice, empowerment and health promotion have been sharply criticized.

In the first place, empowerment and health promotion efforts have been criticized for failing to adequately address equity and social justice. Empowerment is characterized by local people as having increased control over their own lives and wellbeing and able to set their own agenda. For example: Live and Learn is a, non-profit, education based organization. Their main aim is to promote sustainable development and reduce poverty through education and learning. They have been using a model called MAIA- model for NGO and Community Based Organization (CBO) mobilization. By using this model they have implemented some programs in different atolls. Community facilitators trained prior to implementation and waste management program. The facilitators' re-trained local community to sustain this program in the community (Live and Learn, 2009).

Another example is the Care Society; a NGO who advocates for the rights of disabled persons who involved with rehabilitation initiatives. According to surveys conducted by the Ministry of Health and Family, Maldives (MOHF) shows that 3.4% of the total population of the country are disabled (MOHF, 2003). The organization provides care and development center for disabled children and their families to take part in rehabilitation process. Community based rehabilitation plays major role in rehabilitations for disabled people. At island level they educate volunteers to support activities like raising awareness among family; as well as conducting series of community mapping survey to concretely identify disabled persons in the population.

One more example of community participation program in Maldives is the Waste management Project, which was funded by the UNDP. A waste management center was provided in selected residential areas. One of the strategies is substituting plastic bags with re-useable cloth bags, thereby reducing the overall waste produced

and resultant impacts (Ministry of Home Affairs and Environment, 2004 cited in Live and Learn 2009).

In accordance with the prior statement, needs to motivate local authorities to take part in health promotion programs are essential in Maldives. Regarding the above matter, the final question that I want to answer in this study is *how could Maldives community be empowered to participate in the national health promotion programs?*

1.3 OBJECTIVES OF THE STUDY.

General aim of this study is to assess Maldives community participation in health promotion programs. Its specific objectives are:

1. to identify segments of Maldivian community who are participating and not participating in community health promotion programs,
2. to identify types of community participation in health promotion programs in Maldives,
3. to identify factors affecting Maldivian participation in health promotion programs; and
4. to propose an alternative module of effective community participation in health promotion; based on the research findings.

1.4 SCOPE OF THE STUDY

Main focus of this study is community participation in health promotion. The scope covers types of community participation, and factors to active participation.

A community involvement process occurs when an organization such as a government agency or a private corporation proposes a project and it wants to elicit responses and suggestions from community who are most likely to be affected by the proposed project. In contrast to this, the types of community involvement process are reviewed. The types of participation are based on Cohen and Uphoff (1977) model of participation which comprise of development activity- decision making, implementation, benefits and evaluation. Interactions among them are summarized in Figure A.

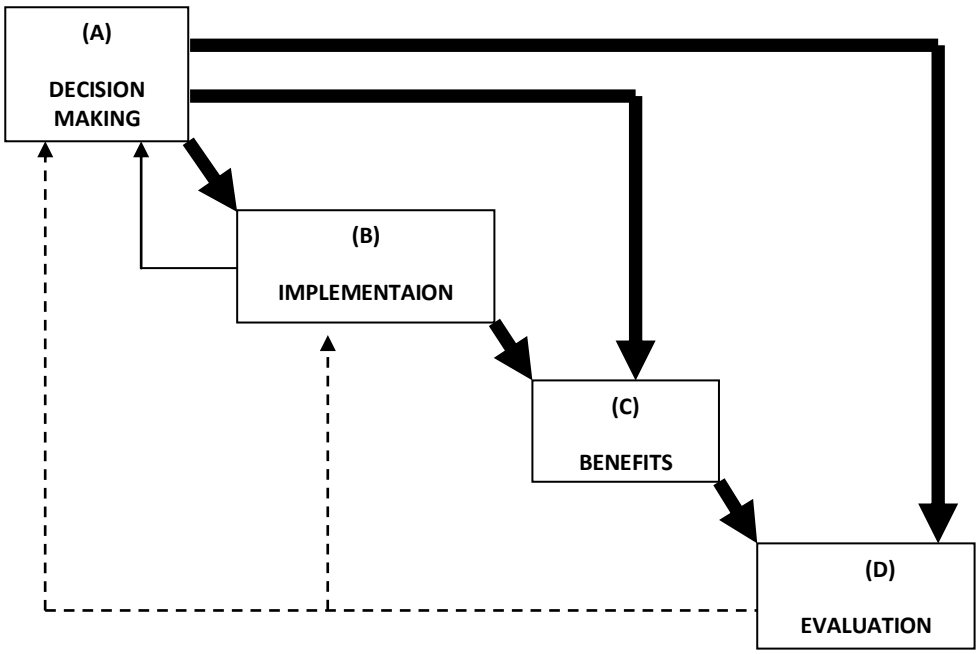


Figure A: Four types of participation Cohen and Uphoff, (1977)

Participation in decision-making is an important input for development of projects, providing authorization and resources as well as organizational and design of activity. Processes involve in assessing participation in decision-making are initial decisions, ongoing decisions and operational decisions.

Decision-making deals most directly with implementation participation, namely resource contribution, administration and coordination and enlistment in

programs. These three can be analyzed according to the different types of participants and their background characteristics, matching the “what” dimension with the “who” dimension of community participation.

Benefits from community projects include collective as well as individual gains, indirect as well as direct effects of project activity, and no-material as well as material benefits. Indeed, most information on participation is a “benefit”. At the process of evaluation (D), the main concern is the role the participants played in the process. In any kind of project bonfires are the implementers in different ways. Evaluation describes the overall impact of the project and if it fails, the effects could be due to implementation and how the inputs were administered. The dotted line represents that participation might impact either way due to implementation as well as decision- making process.

Even though community participation is recognized as a success factor underlying healthy and sustainable planning and programs, achieving participation can be a major challenge. There are many potential barriers to community participation as identified in Table 1.1, which summarizes factors that emerged from a review of literature by Murray (2004).

Table1.1 Factors that affects community participation in health programs.

Structural Readiness
Expertise Attitude of the professional Structure of the health care system Trained local human resources Resources for community participation
Operational Readiness
System of health governance Political will Coordination Collaboration Information Political and bureaucratic support Communication Administrative support
Community Readiness
Stakeholder commitment to community health Trust Leadership
Participant Readiness
Active citizens- culture of participation Comfort with being a participation Perception and issue salience – importance of, motivation and commitment to community health Time and resources Trust Responsibility Expectations of participation

Sources: Murray, 2004

Successful community participation in public health planning projects and their implementation requires overcoming barriers at a number of levels, namely the participant, the community, the operational and the structural level.

At the structural level, the professional support and commitment to community health and community participation, expert skills, local human resources, resource dedication to support participation policies and an appropriate health care structure that is able to be responsive to local involvement are very important.

At the operational level, a number of inputs are important to optimize the success of involving community in health planning. They are political will, bureaucratic and political support, and a health care system which has principles aligned with that of

community participation, coordination, collaboration, communication, available information and administrative support.

Community readiness requires the equal value of commitment within the organizations of the health care system as well as commitment within the community. The most important from the process of health planning is the readiness of citizen.

Important elements at the participant level, which impact on participant readiness are an active citizen culture, comfort with being involved, a belief that community health is important, a belief that participation is a citizens role, a capacity to participate responsibly, adequate time and resources to participate, and a trust of the participatory process (Murray, 2004).

For community-based health promotion to become a mainstream mode of dealing with public health, a major reorientation of attitudes in government and medical circles will have to occur. Moreover, the political realities of social change needed to occur with community development in order to pursue a more equitable system (Guldan, 1996).

Participants' characteristic such as age, sex, education, occupation and ethical background have been cited as the greatest predictor of participation (Pateman, 1976). Numbers and types of community participants are influenced by geography (Cohen, 1985), socioeconomic status (Widmer, 1989), gender (Wells, DePue, Buehler, Lasater, & Carleton, 1990) and group heterogeneity (Cohen, 1985).

The focus of the study is confined to the participant's characteristics and factors affecting community participation in health promotion programs towards types of participation, as illustrated in figure B.

Independent Variables **Dependent Variables**

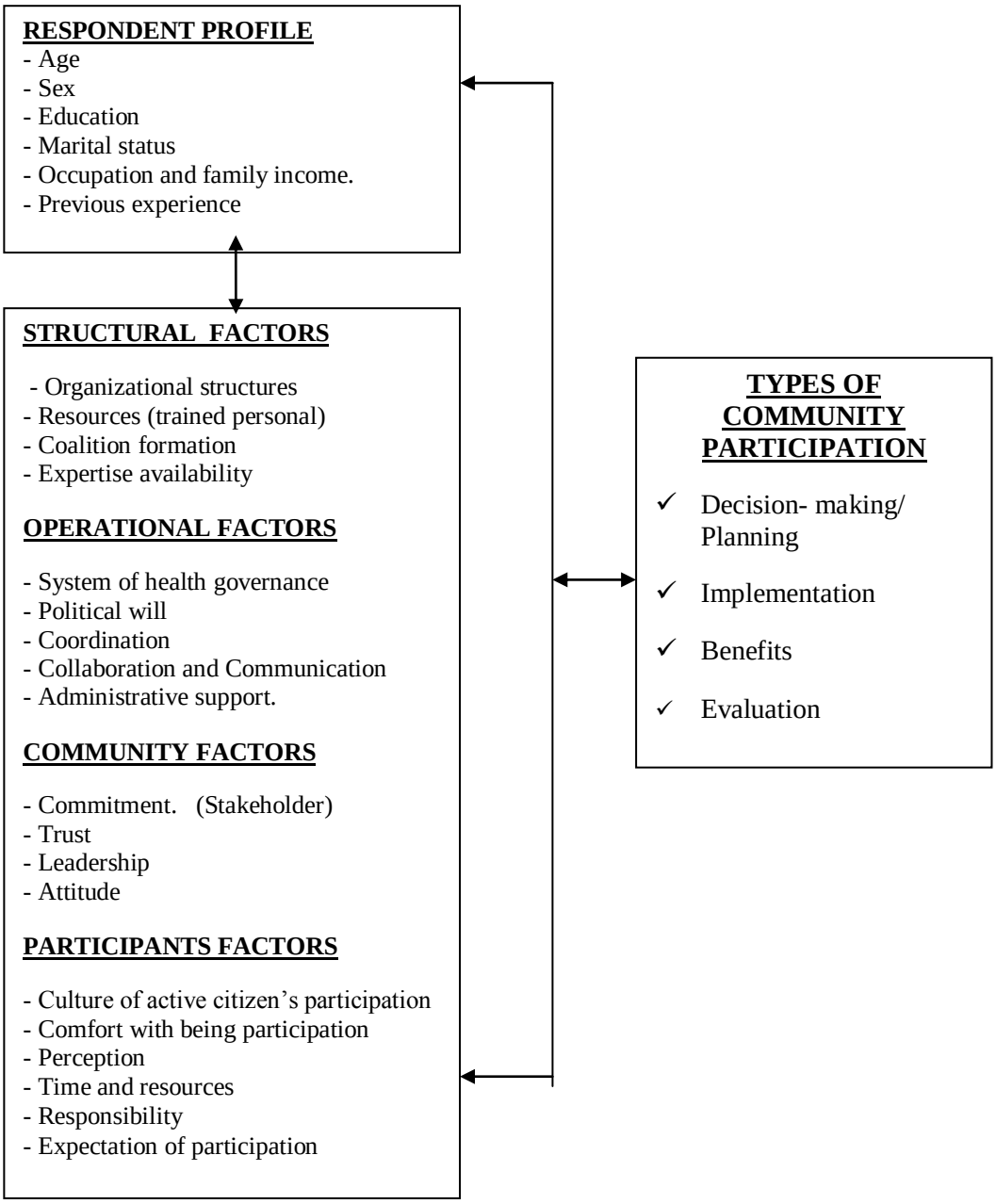


Figure B: Conceptual Framework

1.5 RESEARCH METHODOLOGY

1.5.1 Research design

The purpose of this study is to do an assessment on types of community participation and factors affecting the levels of community participation in health promotion. In this matter, a cross-sectional descriptive study is more appropriate as it describes multivariate numerical data.

The survey adopted a self-report technique to gather information about individuals who have been engaged in health promotion. The reason of using self-reported technique is that the researcher wants to get accurate image of the involvement of community in health promotion activities. The number of participant who does volunteers works in health promotion are less compared to other developmental activities and it would be easy to get valid information if self-reported technique is used in this study. This technique is more sophisticated in design, making it is more reliable and valid and extending its applicability to a myriad of issues (Thornberry & Krohn, 2000).

1.5.2 Study population

The target population for this study is all Maldivians who are from 18 years and above, who are either participate or not participate in health promotion programs. This study includes both categories because it could provide unbiased and/or neutral information on about factors affecting Maldivian participation in the programs.

1.5.3 Sampling frame

The sample would be drawn from 2006 population census. The population of the Maldives is estimated to be 298,968 (Maldives, 2010) and consist of 151,459 (50.7%) male and 147, 509 (49.3%) female. In addition to this, there are about 70,259 foreign workers and their dependents (male 64,739 and female 5,520). About 26 percent of the population lives in the capital island of Male'. The population density of Maldives is 800 person per km² compared with 30,000 persons per km2 in Male', indicating a very high and increasing pressure on land in the capital city.

The Republic of Maldives is a nation of 1190 small coral islands, which form a chain that is 829 km. in length and 130km. as its width, which of 99% of its area compost of the sea. The Republic is divided into 20 administrative units, also called Atolls. Only 194 islands are inhabited now and most with less than 1sq.km. and are low lying, with an average elevation of 1.6 meters above mean sea level.

In 2008 a new president was elected and the government took over its executive functions in November 2008 with the mission to deliver 5 key pledges; which are (i) establishing a nationwide transport system, (ii) ensuring affordable living costs, (iii) provision of affordable housing, (iv) provision of quality health care for all and (v) prevention of narcotics abuse and trafficking (Manifesto, 2009). The government initiated a local governance system which was stipulated in the law no 7/2010 on decentralized governance providing the elected atoll and island councils the power of local administration in that particular atoll and island. Regionalization and

decentralization would ensure accessibility of services to the people and the realization of human rights and the principles of good governance.

The government has grouped the atolls into seven provinces in order to achieve more effective and efficient service delivery at the local level. The rationale for clustering two or more atolls to form a province is to achieve effective and efficient planning, coordination and management as a means to facilitate effective administration decentralization and accelerate local development. Health facilities have been corporatized with the reform, especially changes brought to important public health programs like immunization, child growth monitoring and family planning. The government aims to increase community participation in development programs and empower young generations through an inclusive approach.

1.5.4 Sampling procedures

Multi-stage cluster sampling techniques were utilized to select the respondent for this study. The total geographical area was divided into 7 provinces and 3 provinces were taken for this assessment. However, this is not achievable as a natural cluster may vary considerably in size.

The technique/ stages involve the procedures below;

(a) Zoning Maldivian geography to three zones – North, Central and South. (Column 1, Table 1.2)

(b) In three zone have 7 provinces as shown in Column 2, Table 1.2 and each province consists of 3-4 atolls (column 3, Table 1.2).

(c) From 7 provinces, three provinces were randomly selected for this study. That is upper north, central and upper south province (Column 4, Table 1.2). The upper north and upper south were most densely populated and situated at the two ends of the country, which makes most difficult to seek tertiary health care. Central province is situated at the capital province, which can excess easily to tertiary health care.

(d) From the selected provinces, atolls are randomly selected based on health care delivery system (Column 5, Table 1.2)

(e) From the selected atolls, health care was selected based on the levels of service (Regional Hospitals, Atoll Hospitals, Health Centers and Health Post/ Family Sections (Column 6, Table 1.2

(f) From the selected island total population was identified on each 3 selected atolls. (Column 3, Table 1.3)

(g) Sample was determined by using Krejcie and Morgan (1970) table for determining sample size from a given population (Appendix A) (Column 4, Table 1.3)

Table 1.2 Multi-stage cluster sampling

(1)	(President's Office)	(3)	(4)	(5)	(6)
Zone	**Province**	**Atolls**	**Selected province**	**Selected atolls**	**Selected health care facilities**
1. North	Upper North (Mathi Uthuru Province)	Haa Alif Atoll Haa Dhaal Atoll Shaviyani Atoll	**Upper North** **(Mathi Uthuru Province)**	**Haa Dhaal Atoll**	H.DH Kuludufushi (Regional hospital) Hanimadhoo (Health Center) Finey (Health center)
	North (Uthuru Province)	Raa Atoll Baa Atoll Noonu Atoll Lhaviyani Atoll			
2.	North Central (Medhu Uthuru Province)	Alifu Atoll **Alifu Dhaalu Atoll** Kaafu Atoll Vaavu Atoll	**North Cenral** **(Medhu Uthuru Province)**	**Alif Dhaalu Atoll**	Mahibadhoo (Atoll Hospital) Maamigilli (Health Center) Dhidhoo (Health Post)
	Central (Medhu Province)	Faafu Atoll Dhaalu Atoll Meemeu Atoll			
	South Central (Medhu Dekunu Province)	Thaa Atoll Laamu Atoll			

3. South	**South (Mathi Dekunu Province)** Uppe South (Dhekunu Province)	Gaafu Atoll **Gaafu Dhaalu Atoll** Gnaviyani Atoll Seenu Atoll.	**South (Mathi Dekunu Province)** →	**Gaafu Dhaalu Atoll**	Thinadhoo (Regional Hospital) Madaveli (Health Center) Rathafandhoo (Health Post)

Table 1.3 Sample size determinations

(1)	(President's Office)	(3)	(4)	(5)
Selected atolls	**Selected islands**	**Population/ Total**	**Total Sample/ Atoll (Krejcie and Morgan sampling technique)**	**Total sample PPS**
H.DH Atoll	H.DH Kuludufushi Hanimadhoo Finey	6,998 923 430 8,351	367	Kuludhufushi → 307 Hanimadhoo → 41 Finey → 19
Ari Atoll	Mahibadhoo Maamigili Dhidhoo	1,780 1,671 116 3567	346	Mahibadhoo → 173 Maamigili → 162 Dhidhoo → 11
G Dhaalu Atoll	Thinadhoo Madaveli Rathafandhoo	4,442 1,065 492 5,999	361	Thinadhoo → 267 Madaveli → 64 Rathafandhoo → 30
TOTAL			**1,074**	**1,074**

Stages involve in determining samples

At the initial stage, the researcher clustered the geography area of the whole country into 3 zones (figure 2). In the second stage, the researcher identified provinces in each zone (7 provinces). At the next stage the researcher identified 3 provinces and selected island from each province to conduct survey (Column 6, Table 1.2).

The researcher selected 3 levels of health care services in the country so that she can compare the levels of participation among the population at different health care availability. As summarized in Column 4 and 5 of Table 1.2, from zone 1 selected Upper North Province and from that Haa Dhaal (HD) Atoll was selected for this study. From the HD atoll, the researcher selected 3 main islands namely Khuludhufushi Island with total 6,998 populations, Hanimadhoo Island with total 923 populations and Finey island total 430 populations.

The researcher determined sample by using Krejcie and Morgan's (1970). Based on this, the researcher has calculated proportionate to size for each island. From Khuludhufushi Island sample size is 307 people, Hanimadhoo Island sample size is 41 people and Finey Island sample size is 19 people. Thus, the total sample size in HD Atoll is **367** people. In the same manner from zone 2 North Central Province was selected. From North Central province Alif Dhaal (AD) Atoll was selected for this study. In AD Atoll 3 Main Island was Mahibadhoo with total 1,780 populations, Maamigilli with total 1,671 populations and Dhidhoo with total 116 populations. The researcher calculated proportionate to size for each island, Mahibadhoo Island sample size is 172.6 people, Maamigilli Island sample size is 162 people and in Dhidhoo Island sample size is 11 people. This makes total of **346**

respondents. Finally from zone 3 South provinces Gaafu Dhaalu (GD) Atoll was selected for this study. From GD Atoll, Thinadhoo Island with total 4,442 populations, Madaveli Isaland with total 1.065 populations and Rathafandhoo Island with total 492 populations. Proportionate to size was calculated and from Thinadhoo Island sample size is 267 people, Madaveli Island sample size is 64 and Rathafandhoo Island 30 people. This makes the total of **361** respondents. Therefore the total respondents for this study are 1,074 people.

(h) From selected island respondent were selected by using probability proportionate to size (PPS) as show in Table 1.3 (column, 5). Sampling with probability proportionate to size allows the larger clusters to have a great chance of being selected.

The selection of the respondents was made by using simple random sampling technique. To select the sample according to this technique the following steps has been followed.

- Meet the province office head to explain the research objectives and work schedule to gain maximum consideration.
- Collected list of people in island along with house name to reduce work load.

Selection of the study sample was made using simple random sampling technique. To select the sample according to this technique, the following four step of sampling has been done. First step is identifying the number of adult population including name of the houses with age 18-65 years. The list was taken from island office or province office. The researcher identified among the total population particular to catchment area in the given population and inclusion criteria as follows:

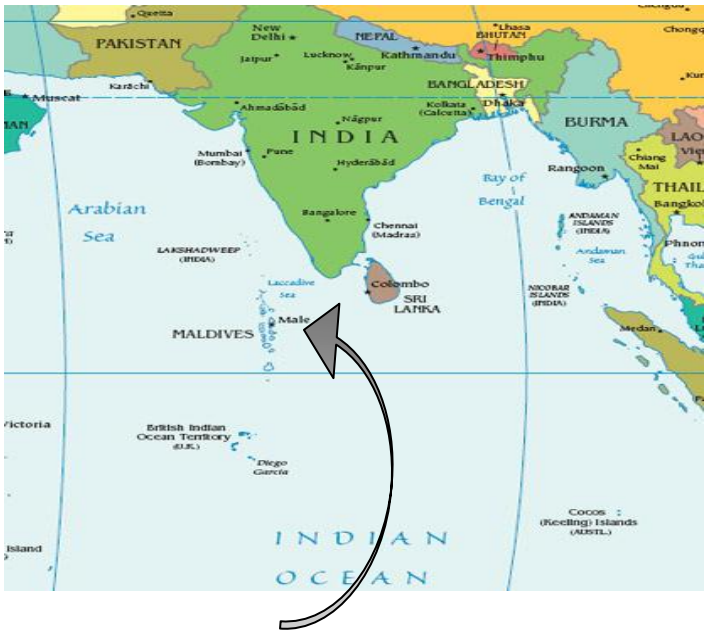
- 18 - 65 years of age
- Male or female participant
- Residence of the community
- Willing to provide answer to study

Exclusion criteria:

- Respondent who cannot speak or listen
- Who have mental or psychiatric problem
- Not living in island or residence of that island

For example if an island has 6900 population that fit to this study, the researcher uses four-digit number for each person, beginning with 0001 until 6900. Using the Random Number Table, the researcher identified the number of respondents fit for sample from each identified island. The researcher chooses respondents from each island until total number of respondent are complete. For in-depth interview researcher collected the list of committees in the community

Figure: C Map of Maldives



1.5.5 Research instrument

This self-reported study uses survey technique to gather raw data. This survey involves distribution of 1,074 structured questionnaires (Appendix A) to randomly selected respondents. . Questionnaires are an inexpensive way to gather data from a potentially large number of respondents (Ahmed, 2007).

The structure of the questionnaire was divided into four components. Each component describes one objective of the study. The first component is the respondent profile which contains the respondent's personal information. Respondents are required to write their personal information (i.e., age, gender, marital status, education attained and occupation), and socio-demographic profile of their family (i.e., family income, numbers of breadwinner in one's family).

The second component is about the respondent's involvement or participation in health promotion activities. Questions in this section seek to find respondents experience engaging with health promotion activities. This part also consists of questions about respondent involvement in any kind of health allied activities.

The third component is the types of community participation in health promotion in terms of decision making, implementation, evaluation and benefit sharing. The questions focus on types of community participation and level of participation.

The fourth component is the factors affecting participation in health promotion activities. The questions are focused on structural factors, operational factors, community factors and participant's factors.

The last component is an open ended question about ways in which community participation can be improved for the purpose to build sustainable society; from the respondent point of view.

1.5.6 Pre-testing of the questionnaire

Before conducting the actual survey, the questionnaire was pre-tested on 30 respondents in one of the Maldivian community. This pre-testing was conducted after the questionnaire was developed and was translated into Dhivehi. Some respondent gave feedback that some of the questions were complicated and difficult to understand. Therefore, the researcher reconstructed some of the sentences to make it respondents–friendly. Its reliability was measured by Cronbach's Alpha for the perception part. The result was 0.845 on Cronbach's Alpha, which indicate the instrument is valid.

1.5.7 Data collection techniques

Generally, data can be collected using different techniques. Apart from the questionnaire, the researcher has performed extensive library and web pages research to collect updated information for this study. From the initial stages till the end, the researcher had read several books, journal articles, magazines, and government reports related to this research.

Once permission is granted, the researcher went to each island to distribute survey forms with the help of community coordinators; since the researcher is unfamiliar with the island.

Open-ended interviews are conducted to public health officer, community leader and committee member. This information was drawn from island/ province office (Appendix B).

A cross-sectional survey was conducted at 3 selected atolls in total 1,074 participants, within 1-2 month. In order to facilitate the research process and on-site organization, two coordinators from existing community development project was hired and trained to conduct the interviews. The interviewer was given one day orientation and interview training. A skilled interviewer can adopt a conversational style that puts participants at their ease, yet guides them smoothly along the prescribed path of question and response alternatives (Hyman 1955, as cited in (Neale, 2009).

Multiple methods of investigation were employed in this study in order to maximize the validity and reliability of the data (Yin, 1984 as cited in Pederson, 1989).To gather secondary data, four sources of data were used in the preparation of this thesis. This contains government documents in the public health domain, including reports from government, "grey" (unpublished) literature, and key informant or focused interviews and Library sources including thesis, online journals and books.

1.5.8 Data Analysis Technique

Data were numerically coded and statistical analyses by using Statistical Package for the Social Sciences (SPSS) version number 17.0 A simple descriptive statistics are analyzed to produce basic summary information about the data and sample. This

would include measures of central tendency (mean, mode, median) and dispersion (standard deviation).

The results are presented by two statistical methods; frequency distribution for personal characteristics and, structural factors, operational factors, community and participants' factors and types of participation. Mean and standard deviation are computed for total score of the factors and types of participation. Inferential statistics, Chi-square (x^2) are used to draw broader conclusions about significance association between dependent and independent variables.

1.6 LIMITATION OF THE STUDY

Health service delivery to the scattered islands in Maldives had always been an extremely difficult task. The monsoon weather, the distances in time and cost of travel, and shortage of health workers in both quantity and quality were significant disadvantages the country had to deal with. Transport is the biggest problem and the main access to the 200 to 300-odd islands that are inhabited, of the archipelago of 1,100 tiny islands, is by boat/dhoni. The remoteness of some of the islands and the consequent transport difficulties is still a challenge in Maldives.

The mobile team approach was adopted to provide the link to bridge this gap of service delivery, supervision and intelligence gathering support to these neglected locations. Up until now, the supervisory and supply support link of the islands with the central health system had been through a costly single purpose program approach. This could be due to unavailability of motivated senior staff members with relevant technical and managerial and visionary zest for carrying the process, and a multi-

lateral donor climate that was conducive to supporting the initial trial funding make health promotion difficult in Maldives.

The health preventive health care is designed on the need basis and there are no ultimate health promotion programs in health care policy to involve community in health promotion programs. Therefore it is very important to integrate community participation component into policy for sustainable change in health of the local community. To overcome the above mentioned difficulty the researcher conducted in-depth interview with key informants to get the picture of the situation. Financial backup are also very important to cover the traveling cost of this research. Thereby university of Malaya research grant fund has been approved to cover some traveling cost for this study.

Other possible limitations in this study might be the sampling technique. The multi-stage cluster sampling which require the researcher to include 3 provinces from 7 provinces and the capital city of the country which covers 26 percent of the population lives in the capital was a demanding procedure. The researcher experienced some difficulties due to dispersion of the population. To overcome the challenge, the researcher travel to the respective island and collect the data and replace the respondents who are not available in at the time of data collection.

1.7 IMPORTANCE OF THE STUDY

Specific health promotion research and evaluation reports on interventions carried out in Maldives are limited. There are also very few trained health promotion specialists capable and in the position to inform politicians and opinion leaders about

the relationship between health and social determinants, and the evidence of effectiveness of health promotion actions. This might be due to financial constraints of the country and lack of experts in this field. This study would help to explore more about pros and cons of health promotion behavior in the country from both community and government level. Findings of this study would be very helpful to social policy makers to demonstrate local evidence of community health promotion effectiveness to politicians and social health programs funders in Maldives.

Findings of the study could be used to guide the educational program or intervention to improve community involvement in Maldives. Moreover it can be useful prior to put the volunteers in the responsibility on health promotion in order to improve the outcome of the programs. Furthermore the clinical guidelines would be developed based on evidence-based practice and then seek to encourage its wider diffusion throughout the profession. Nevertheless, often a policy-making stage in knowledge utilization is important if the final outcomes of health, health equity, and social and economic gains are to be achieved.

CHAPTER TWO

LITERATURE REVIEW: HEALTH PROMOTION PROGRAMS IN MALDIVES

2.1 INTRODUCTION

Health promotion is a large and diverse field. Although "community participation" is used in the literature and in practice, its meaning is often unclear. This chapter begins with literature regarding the interpretation of community participation in health practice. The second part includes the significance or function of community participation in health development, followed by the interpretation of ill health and disease in relations to health care services. The third section of this literature focuses on the operation of health promotion programs and its challenges in relation to community involvement.

2.2 COMMUNITY PARTICIPATION CONCEPTS

"Community participation" consists of two big social jargon; "community" and "participation". In this sense, the community and participation are intrinsically linked. Both concepts are elaborated below in their relation to each other.

2.2.1 “Community”

The word community rooted in the Latin word “communities”, meaning common. It became established in English in a variety of sense; a state of organized society, in its later uses relatively small in groups and also the people of a district (Farquhar et al., 1985).

The ideas regarding people’s participation in the development of health services and promotion have crystallized around community involvement in health (Oakley, 1991). The concept of community participation is at all not new. Different types of participation have been manifested with time of community participation. Traditionally in times of poor ill health, the community lends positive community action to tackle existing health problems and needs.

Community has traditionally referred to a specific geographical area or locality (Williams, 1976). This definition, however, is now considered to be obsolete in many societies where communities within which people live and work are not necessarily those which contain the associations that are most significant to them.

Community is also used in the literature to describe a relational community, referring to the social cohesion that can develop as a result of close interpersonal ties, and as an entity with collective political power (Heller, 1989). Unlike geographical communities, relational communities are not limited by locations as the availability of resources such as mass transportation, communication and global media enables

communities of common interests and needs to form regardless of geographical proximity (Florin & Wandersman, 1990).

As a result to the debate, community can be defined as "an entity with collective political power recognizes the power of organized constituencies as a lever for social change, irrespective of whether this leverage stems from localities, organized interest groups or both" (Heller, 1989). According to Arnstein, (1969) citizen participation should be the 'redistribution of power that do not have power, presently excluded from political and economic process, to be involved in the future'. Nonexistent of this redistribution of power may resulted to an empty and frustrating participation process (Arnstein, 1969).

Williams (1994, in Dziuba-Leatherman & Dolan, 1994) states that: *"unlike all other terms of social organization (state, nation, society, etc) community seems never to be used unfavorably" (p.66).* Community is associated with positive descriptors and conjures up ideal images of supportiveness, natural ties, and cooperation. It is rarely seems to generate a negative impression unless it is attached to a specific affinity or geographical descriptor. These examples further illustrate Cohen's (1985) position that two central ideas are found in the notion of 'community'. They are aggregation and social relations. The former idea involves the aggregation, or grouping together, of people who have something in common. This perspective disagrees with idealist notions of community as being non - conflictual and is supported by numerous empirical studies which demonstrate heterogeneity and conflict in communities (Cohen, 1985; Jewkes & Murcott, 1998; Midgley, 1986; Rifkin, 1986; WHO, 1988).

For the interest of this study the word “community” is used to refer to voluntary organization that is a person which has recognized their affinity or geographic relationship and which value these enough to join together formally. In this regard, community implies a community of organizations, or formal associations and also as an individual. People make better use of existing health services and suggest of new services by involving in decisions about their own development.

2.2.2 “Participation”

Participation, like other social phenomenon such as education, can be conceptualized as both a means and an end it itself. When understood as a means, the term ‘instrumental participation’ is used to indicate the process of involvement to achieve some predetermined social goal or objectives. Participation in this sense is “*way of utilizing the existing physical, economic, and social resources of people to attain a valued outcome or benefit*” (Boyce, 1997: pp. 46), and is also a means to achieving efficiency in project management (Oakley, 1991).

Participation does not occur overnight. It involves over a period of time and in relation to a particular interpretation. Therefore, participation can be understood as a process that can be divided into series of stages involved with equally methodology that consists of series of stages towards ultimate objectives.

World Health Organization (WHO) and United Nation International Children’s Emergency Fund (UNICEF) were the multilateral sponsors of community participation in health. Their names are most strongly associated with the concept. Both concept are inspired by similar ideas and imply similar processes. The

phenomenon of participation has been the subject of lengthy debates on its historical origin, and its practical application.

Participation is not some universal thing to be measured but rather an umbrella term covering a variety of related activities, at different context (Kahssay, 1999). The nature of the development task and task environment with who, what and how participation that constitute into three basic dimensions; which are how the context of participation may affect its extent and substance; to understand this context, analysis of the nature of the development task and the features of the environment (Cohen & Uphoff, 1977).

There are different interpretations, terms and processes used to understand community or citizen participation. One approach to participation, which has focused on community or social participation are the civil society sphere, in which citizens have beneficiaries of government programs. On the other hand, there is a tradition of political participation, through which citizens engaged in traditional forms of political involvement such as voting, political parties, and lobbying political parties (Gaventa and Valderrama, 1999).

In many sectors, participation is viewed as either a means or end. For example in the area of public health, it has been proposed that community participation is means, or process, leading to improved health status (House, Landis, & Umberson, 1988). Oakley, (1991) argue that participation is valued end, or outcome, in itself. However, the reasoned theory, strategies, and methodological approaches vary in these two understandings of participation and lead to considerable conceptual confusion (Pitkin, 1969).

Therefore ‘participation’ is considered as a voluntary action by the people in a community to support and contribute to national development. Furthermore it includes people’s involvement in decision-making, implementation and benefit sharing and also to evaluate the programs (Cohen, 1977).

2.2.3 “Community participation”

Community participation has been considered to be major importance in health programs in the developing country (Midgley, 1986; Rifkin, 1985). The concept of community participation gathered renewed strength in the 1990s (WorldBank, 1998). In 1990, for example, the UNICEF undertook a formal examination of the usefulness of participatory approach to its work. In the same manner, in 1993 the Organization for Economic Co-operation and Development (Organization for Economic Co-opertaion and Development) undertook the effectiveness of community participation in OECD supported programs. Then, in 1994 the World Bank issued a major statement on the importance of community participation in its work and approached to its loan operations (WorldBank, 1998).

The domestic and international literature suggest three broad purposes, or functions, of community participation which are linked to means or end goals (Oakley, 1991; Stone, 1992; Zakus & Lysack, 1998). They are:

1. Participation as ‘contribution’ is the voluntary donation of people’s resources to a common good or goal. This type of participation is proposed to be initiated by the

state in a top-down fashion and does not necessarily imply the control and direction of activities pass to the local people (Cohen & Uphoff, 1977).

2. Participation as 'collaboration' in which people voluntarily participate as a result of some persuasion or incentive, agrees to collaborate with an externally determined development project, often by contributing their labor and other resources in terms of their benefit (Kahssay & Oakley, 1999). In programs like health, resources conservation or agricultural production, people's collaboration is required as a means of ensuring the success of the program. They might collaborate rather; they have less direct involvement in design, control or management of the program. (Kahssay & Oakley, 1999).
3. Participation as 'specific targeting or project benefits'. In developmental activities, targeting directly to small farmers, landless people or the urban poor are expecting more benefits. In the process of measuring beneficiaries the targeted groups are investigated and then their views are taken into account in the project process. Paul (1987) summarizes this justification when he defines community participation as *"... an active process whereby beneficiaries influence the direction and execution of development projects rather than merely receive a share of project projects" (pp. 2).* In most of the development projects seek to put Paul's interpretation into practice, the scope to which beneficiaries effectively influence the direction and execution of development projects varies considerably and may, in some cases, be negligible.

The term *empowerment* has entered the development vocabulary after gaining public support as an exercise in empowering people. The 1979 World Conference on Agrarian Reform and Rural Development emphasized the transfer of power as implicit in people's participation. Then, in the 1980s the United Nations Research Institute for Development adopted the term as its working definition of participation;

as well as its main strategy to increase access and control over development resources among the excluded groups in one's community (Kahssay & Oakley, 1999). Participation also can be defined as empowerment tool through which local communities take responsibility for diagnosing and working to solve their own health and development problems. Rifkin (1986) identifies the core concern; that is to address the issue of participation is to address the issue of power.

Community participation as empowerment implies both the development and management skills in local people and their ability to make decisions which affect their lives. The term empowerment has come to be very loosely to describe any development process or activity, such as skills training, management techniques and capacity-building, which might have some impact upon people's ability to deal with different political administrative systems and influence decision making.

In summary, the term 'community participation' is used in this study to include participation by patient, clients, consumers, community representatives, community members and citizens. Community participation is defined as "*the involvement of consumers in the development of health service, this can include involvement in policy development, strategic planning, service planning, service delivery and evaluation and monitoring"*. (Commonwealth Department of Health and Aged Care, 2000, as cited in Jolley, 2008).

Also, it can be concluded that the search for a definition of community participation may be futile as the process of participation is a dynamic one and in

constant state of change. As a result, health workers need to be flexible as both people and objective change.

2.3 COMMUNITY PARTICIPATION IN HEALTH PROMOTION PROGRAMS

There is no consensus on a definition of community participation in health; despite numerous debates in the literature on the potential benefits of participation and the process associated with it. Rifkin (1986) has identified three approaches to describe the method used by health planners and agencies to develop community participation in health programs.

In the medical approach, health is defined as the absence of disease and community participation as health promoting activities undertaken by people under the direction of health professionals.

In the health services approach, the World Health Organization's (1986) definition of health as the physical, mental, and social wellbeing of individual whereas community participation is defined as the mobilization of people to participate in health service delivery.

In community development approach, where the impact of the social, economic and political environment on health is emphasized, community members participate in all aspects of decision-making includes the identification of health needs and strategies to address these needs (Rifkin, 1986).

With the rapid rise in cost of health care, it has become imperative that departments of health services find effective and affordable ways to prevent disease and promote health. During the past 20 years, most of the major educational interventions in most of the countries designed to prevent disease by changing behavior have not been as successful as expected. At the same time, there is increasing evidence that community participation, a central feature of the 'new public health', is a powerful component of the programs that have been successful.

Community participation (CP) was one of the founding principles of PHC. This principle reflected the underlying value of social justice, confirming the view that all people have the right to be involved in decision making that affect their own lives. It also reflects the value of improving health among the poor, particularly in the rural area, based on health programs mainly in the non-governmental organization (NGOs).

For the purpose of providing basic health care at least eight essential components of PHC are to be implemented. (Levine et al.,1994): (1) Education of the people about prevailing health problems and the methods of preventing and controlling them; (2) Promotion of food supply and proper nutrition; (3) Adequate supply of safe water and basic sanitation; (4) Maternal and child health care and family planning; (5) Immunization against major infectious diseases; (6) Prevention and control of locally endemic disease; (7) Appropriate treatment of common disease and injuries; and (8) Provision of essential drugs. For the successful implementation of these components active involvement and participation of the community would be crucial (Roy, 1986).

Different communities have different problems, needs, beliefs, practices, assert, and resources related to health. Getting the community involved in program design and implementation helps to ensure that the adopted strategies are appropriate to the community. Community participation promotes shared responsibility among service providers, community members, and youth themselves in the community. It occurs when a community organizes itself and takes responsibility in identifying the

problems, developing actions, putting them into place, and following through in a sustainable way (Roy & Sharma, 1986).

Evidence of the health-promoting influences of primary health care has been accumulating ever since researchers have been able to distinguish primary health care from other aspects of the health service delivery system. This evidence shows that primary health care helps to prevent illness and death, and more equitable distribution of health in populations, a finding that holds both cross-national and within-national studies.

Community participation is a fundamental principle of both Local Agenda 21 and Healthy Cities. It contributes immeasurable benefits for individuals, communities, organizations and societies (Smithies & Webster, 1998). These benefits relate to both the process, and the effects and outcomes of participation as end in itself and participation as a means to achieve other goals (Kahssay & Oakley, 1999). The WHO is calling for PHC to be renewed. The World Health Report 2008 is entitled *Primary health care: now more than ever* (Organization, 2008). UNICEF has adopted several approaches which involved community participation through community development activities in addition to health services, including food production, nutrition, water and sanitation, education, and income generation. UNICEF experience of this approach to community participation has helped to understand of how people can be motivated in the community in improving their own health (Rifkin, 1990). For this reason, if no other, it is timely to review the principle of community participation and seek, from experience, insights to help assess its contributions and the challenges it presents to health programs. Distilling the arguments of WHO, the UNICEF and the Christian Medical Commission, all of which played influential roles in the formulation of PHC, the following reasons may be cited:

1. People are more likely to use and respond positively to health services if they have been involved in decisions about how these services are delivered, thus helping to make the service sustainable;

2. People have individual and collective resources (time, money, materials and energy) to contribute to activities for health improvements in the community;

3. People are more likely to change risky health behaviors when they have been involved in deciding how that change might take place;

4. People gain information, skills and experience in community involvement that help them take control over their own lives and challenge social system that have sustained their deprivation.

The key concept behind the principle of community participation in health programs during and after Alma-Ata declaration is quite difficult to put in to practice. Community participation can therefore make important contribution to achieving a number of objectives, as detailed below:

(1) *(1) Increasing democracy*. Community participation in decision-making, planning and action is a human right. An increasing number of citizens are disillusioned with government and want to see more participatory approaches to democracy. It is being argued that the structure of governance has to be changed of viewing as a passive recipient and enabling genuine participation and empowerment and citizenship (Bookchin, 1992).

(2) *Empowering people*. Community can be both an outcome of empowerment and an effective empowerment strategy (Minkler, Wallerstein, & Wilson, 1997). The actual process of participation can inherently empower individuals and communities to understand their own situations and to gain

increased control over the factors affecting their lives. This promotes people's sense of wellbeing and quality of life as mentioned in Health 21.

(3) *Mobilizing resources and energy*. Community have a wealth of untapped resources and energy that can be harnessed and mobilized through community participation, using rage of practical techniques that can engage people and, where appropriate, train and employ in developmental work (Breuer, 2002).

Five different levels can be distinguished in community participation in health component; which are:

1. *Peoples participate in the benefits of the programs*. Members receive education and services by the planners and agencies, such as curative services, preventive immunizations, antenatal care, improved water and sanitation facilities and health information. Mostly obtaining free of charge or payment of a small fees for maintenance. In this case community participation may be considered passive. In health services that are community oriented rather than individual-oriented, communities do not receive benefits and many passively accept the health services that are provided.
2. *People participate in program activities*. In addition to the above, some community contributes land, labor and money to health programs. They might construct a clinic or distribute contraceptives, or provide drugs and other medical equipments. This can be considered as active participation. In some program activities participant do not participate in decision how it has to be carried out, which is mostly done by the health planners,

agencies or the government. The members of the community simply agree to conduct the activity which has been planned by the professionals.

3. *People participate in implementing health programs*. To implement a program members of the community may choose the site of a clinic, run drug-purchasing schemes, organize infant welfare and nutrition clinics. At level of making decisions about how the activities have to be carried out the planners are focal point rather than the community. Since it involves some managerial responsibilities the communities do not take initiative.
4. *People participate in monitoring and evaluating programs*. In addition to the above mentioned method, community members help planners to judge whether the programs objectives have been met and if not, why not. At this level they are involved in deciding how to measure objectives and in systematically monitoring activities. They can only modify the program objectives but cannot determine those objective themselves, a task which is still of the planners. It is because only lip service is paid to monitoring and evaluation and are often not clearly stated and therefore cannot be measured.
5. *People participate in planning programs*. From the above mentioned four preceding sections, people from community (leaders and key members such as teachers) decides what health programs are to be undertaken and ask for the expert opinion from health professionals and agencies. At this level community participation is broadest, in both range and depth. They involves in receiving the benefits, in joining the activities in implementation of projects, in evaluation and monitoring the project, and making decisions about program policy and management. (Rifkin, 1990)

Community participation also poses some important challenges. Community participation and program outcomes have not been examined as thoroughly due to methodological difficulties confronting community trails. Most of the literature discussed about the logistical, organizational and political changes to conducting and evaluating health promotion programs in community settings. The major factor shaping the active role of community-based programs is the difference in goals and priorities found among communities and researchers. These differences often lead to struggles over power and control of program and reflect mutual respect and building trust. A common problem confronted by many health programs is the insufficient time allowed for engaging multiple groups of stakeholders who may have competing priorities. The time constraints result in avoiding readiness of the community to adopt program activities and phasing problems with development and implementation activities.

As seen in Table 2.2 almost all of the HIV projects had some form of community advisory board involved. However, these boards had limited voice in determining the issues to be addressed by the project. Mostly the funding agencies take leads, due to insufficient funding to provide technical support and ongoing support of community. Almost all the articles reviewed in this study do not include detailed information about the nature of community involvement; some aspects can be noted regarding the stages of community readiness has been identified (Goodman et al., 1996). The first stage involved community mobilization and establishment of program organizational structure. The second stage, entailing building capacity for action through program planning and implementation, appears to be at the greatest level that has been occurred in the programs. The last stage, modification and institutionalization of intervention can help to ensure that a community continuous to

address health promotion issues. These challenges are reflected to the experience from many prevention programs, which encountered numerous difficulties in implementing community mobilization models and sustaining participation (Merzel, 2003).

In a review by Israel and his associates (1998) categorized challenges in community based research in public health to three broad categories: (1) issues related to developing community research partnerships, (2) methodological issues involved in community-based research, and (3) broader social, political, economic, institutional, and cultural issues. Within each category, key challenges are examined. Most issues are related to the development and maintenance of partnerships between community members and researchers. The lack of trust and respect, inequitable distribution of power and control, conflicts over funding and task and orientation process makes it difficult to raise voice of community. Moreover, due to time consuming process and who is representing and how is community defined in the program also slows down partnerships. Most of the studies disused on the issues related to partnership and social issues in their research paper For example, questions of scientific quality of the research, success in intervention, inability to fully specify all aspects of research up-front and balance between research and action, time demand, and interpreting and integrating data from multiple sources. The members have to go through broader social, cultural and economic issues to shape the partnership. Mostly due to competing underlying institutional demands and social dynamics of the community (Israel et al., 1998).

Community participation is considered as a basic principle of health promotion and, by extension, of health promotion research. According to BJÃRÅS, Haglund and Rifkin (1991) and Raeburn (1992) the major purpose of community participation is to avoid professional identification of problems and disuses in

isolation from the subjects under study. Community participation in health promotion research and health promotion programs is not same. In the case of health promotion research, community participation may consist of involvement in establishing the research question, planning and organizing the research data collection, data analysis and interpretation, and application. On the other hand, health promotion programs, community participation in decision-making, participation in implementation, participation in benefit sharing and participation in evaluation.

2.4 ILL-HEALTH AND HEALTH CARE SYSTEM OF MALDIVES

2.4.1 Health and illness in the Maldives context

The global population was 5 billion in 1987 and 7 billion now (UNFPA, 2012). It will increase by nearly 80 million per year to reach about 8 billion by the year 2025 (WHO, 2012). Every day in 1997, about 365,000 babies were born and about 140,000 people died, giving a natural increase of about 220,000 people a day (WHO, 2012). Demographic trends provide evidence of changing situation by declining fertility, longer life expectancy, increased dependency ratio and ageing population throughout world. The transition of an older population has already occurred in countries that developed rapidly and has reduced the fertility of working-age population (WHO, 2008). Health systems and programs in both developed and developing countries are coping with the burden of chronic diseases of older person and new health and welfare issues might pose devastating problems in the near future (WHO, 2008).

In general, health indicators for the poorest countries lag far behind the wealthiest and within some countries it is much worst for the poor. In less-developed countries, most deaths occur at younger ages rather than the older ages. Deaths from communicable, pre-natal, nutritional and maternal conditions have declined to 20% of total death in the Asia- Pacific Region. Among the deaths from non-communicable diseases are now over 60% and injuries

accounts for 10% (WHO, 2008). The burden of non-communicable disease is closely related to risk factors which includes underweight, unsafe sex, high blood pressure, tobacco consumption, alcohol consumption, unsafe water, sanitation and general hygiene; iron deficiency; indoor from solid fuels; high cholesterol; and obesity. Together, these account for more than one-third of all deaths worldwide. The global population is growing, but the number of health workers is stagnating or even falling in many countries where they are needed most. Shortages are most sever in sub-Saharan Africa, which has 11% of the world's population and 24% of the global burden of disease but only 3% of the world's health workers (WHO, 2006).

The scope for improving the human condition is therefore great and the action required is urgent. Four-fifths of the populations still do not have access to health services on a permanent basis, and notions cannot extend their existing health services to cover entire population (WHO, 2007). Health for all, therefore remains as a dream and it will remain so as long as the dream is formulated in terms of drugs, nurses, vaccines, hospitals, doctors, and X-rays equipment. If this has to be turned into reality, existing health care strategies will have to be vigorously transformed (Mahler, 1981).

In the late 1970s and 1980s began to understand that underdevelopment is due to poverty and suggested different forms of project intervention. Since, the earlier strategies were planned for the people by outsiders, where people were considered as mere recipients and high technology was thought to be adequate for development. Emphasis was laid on the active participation of people and make development strategies more people centered, based on this idea community participation emerged as a fundamental component of any development strategy including health development (Bhuyan, 2004).

The health service's capacity to meet need has been subjected to extensive scrutiny. The different impact of mortality and morbidly has been revealed from epidemiological

studies. These show considerable differences in the experience of ill health among different regions of country or at different ethnic groups. The statistics on infant death in developed country have been given particular attention. According to National Vital Statistics Report; the infant mortality rate (deaths in the first year of life by 1000 live births) varies widely from race to race in United States. In 2008 Hispanic origin of mothers were 12.67 per 1000 live births for non- Hispanic black mothers, 2.8 times greater than the lowest rate of 4.51 for infants of Asian or pacific Islanders. Rates were also fairly high for American Indian (8.42) and Mexican mothers (5.58) (NVSS, 2008). In the same manner in UK, in 1977 varies widely with region by region. The highest rates were 17.2 in Northern Ireland, 16.1 in Scotland, and 15.5 in the Yorkshire region. The lowest were 11.2 in East Anglia and 11.6 in South West Thames region (HMSO, 1979). Similar experience can be reveled from other countries.

The extent to these differentials attributable to differences in the availability of health services is a matter of policy concern. More factors like low income, poor housing and access to information can contribute to differences in the availability of health services. There are variations between and within regions (Hill, 1997). Similar difference can be found in availability of specialized care per head in Maldives. In 2007 there were 552 medical doctors with a ratio of 1:541 practicing per population (Health, 2009). The poor are exposed to greater personal and environmental health risks, are less nourished, have less information and are less able to access health care; they thus have a higher risk of illness and disability. The poor were excluded and marginalized from societal participation and direct involvement in developmental initiatives. At the same time policy maker and planners began to direct their strategies towards direct involvement of poor people.

In the context of Maldives also, the most frequent cause of deaths are chronic diseases, including heart disease, cancer, lung diseases, and diabetes's (MoHF, 2009). Behavioral factors, particularly tobacco use, diet and activity patterns, drug and alcohol consumption, sexual behaviors and avoidable injuries are the most prominent contributing

factors to mortality. The behavioral modification approach to prevent disease and health promotion focuses on persons' health related behaviors. For example diet plan and exercise program, smoking cessation and safe or unsafe sexual practices and personal actions to reduce stress that can reduce bodily injury, such as helmet and seat belts (Stokols, 1996).

The socio-ecological approach integrates person-focused efforts to modify persons' health behavior change with environmental factors to enhance physical and social surroundings. To modify individual's unhealthy behaviors and lifestyles have been guided by several theories of social influences. Social influence is the alteration for a person's thoughts, attitudes and behavior in response to the actions or feelings of others (Friedman et al., 1986). During 1970 a study conducted to find the empirical links between persons' routine health practices, stressful patterns of living and their susceptibility to disease condition and death (Stokols, 1996). In the same study, environmental enhancement strategies of health promotion also linked with lifestyle and behavioral modification. The theoretical underpinning of environmentally based health promotion programs benefits all in the community by exposing to that particular environment rather than focusing narrowly on improving the health of one person at a time.

Additionally, health systems must include institutional arrangements for the active and informed participation in strategy development, policy making, implementation and accountability by all relevant stakeholders, including disadvantaged individuals, communities and populations (Geneva, 2000). Effective provision of health services can only be assured if people's participation is secured by states.

Better health is central to human happiness and wellbeing. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more lives. Since 1990s the people's participation in development has been

dominated to promote people's participation by major donor agencies (OECD, 1994; World Bank 1994).

Inevitably, the re-examination of development filtered into the health field and began influence the practice of health care development. The 1978 Declaration of Alma-Ata was served as an important guide of health policy and development in many countries. An important element in the Declaration's emphasis on primary health care (PHC) is the involvement of people in defining health priorities and allocation of scare resources at the district level (Kahssay & Oakley, 1999). The development of health promotion with a view to increasing social and community control and participation in health started in the 1980s. It was motivated by the recognition of the impact of social behavioral, economic and organizational factors on health status. Since most of the health problems have multiple causes, an integrated response to these problems became necessary (WHO, 2001).

On January 1, 2011, Maldives has been graduated as Least Developing Country (LDC) status after a long than usual transition period. Now Maldives is classified as an Upper Middle-income country by U.N and World Bank. The Committee for Development Policy (CDP) had found that the country met the graduation criteria in two successive triennial reviews (2001 and 2004). The recommendation was endorsed by the Council (resolution E/2004/67) and taken note of by General Assembly (A/RES/59/2010).

Many factors influence health status and country's ability to provide quality health services for its people. Ministry of Health is important actors, but so are other government departments, donor organizations, civil society groups and communities themselves.

The health status of Maldivian population has improved notably in the last decade. Maldives has achieved significant progress in MDGs, has successfully achieved, 5 of the 8 MDGs making it South Asia's first MDG + country with highest per capita income in the South Asia Region. ($ 8000/capita) as below;

1) MDG 1, (Eradicate extreme poverty and Hunger) proportion of population living below $1 per day is 1% according to the 2004 Vulnerability and Poverty Assessment.
2) MDG 2 (achieve universal primary education), net enrolment ration level education is 95.5% in 2010.
3) MDG 4 (reduced child mortality) reduce by two thirds.(1990-2015) The most recent estimates from 2011 suggest that U5MR is close to 11 per 1,000 live births and NNMR dropped from 36.4 to 6.5 (per 1,000 live births) during 1990-2011 while IMR decreased from 75.7 to 9.2 (per 1,000 live births).
4) MDG 5 (Improve maternal health) reduces by three quarters and universal access to Reproductive health services. MMR rate reduces from 143/1,000 live births to 46 in 2007- 2001. Skilled birth attendance rate was 94.80% in 2009.
5) MDG 6 (Combat HIV/AIDS, malaria and other infectious diseases)), Malaria was eradicated since1984 TB prevalence is low. The state of the epidemic in the Maldives is characterized by low overall prevalence – less than 0.1%. The government provides medication to all those who require it as the Maldives has very few people living with HIV and AIDS. However, the recent detection of HIV in the IV drug user population (2013) poses a potential for a concentrated HIV epidemic. Stigma and taboos related to sex work and MSM are widespread, putting the Maldives at risk of spread of STIs, HIV and hepatitis.

All the indicators had shown a steady improvement. as it needs to be more on focusing prevention and rehabilitation aspects of health system by strengthening local community in planning their health care.

The health status of the children has been improved but nearly one-fourth are underweight. Worm infestation is high in the country and 50-75% children below five years of age are estimated to be affected. According to Health Statistics (2012) estimates that 36% of all years of life lost in Maldives in 2002 were due to Non-Communicable Diseases (NCD). NCDs are the most leading cause of death in the country. The top three leading causes of death are due to cardiovascular disease, respiratory disease and neoplasm (Table 2). The Maldives has one of the highest known incidences of Thalassaemia in the world. It is estimated that one in six Maldivians carry the carrier trait and about 60-70 children are born with the disease every year through only one-sixth of them are diagnosed (Nearly 694 cases of Thalassaemia are registered by 2009) (MoHF, 2009). The national Thalassaemia Center (NTC) and a NGO - Society for Health Education (SHE) are the major players in the treatment and management of the disease in the country. Disability prevalence in the country ranges from 9% to 11% (MHF and Handicap International, 2009).

Despite these significant achievements and improvements, there are two valid concerns: cumulative achievements do not translate into an equitable and just distribution of the gains from development. Due to rapidly changing landscape, multiple crisis due to political instability, demographic and democratic transition have been consorts that impact MDGs, and made it harder to sustain or even accelerate on indictors related to health, nutrition, gender empowerment, environment and global partnerships.

Table: 2.1 Ten leading cause of death for all ages in Maldives (2008)

	CAUSES	2008
1	Diseases of the circulatory system (I00-I99)	395
2	Diseases of the respiratory systems (J00-J99)	158
3	Symptoms, Signs Abnormal findings not elsewhere classified (R00-R99)	152
4	Neoplasms (C00-D48)	81
5	Certain Infectious and Parasitic Diseases (A00-B99)	59
6	Certain conditions originating in Perinatal period (P00-P96)	51
7	External causes of morbidity & Mortality (V01-Y99)	39
8	Diseases of Digestive System (K00-K93)	33
9	Diseases of Nervous System (G00-G99)	23
10	Diseases of Genitourinary system (N00-N99)	22

Source: Center for Community Health & Disease Control 2009

2.4.2 Health care system of Maldives

Health care system in Maldives has inclination towards a totally integrated system where most of the financing, provision and stewardship is the responsibility of the government. However, the public integrated system is supplemented by a variety of private clinics ranging from single doctor consultations to group practices with laboratory services and inpatient facilities.

The health system is financed predominantly through indirect taxation. Over 13% of total government expenditure is on Health Sector. (Health Statistics, 2012) Maldives is in a period of transition in health-care financing. The universal social health insurance scheme a public-private partnership with Allied Insurance was established and it was activated on 1st January 2012.

"Aasandha" has been introduced with a free universal access to the scheme of the entire population, with annual individual financial limits. Under the agreement, Allied distributes the scheme's shared 60- 40 with the government. The actual insurance premium will be paid by government, whole claims, billing and public awareness will be handled by the private health sectors. According to the bill citizens receive government-sponsored coverage up to Rf100,000 (US$ 6500) per year and includes who require further financial assistance (Minivan News 2001).

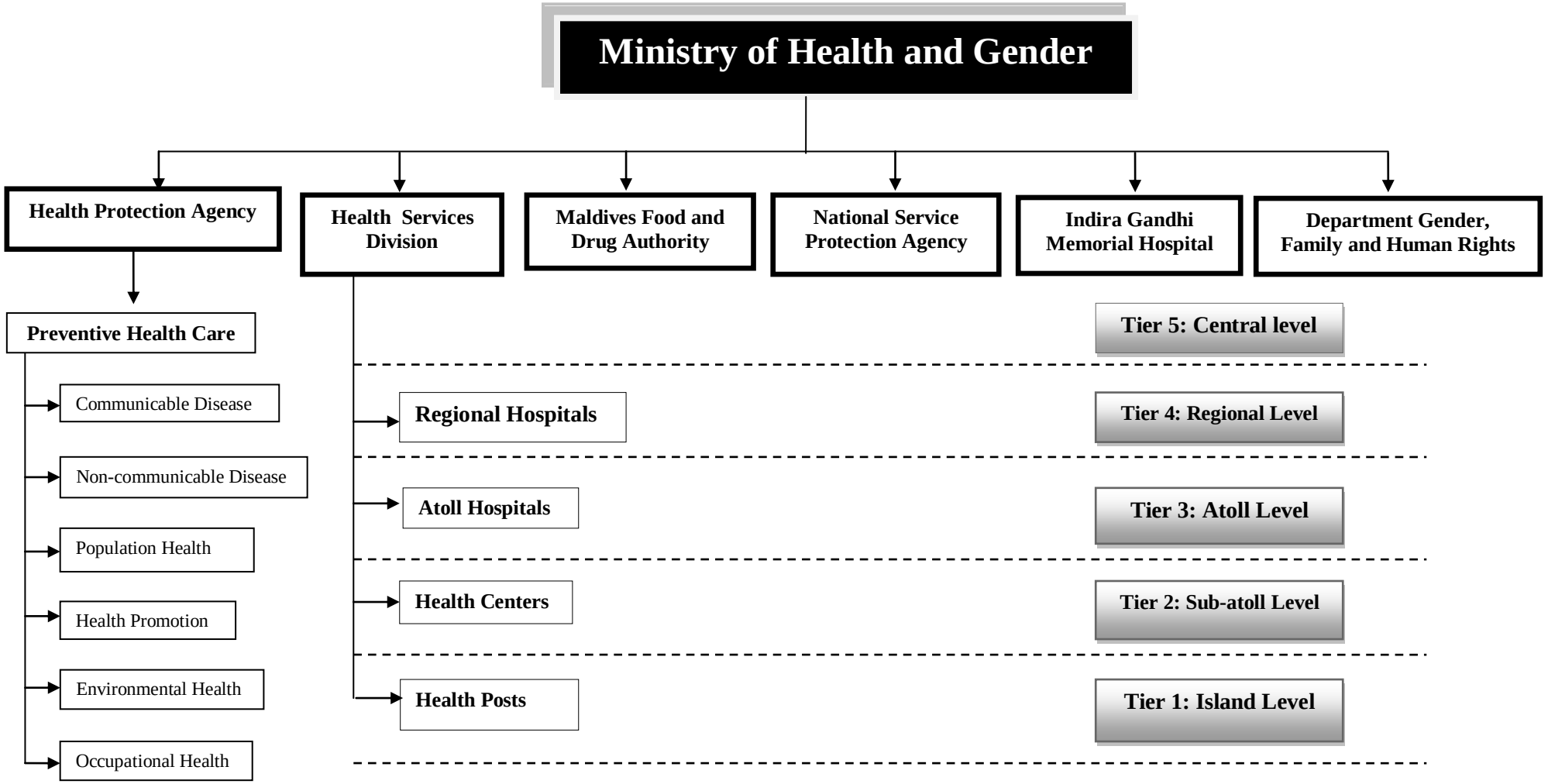
Before the universal insurance, the main mode of financing is fee-for-services with out-of-pocket payments and needed applied for subsidies under the welfare system. The government has mandated the Ministry of Higher Education, Employment and Social Security to formulate a scheme for government employees and their dependents (which started in the beginning of 2007).

Figure D. shows the health system is structured into four-tier hierarchy with the Ministry of Health sitting at the top as the overall health policy and regulatory body (Health, 2006). Health Protection Agency (HPA) is responsible for delivering preventive health programs for the prevention and control of communicable diseases and for the promotion of health and well-being. Indira Gandhi Memorial Hospital (IGMH) is the main tertiary referral hospital in the country.

Health Service Division (HSD) is responsible for organizing and delivering curative services to the region and atolls and islands. The Maldives Food and Drug Authority (MFDA) are responsible for regulating and setting standards for pharmacies and laboratories. It also supervises the work of the National Health Laboratory. Five regional hospitals with operation theaters and some specialty services operate to cover a group of islands and are the referrals centers from second tier. The atoll health centers and the island health posts at the third and fourth tier of the structure

respectively, provide mainly preventive and promotive care and maternity services with limited number of curative eservices.

Figure D: Organization of Maldives Health System.



Health education and promotion division is under Health Protection Agency. Health promotion is a high priority for the Maldives Government. Policy 13 of the 6th National Development Plan 2001-2005 is to 'promote healthy lifestyles and healthy communities'. Health promotion is also a strong theme in the Ministry of Health's Health Master Plan 1996-2005 (HMP), which states that: 'The Government recognizes health promotion as a social, education and political action that enhances public awareness of health, fosters healthy lifestyles and community action in support of health, and empowers people to exercise their rights and responsibilities in shaping environments, systems and policies that would enable them to lead healthy lives.' The HMP laid out the goals of the health education and promotion program, which were to:

- improve knowledge and understanding of health
- create social, economic and environmental conditions that are conducive to health
- encourage public policies that are supportive to health
- foster healthy lifestyles
- Enable people to participate fully in national and community health actions.

In the second Health Master Plan 2006-2015 (HMP), according to policy goal one; is to ensure people have appropriate knowledge and behaviors to protect and promote their health. The scope of this policy is to develop and implement health promotion strategies through a life course approach including neonatal, childhood, adolescence, pregnancy and child birth and as well as old age. The focus was given to priority areas like reproductive health, nutrition, and risk factors for chronic

communicable disease and emerging diseases. In addition strategic advocacy for addressing social determinants of health will be implemented through adoption of integrated multidisciplinary approaches in collaboration with NGO, community, public and private sector participation and community participation and partnerships.

To support the health promotion goals of the HMP, DPH developed the first National Health Promotion Plan. The NHPP 2000-2003 outlined detailed activities under nine objectives:

1. To place health high among priorities for national development by advocating and promoting health as an economic and political asset.
2. To increase adoption of healthy lifestyles among all population groups with special emphasis on active living, the practice of safer sex, healthy dietary habits, reduction in smoking and substance abuse and increased regular exercise.
3. To improve reproductive health based on the life span approach.
4. To cultivate healthy dietary habits and reduce under-nutrition and micronutrient deficiencies.
5. To improve the control of emerging and re-emerging infectious diseases through community empowerment and mobilization.
6. To improve promotion, prevention and effective management of non-communicable diseases.
7. To establish the concept of healthy settings with emphasis on schools, islands, hospitals, workplaces and atolls.
8. To reduce the number of accidents, preventable environmental and occupational hazards.

9. To improve health promotion planning, implementation and evaluation.

Before developing the second Plan, MOH decided to conduct a wide-ranging review of health promotion activities in the country. The review was carried out from December 2003 – May 2004 by Dr. Heidi Brown, Health Promotion Officer in the Health Education Unit, MOH, with input and assistance from other members of the HEU and supervision by Dr. Sheena Moosa and Mr. Ahmed Afaal, MOH. After the review they suggested to improve the overall health promotion activities of MOH in the future (Health, 2006):

1. Build health promotion capacity in the health sector
2. Improve the evidence base for health
3. Increase the effectiveness of health education.
4. Raise the profile of health promotion.
5. Ensure the new Health Promotion Plan is implemented..

This National Health Promotion Plan (NHPP) 2006-2010 builds on the progress made under the Health Master Plan 1996-2005 and the first National Health Promotion 2000-2003. It provides a framework for improving the quality and effectiveness of health amid the changing health challenges resulting from rapids development in the Maldives. The NHPP 2006-2010 outlined detailed activities under nine objectives:

1. To improve the health promotion skills base.
2. To increase the capacity of health education unit to promote health and support health promotion activities of MOH/HPA programs and other organization.

3. To increase the impact of health promotion activities and materials by making them more evidence based.
4. To facilitate sharing of best practice.
5. To improve health promotion in central region.
6. To strengthen regional health promotion with PHUs as central co-ordaining units for each region.
7. To increase the impact of health promotion through mass media.
8. To improve inter-sectoral collaboration in health promotion and
9. To mobilize resources for health promotion.

The Maldives Health Promotion Network, which was established in 2003 and is increasingly active, provides a forum for inter-sectoral collaboration and communication in health promotion. Its role and potential benefit should be expanded in the future and needs to include health promotion activities beyond Male'.

2.5 HEALTH PROMOTION INITIATIVES IN MALDIVES

The promotion of a good health, with an emphasis on the importance of preventing disease from developing in the first place, is not a new idea or practice, in Maldives or elsewhere. In the 18th century, the Austrian "epidemiologist" made the tie between health and wealth, claiming that the wealth of a nation depends upon its citizenry's health and productivity (Frank, 1976).

The World Health Organization (WHO) came into force on 7 April 1948 from the union of the previously existing office International d'Hygiene Publique (OIHP) and the health Organization of the League of Nations (Pederson, 1989). Over the sixty years of its existence, the WHO has been involved in public health efforts around the globe, ranging from vaccination to man power training to research and diseases surveillance.

Maldives joined the WHO on 23 May 1965, although Maldives and WHO had limited collaboration from the late fifties in disease control and health manpower development. With the collaboration, the modern concept of health care was gradually implemented in the country. The first interventions were in the nationwide Tuberculosis and Malaria control activities.

In 1977, delegates to the World Health Assembly unanimously endorsed a resolution that a main social goal of government should be "the attainment by all citizens of the world by the year 2000 of a level that will permit them to lead a socially and economically productive life" (WHO, 1978). This resolution is commonly referred to as the "Health for All by the Year 2000". WHO's objective of "Health for All" means the attainment by all peoples of the highest possible level of health. It requires that, as a minimum, all people in all countries achieve a level of health that will enable them to work productively and participate actively in community life. WHO acknowledges that each country will interpret the meaning of health status and morbidity patterns of its population, and the state of development of its own health system.

A year later (1978), International conference held in Alma Ata, U.S.S.R agreed that primary Health Care (PHC) was the key strategy for attaining this target of health for all. Primary health care has been defined as " essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their full

development in the spirit of self-reliance and self-determination" (Nutbeam, 1998). This definition of primary health care views health as an integral part of development. As such, health is the responsibility not of the health sector but also of other sectors as well, including industry, business and other voluntary sector. Thus, inter-ministerial action on issues affecting health which do not fall within the typical domain of medical on issues affecting health which do not fall within the typical domain of medical care and health advocacy for those unable to participate in the political process affecting are seen as two important components of primary health care.

a) Maldives enter the Primary Health care era

From Maldives Minister of Health, Ms. Moomina Haleem led the team to Alma Ata Conference in 1978. On return she and her team disseminate the concept and try to incorporate into health policy. The idea of PHC concept was quite new to Maldives, conducted series of meetings with village leaders in most of the Atolls before finalizing Country Health Plan in 1980. With the finalization of health plan training had been conducted to implement the concept, auxiliary training school trained health workers (Sheena, 2008).

The major fillip to the advancement of the Primary Health Care concept was given by the WHO Regional Committee Meeting that was held in Male'. The director general of WHO Dr. H. Mahler, the outgoing regional director, Dr. V.T.H. Gunaratne, and the delegates from the 9 member states attended the meeting. In this meeting the Regional Charter for Health Development has signed from Maldives, President of Maldives Maumoon Abdul Gayoom.

After release of the health promotion discussion document, a conference was held in Ottawa in November 1986 to consider the role of health promotion in industrialized nations. Two hundred and twelve delegates from 38 counties attended the conference, which was marked by the releases of the Ottawa Charter for Health promotion (1986). The Charter

adopted the WHO view of health promotion and defined priority health promotion actions. Five strategies for health promotion were outlined; which are to build healthy public policy which sets the political and social context for greater equity; to create supportive physical and social environments; to strengthen community action; to develop personal skills through providing information, education for health and enhancing life skills; and to reorient health services toward the pursuit of health. Healthy public policies were identified as the underpinning for the other four strategies and it was suggested that this was therefore the top priority approach to improving health (WHO, 1986).

A second International conference on health promotion focusing specifically on healthy public policy was held in Adelaide, Australia in April 1988. Working from a collection of case studies on healthy public policy efforts from around the world, the conference delegates drafted a paper on the concept of healthy public policy and key priorities for action in the field. The Adelaide Recommendations affirm that healthy public policy is chartered by an explicit concern for health and equity in all areas of policy and accountability for health impact (WHO, 1988). Priority areas for healthy public policy initiatives were identified; which are health of women, food and nutrition, tobacco and alcohol, and creating supportive environments.

In 1984, a conference "Beyond Health Care" was held in Toronto as the Department of Public Health contribution to the City's sesquicentennial celebrations. As a one day follow-up to the conference, a workshop on "Healthy Cities" was held. Leonard Duhl, a psychiatrist and urban planner from the United States, was a key force in the workshop, which explored the meaning of a broad ecological view of health for creating livable, healthful cities. Ilona Kickbush, from the European Office of WHO, subsequently brought together health and social planners to elaborate on how the WHO could develop a project to encourage the adoption of "healthy cities" style thinking and planning throughout Europe. Since 1984, this

project has emerged as a key at the municipal level. Currently, some 24 cities consider themselves to be participants in this project (WHO, 1988).

Primary health care became a core policy for the World Health Organization with the Alma-Ata Declaration in 1978 and the "Health for All by the Year 2000" program. The commitment to global improvements in health, especially for the most disadvantaged populations, was renewed in 1998 by the World Health Assembly. The progress in health system development in Maldives in the post Alma Ata period classically exemplifies the degree of equity and social justice that can be achieved by following the basic principles of PHC. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Maldives formulated its PHC plans in the early eighties in an electric manner where the widespread commitment to the principles of primary health care was matched by an equal commitment to diversity in the way in which those principles are applied. Maldives firmly underlined that primary health care was a vital means through which not only many preventive, diagnostic, treatment, rehabilitation and support services are provided for individuals, but importantly the means through which many public health services and interventions are provided for local communities.

2.6 HEALTH PROMOTION PROGRAMS /PROJECTS IN MALDIVES

2.6.1 National nutrition program

Nutrition program is to prevent, reduce and eliminate malnutrition in Maldives and promote sustainable health and nutrition well-being for less than five years of children. As a result, attention is given on development of the nation by reinforcing and accelerating development agenda.

Integrated Early Childhood Development (IECD), Positive Deviant (PD) /Hearth Programme were launched on 2007. The target group is children in the age of 6 month to 3 years. IECD PD/Hearth program is specifically designed to address the behavior change aspect of nutrition, focusing on Infant and Young Children Feeding (IYCF) practices, hygiene and empowerment at the family level. The program is community-based. It uses the Positive Deviance (PD) approach which offers an alternative to needs-based approaches for development. The "traditional" application of the PD approach for childhood malnutrition involves studying children who grow well despite adversely, identifying uncommon, model practices among PD families, and designing an intervention to transfer these behaviors to the mothers of malnutrition children. The goal of the program is to improve the health, nutrition and development of young children through improved practices of others and empowering their communities, in targeted areas of Maldives. The key stakeholders of this program were from UNICEF, CCHDC, community health workers/ family health workers, women's development committee members, island development committee members, preschool teachers and care group mothers and volunteers. This program was first implemented on 5 atolls in Maldives. They are in Haa Alif, Noonu, Laamu, Gaaf Alif and Seenu Atoll. The program was planned by UNICEF and HPA. At the implementation process training were given to community health workers and family health workers and also to care group from community. In this program monitoring was done at three level Island level, Atoll level and

central level, to monitor the progress of the program and challenges in implementing the program.

Some challenges during implementation are below:

(i) Challenges in relations to staff and health facilities - frequent staff turnover due to unavailability of time and no incentive provided for the staff, time conflicts between staff and care providers in community, lack of support from management are the main constraints.

ii) At the community level there are some challenges in implementing the program - less effort from committees to mobilize the locals, transportation cost is higher, food price is higher and some cannot afford the recommended food for the children, lack of time for mothers and conflicts between health centers and community which are the main problem faced in this program.

iii) Moreover there are some political issues and structural issues in the health system that makes difficult to reach program goals. Table 2.2 below summarizes the indicters shows that the nutritional status of the country.

Table 2.2: Nutritional indicators, Demographic Health Survey, (2009)

Nutritional Status in Maldives	**(%)**
Infant with low-birth weight	**10.5**
Underweight	**17.3**
Stunted growth rate	**18.9**
Wasted	**10.6**
Vitamin A deficiency	**5.1**
Iodine deficiency	**0.7**
Exclusive breast feeding	**47.8**
Babies receiving complementary food at 6- 59 month of age	

Source: Demographic Health Survey, 2009

2.6.2 Communicable disease control program

Even though the social behavioral patterns changes constantly, communicable disease remain the leading cause of morbidity and mortality in least and less developed countries. At

South-east Asia Region, most of the countries still have a high burden of communicable disease. Some of the highest annual incidences worldwide of diarrheal diseases, lower respiratory infections, malaria, measles and dengue appear in the region. The percentage of the world's disease burden contributed by countries of the region is 64 for measles, 36 for TB, 33 for upper respiratory infections, 52 for dengue and 28 for diarrhoeal disease (WHO, 2008). The share of total Disability-adjusted life years (DALYs) lost due to communicable diseases is higher than the regional average (approximately 30%) in Bangladesh (48%), India and Bhutan (44% each), Myanmar (46%), Nepal (49%) and Timor-Leste (58%). In contrast, this proportion is lower than the regional average in Sri Lanka (15%), and similar to it in the Democratic People's Republic of Korea, Indonesia, Maldives and Thailand.

Relatively older diseases such as TB, malaria, cholera and meningitis have recently reoccurred worldwide. At the same time, newer or re-emerging diseases such as infection with influenza A (H5N1) virus (avian flu), sever acute respiratory syndrome (SARS) and chikungunya have reached epidemic proportions in some countries.

The WHO Regional Director's annual report for 1965 states Malaria is recognized as the leading health problem in the Maldives, and following a study of the epidemiology of the disease and the feasibility of control measures, plans have been made for embarking on a pilot control program as an integral part of the development of health services. The main communicable diseases in Maldives in the sixties and seventies were Malaria, Tuberculosis, leprosy and filarial. Diseases like dengue started appearing in the later in the seventies and eighties. Maldives had eradicated malaria from the country in the early eighties (1984) and this, by any estimate, is a phenomenal achievement in a country where communication and transport was a serious problem.

Today no child dies nor is disabled due to diseases such as neonatal tetanus, polio, diphtheria and whooping cough, and also tuberculosis. Vaccination coverage under one year

olds has been sustained at over 95% for over 15 years and 95% since 2001. Maldives has remained polio free since 1981 and no indigenous polio case has been detected since then. AFP surveillance has been maintained at recommended level for the population for over 10 years. But measles is still sporadic and the country has occasionally experienced a measles epidemic.

Universal Child Immunization was introduced to the country in 1985, first it was intruded to capital and nearby island and latter it was introduced to whole country. In the late seventies and early eighties the TB and leprosy mobile missions that took "primary health care" were the most effective in achieving outreach in the islands. However if the vaccines were available in good quality, the island chief was able to ensure near 100% coverage.

More recently, based on a risk Assessment for Rubella Congenital Syndrome conducted, a measles-rubella immunization campaign was launched in 2005, targeting children between 5-14 years and women of child bearing ages, achieving 85% coverage. Country has introduced the MMR vaccine in EPI in 2007. The other noteworthy feature of the Maldives immunization program is that the country has attained self-procurement of all EPI vaccines, a key step towards its sustainability.

In Maldives there are large numbers of viral fever or fever of unknown origin due to the lack of laboratory diagnostic facilities and confusing clinical manifestation of diseases. Cats, rats, bats and crows are potential source of zoonosis in Maldives and surveillance of disease and infection is important. Toxoplasmosis and scrub typhus are common in southern islands and limited capacity for health research is a major constraint for identifying socio-cultural behavior and developing appropriate public health measures for prevention and control. There is limited knowledge about zoonosis among general public and health professionals. Awareness and education on zoonosis, legal framework for surveillance, prevention and control of human and

animal diseases and capacity building for clinical recognition of endemic and potential zoonosis, laboratory diagnosis and case management are priority areas (HPA).

Scrub Typhus is a major concern in Maldives. It was first recorded among the British troops stationed in Addu atoll during Second World War. After that scrub typhus was visible in May 2002, total number of 103 cases with 9 deaths. The island leaders began an intensive campaign to clean up trash sites and yards. The incidence rate have declined during 2004, total number of 159 cases with 1 death. Since then, scrub typhus cases have been routinely reported throughout the country and case fatality has been zero since 2007. Considering the impact of zoonotic diseases the health of the population and the potential economic consequences, it is important to decrease the spread of these. It is also vital to timely and correctly manage patients of these diseases in order to minimize the morbidity of these diseases. To enhance clinical skills in clinical recognition, diagnosis and case management clinician's training was given from HPA. In this training health care providers from selected atolls were trained and also from IGMH, ADK, Hulhumale' Hospital, and Male' Villingili hospital.

Dengue fever is a disease caused by family of viruses that are transmitted by mosquitoes. Dengue is prevalent through the country. Outbreaks have occurred during 2011 killed 12 children and adults and reported 2909 cases. The prevention of dengue fever requires control or eradication of the mosquito breeding places which carries the virus that cause dengue. Mostly in Maldives Dengue is spread during rainy session, from April –July. Since 2011, every year dengue prevention and control campaign are conducted by HPA and other concerned organization.

Maldives have focused on prevention and public health aspects of health services. Primary health care, at island level, with `the support of Island Chiefs and dedicated and visionary health workers has been the main contributing factors to achieve the positive impacts on controlling communicable diseases. In the mid seventies, treatment of the common illnesses received attention, particularly through the mobile teams that visited the islands. In fact all of the islands in the earlier years it was the community that donated or built the health facilities and provided a considerable amount of volunteer work in running them. The island atoll chiefs played very significant roles in this work (WHO, 2007).

2.6.3 Community- Based Intervention (CBI)

With the ongoing societal transition, Non-Communicable Diseases (NCD) are becoming a major cause of morbidity, disability and mortality in Maldives. This societal transition is manifested by urbanization, physical inactivity, changes in diet and substance use including tobacco. This high prevalence of risk factors is evident from the NCD risk factor survey conducted in Maldives in 2004.

As NCDs constitute the burden of mortality and morbidity in the, it is important to address effectively their risk factors and determinants. Experience from other countries show that population-based approaches aimed at reducing the level of risk factors in population, are effective in preventing NCDs. Demonstration projects in Indonesia and India has shown substantial reductions in risk factors in the community and corresponding cost of morbidity/mortality averted. Also they have

shown that it is feasible with in medium resource settings. As the interventions are community centered it has the potential for positive externalities that can impact overall community health. Because the intervention levels are structured to be thematic it lends to ease of implementation and greater focus. In the context of Maldives NCDs. Demonstration projects was replicated including other risk areas other than NCD with in a community intervention perspective. This project was implemented in Villimale ward (2009). The project was initiated by HPA and WHO was funded to implement the project. Maldivian Nurses Association was involved in planning the activities of entire project and carrying out the initial phases of the project. The risk factors being targeted are obesity, physical inactivity, smoking, hypertension, pre-diabetes. Advertisement and announcement were given to general public of Villimale' regarding the door to door survey to identify potential participants for the project. Moreover it was discussed through media in "Morning talk show (Hendunu hendunaa in TVM)" and flyers were distributed to the residence of Villimale'.

To identify potential participants from the community door to door survey was conducted and 259 participants were identified. Training regarding health education on physical activity, smoking, diet and diet diary was given to the participants. Out of this 10 participant Training of Trainer (ToT) trained to monitor maintenance of diet diary and motivate healthy diet, 5 ToT trained for kitchen gardening, conducted a session with shopkeepers to discuss to increase availability and affordability of healthy foods. At the last phase the project it was terminated due budget constraints and ethical issues involved with implementation.

2.6.4 National AIDS program

In 2006, the National AIDS Commission (Sranacharoenpong) adopted the Situation Analysis on HIV in the Maldives, based on which a National Strategic Plan on HIV and AIDS (NSP) was developed and adopted by the NAC in 2007. The National AIDS Program (NAP) obtained resources from the Global Fund on AIDS, Tuberculosis and Malaria (GFATM) to support it in the implementation of the NSP.

So far, the Republic of the Maldives has seen a very low level of HIV infection, especially when compared to neighboring India and some other Asian countries. While the Maldives must be pleased with this situation, there is no time for complacency. According to the situation analysis conducted by HPA/MOHF with support from UNICEF and WHO, shows high levels of HIV vulnerability in the country. Especially in the capital but also in the outer islands, injecting drug use through which many HIV epidemics have started in the region is on the rise. An economy and society characterized by mobility and gender imbalances further fuels the potential for HIV to spread (Wijngaarden, 2006).

The first HIV-positive case in the Maldives was reported in 1919. Until the mid-2006, a cumulative total of 13 HIV-positive cases have been reported among Maldivians and 168 cases among expatriates. Out of the 13 HIV-infected, 11 developed AIDS; of these ten have died and one is currently on antiretroviral treatment. In Maldives, voluntary, informed and confidential HIV testing with written consent is recommended. Any positive HIV is notified to the CCHDC. The National AIDS Program in the CCHDC will ensure strict confidentiality of this data and will use it only for the purpose of program planning.

Program intervention includes;

- ANC attendees: all pregnant women are screened for HIV along with VDRL and hepatitis B.
- Self-referred clients seeking Voluntary Counseling and testing (VCT).
- Pre-employment HIV testing: international employers and expatriate workers and
- Closed settings/ institutions: entering to drug treatment centers.

A sexually Transmitted infection (STIs) is also a major health problem worldwide. The impact of these diseases is magnified by their potential to facilitate the spread of HIV. In Maldives STI surveillance STIs consists of universal syndrome STI case reporting, sentinel etiological STI case reporting and a cross-sectional community-based STI survey repeated every 3-5 years (Wijngaarden, 2006).

Prevention for youth out of school, UNFPA supports a 'Youth Health Café' located in the Youth Center in Male'. A key informant reported that several calls related to reproductive health and sexuality, including questions about HIV/AIDS, sexual relation, homosexuality and masturbation. Behavioral change communication responses for people with high-risk behavior are not in place, except the work conducted by Journey (NGO) for drug users (Wijngaarden, 2006).

Since 2007 the Maldives have managed to provide a number of interventions to prevent HIV for Injected Drug Users (IDUs); including aftercare services and outreach (IEC) via NGOs Journey, Society of Women Against Drugs (SWAD), Society for Health Education (SHE), a pilot project for oral substitution therapy

(OST) with methadone and a new detoxification center. UNICEF has, for the past three years, supported the NGO journey to run an aftercare service for ex-drug addicts. There are also two centers for rehabilitation run by the Government in Male' and Addu that provide residential care using the 'therapeutic community model'. Several activities related to injecting drug users are currently funded via the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) mechanism, which annually aims to reach 1,200 injecting drug users (including injecting drug users) with peer education; 77 peer educators had been trained as of March 2009, with 1,841 drug users (including IDU) being reached with IEC as of the end of February 20094. In line with the larger share of males versus females using drugs, most of the focus of work on injecting drug use is on male drug users; no specific approaches for female drug users or for the female partners of male drug users have yet been developed. The facts that prevention efforts for drug users have already started in the Maldives before the first (known) case of injecting drug-use related HIV infection has been recorded, and that here is a broad level of support for such interventions, are remarkable achievements (Program, 2009).

2. 6.5 Reproductive Health (RH) program

Reproductive health is a crucial part of overall health and is central to human development. Family Planning and Reproductive Health in Maldives services has been integrated in an incremental approach. Maldives had already achieved Millennium Development (MD) goals of universal primary education by 2008. Then goal of achieving IMR and MMR and is on track to achieve other MDSs except the goal on environment which was due to geographical distribution of the country. The

primary reason for achieving the success are due to provision of accessible to FP services in atoll population, awareness creation among higher risk pregnancies, regular antenatal and postnatal visits (minimum 4 visits), and deliveries attended by skilled personnel. According to Maldives Health Statistics (2009) indicates that 62% of deliveries were conducted by doctors, 25% by staff nurse, 8% by nurse and only around 4% by TBAs. As a result, Maldives experienced a rapid decline in fertility and mortality and its life expectancy at birth increase significantly. With a total fertility rate of 2.5% per women, IMR of 11/1000 live births, MMR of 57 per 100,000 live births and life expectancy at birth of 73 years in 2008 (MOHF, 2009).

However, Maldives also faces challenges in sustaining and merging the gains it has made. Maldives did not have an official FP program until 1984. Planned efforts to reduce infant, child and maternal mortality got some headway between, 1984-89 (Government of Maldives, 1994). During the period, the Government entered into a contract with UNFPA/UNDP/WHO to promote child spacing program to increase the intervals in successive births with the aim of improving maternal and child health. In the early days of the program implementation, distribution of contraceptives was limited and there were no policies and procedures for its promotion and distribution. In 1987, Maldives formulated a policy and procedure for procurement and distribution of contraceptives, provision of contraceptive services, counseling to potential acceptors and monitoring of both supplies and services. The methods selected by the government for child spacing included natural methods, hormonal and the barriers methods, for example, pills and IUDs. Male and female sterilization were permitted only on medical grounds and at the voluntary request of the couple. Given that all island level health posts were not equipped with trained medical personnel, it was also decided that contraceptive methods be distributed only at the atoll level health facility.

The protocol required that the contraceptives be given to couples only by medical doctors or Community Health Workers (CHWs). However, in 1990, realizing that limiting the availability of contraceptives at the atoll level facility hindered access to contraceptives to a large majority of island population, it was decided that contraceptives be made available at islands level also. For that purpose, 57 Family Health Workers were upgraded by providing them training on contraceptives and were positioned in more populated islands of the country (Maldives, 1994). This helped in wider awareness and gradual increase in the CPR in the country. HPA is responsible for planning, distribution and management of Family Planning services in the country. Several programs and campaign have been implemented and the details of these programs are not documented.

2.6.6 Mental health program

The importance of psychosocial support and mental well-being of the community was given after Tsunami disaster. A national plan for disaster preparedness has been developed which includes plan for the psychosocial well-being of affected communities. Suffering associated with physical illness, poverty, unemployment, malnutrition, low educational attainment, disability, trauma, migration, child abuse, and domestic violence, also contribute to the mental health burden in the Maldives. Ministry of Health and Family developed National Mental Health Policy (NMHP) defining the vision and strategy for the development of mental health and psychological wellbeing, and the consequent reduction of the burden of mental disorders, in the population of the Maldives (NMHP, 2007).

The Ministry of Health conducted a nation-wide survey to assess the magnitude of select mental and neurological disorders in the community in 2003 (Mental Health Survey, MOH, 2003). Data from this survey revealed that 1% of the respondents (about 3,000 people) displayed symptoms of psychotic disorder such as schizophrenia and affected both men and women equally. The highest proportion reporting psychotic symptoms were in the 15 – 19 age group and the second highest was in the 20 – 24 year group. The study also reported on the more common mental health problems. Nearly 5% suffer from anxiety and depression and nearly 4% reported somatic symptoms. More than twice as many women suffer from anxiety, depression and somatic disorder. It is estimated that over 10% of the population of the Maldives (over 30,000 people) suffer from common mental health problems. This survey also identified that as many as 6,000 people suffer from epilepsy.

2. 6.7 School health program

The school is where children spend a large proportion of their waking life, including the developmental years in which health risk behaviors are often adopted as lifetime habits (Lynagh, Schofield, & Sanson-Fisher, 1997). According to Maldives 2006 census indicates total population (298,968) out of 36% (106,770) of children were from age 5-19 years. Who will be attending pre-school, primary or secondary or higher secondary schools. Therefore more than one fourth of the total populations are under guidance of education institutions. Schools are recognized places of learning with existing structures and systems that provide opportunities for integration of new knowledge, and skills into the regular curriculum in a cost-effective way. Moreover school curriculum can significantly influence students' attitudes and behaviors.

The declaration of Alma Ata (WHO, 1987) and the Ottawa Charter (WHO, 1986) both recognized that education is just one strategy for improving children's health.

Furthermore argued that health behavior influences from the environment and community in which one lives.

The school health program was established in 1986 by the Ministry of Education (Simoes et al., 2007) in order to give an additional impetus to the health issues related to children. The concept of health promoting schools is put forward as expressed in the WHO's goal of "Health for All" and UNESCO's "Education for All". Promoting positive interaction between the school and the community is fundamental to the success and sustainability of healthy settings approach to address health and social concerns of young generation in the country. The school setting provides several advantages and opportunities for delivering content and skills on health and development issues among learners and teachers as well as parents. Community partnership creates awareness, a sense of collaboration, commitment and communal ownership. Table 3 identifies some of community- based health promotion programs that were discussed above.

Table 2.3 Project intervention strategies and nature of community participation.

Project Title	Level of interventions			Community board	Community involvement in issue selection	Community involvement in program development	Community involvement in program implementation	Community involvement in program evaluation
	Individual- level	**Group- level**	**Community- level**					
Nutrition								
Integrated Early Childhood Development, Positive Deviant/Hearth Program (March 09)	Educate mothers on nutrition; self-help materials; home visiting to educate mothers.	Health care provider training,, Island chief and Committees.,	Verandas had been constructed, Training provided, focal point from each atoll.	No	No	No	Yes	No
Healthy Villingil island project **(2002-2005)**	Awareness on storage of drinking water, smoking cessation, solid waste management and personal hygiene	Information to mothers , household assessment and leaflet distribution	Sustainable development to all component of PHC	Not discussed	Yea	Yes	Yes	Not discussed

Community Based Intervention (CBI) Villimale' Project. (2009)	Health education, yoga class, media messages, flyers, door to door survey to identify participants. Diet plan	NGOs and Clubs, Lay volunteers involved	Shopkeepers- "discount card", Mobile company (Dhiragu), Health Center. Free distribution of Yoga CD S.	Yes	No	No	Yes	No

CHAPTER THREE

THEORETICAL FRAMEWORK: COMMUNITY PARTICIPATION

3.1 INTRODUCTION

The purposes of this chapter are in two fold. First, an overview of types of participation in a community development program or initiatives. This thesis however, addresses the types of community participation introduced by Cohen and Uphoff (1977), in which comprise of developmental activity- decision making, implementation, benefits and evaluation. Second, factors that influence community participation in health promotion programs are examined. Murray (2004) classification of factors that influence community participation; which covers several numbers of levels, namely the participant, the community, the operational and the structural level are discussed in a detail manner in this section.

3.2 TYPES OF COMMUNITY PARTICIPATION

The types of participation in community organizations are numerous and may include those with definite circumstance or problem that they participate, clients or consumers of particular agency work or NGOs, field experts or consultants, a person who have authority, prestige, or power, representing other organization in the field, professional or practitioner, residence of specific geographic areas and a person who advocates for a change.

Literatures suggest that participation involves a large number of independent variables. The effects of participation are not very simple, unidirectional relationships in which the greater the participation, the more positive the effects. Rather, the effect of participation seems to be determined by the transactions of several dimensions. The conceptual framework of community participation in health promotion (Figure B, Chapter 1) summarizes the variables concerned with the background of participation, the participation itself, the factors that influence community participation and the types of participation.

There are several major groups that may be involved in community participation. They may include residents, helpers, and government officials. The involvement of each of these groups will vary with the aims and scope of the organization/program.

Residents are members of a community. They are the focus and core of a community organization. Within the residents' population, each resident may participate or a subset may participate either through self-selection or as representative of the larger group. The representatives may be elected by the residents or appointed by the professional helper or government agency to represent the community.

Helpers are various types of people who may have a helping role in the implementation or certain services. The type of role will be related to the backgrounds including professional with higher education degree or specialized skill training such as social worker, counselor, banker, doctor, and lawyers, local nonprofessionals

people (hired from the community who are paid for their services) and volunteers (e.g., student, girl guide and scouts).

Government officials are public personnel who may have a role in community organization according to the federal regulation or need basis for government services. For example, Neighborhood Housing Services is a private, no-profit services organization which aims to renovate housing in marginal neighborhoods. The roles of these different types of participations will be related to the types of participation.

3.2.1 Participation in Decision- making

Community Participation in decision-making has traditionally been considered as one of the pillars of democratic societies with benefits to be gained at the national, community, interpersonal and individual levels (Florin & Wandersman, 1990 cited in Butler, Rissel, and Khavarpour, 1999). In one's health care system, community participation is regarded as a mechanism, for involving disadvantaged groups in health service planning, implementation and evaluation and increasing awareness of health issues to make sure the services are available according to needs of the community (Butler et al., 1999; Deepak, 2001; Mitchell, 1999).

Involving people in identifying needs, planning and taking action can result in better and more creative decisions being made and more responsive and appropriate services being provided to the community (WHO, 2002). People working in local and health authorities and other agencies, go through many challenges to move from active to passive process of participation that focus on the levels of providing information and consultation, to more active levels and genuine involvement process

which entail advising, joint planning and delegating authority. In order to achieve this some, organizational changes may need to occur to integrate decision-making practices. For example, to ensure resources, coordination, structures, process and cultures within the organization truly support the effective development of tools and techniques for community participation (WHO, 2002). While focusing attention on decision- making, it is useful to see this as a process rather than just a single act at a point in time, and also think it should be recognized as having different degrees. It is important to make a characteristic between direct and indirect participation in decision-making, though it relays to the 'how' variables of empowerment.

Cohen and Uphoff (1977) believed that *"the most direct and empowered participation in decision-making is when a person or group has the formal authority to make binding decisions that will be enforced with the resources of the state if necessary"* (pp. 31). They further mentioned that individual authority to make their own decision that gives more power than shared authority. Less direct and less empowered participation occurs with influence, either because a person or group is allowed to make their opinion or interests known to decision-makers through consultation or lobbying, either one can provide information or suggestion as input to person with authority (Cohen & Uphoff, 1977).

Community involvement is seen as 'a range of activities which provide communities of interest with opportunities to practice in the development and evaluation of health plans (Eagar, Garrett, & Lin, 2001; Murray, 2004). Community participation can go much further into the field of decision-making, even if the initiative comes from outside. For example, Arole's program at Jamkhed in India (Arole,1972,1975 cited in Midgley, 1986) . To improve health care around the

villages in Jamkhed, Arole consulted local community before project design. The following key questions were identified - how did they perceive their health problem? and, what were there priority needs? They were interested to find villagers' main concern was with water and food supplies, so they started with these, and through mobilized community into an active program which later extended to medical care (Midgley, 1986).

According to Chu (1994), types of community participation should be matched to the agenda setting and type of community involved; as well as which also influences the strategies used. For example when the agenda is to be joint responsibility of the community, health professional and government, the type of community participation involve is 'community representation', and strategies of collaboration are required (Chu, 1994). Eagar et al., (2001) outline that type of community involvement is dependent on the objectives of process. Also effective participation is dependent on clear definitions of the objectives of the community participation and of the roles of the health planner/service and the community, 'transparent process' and 'constructive activities'.

3.2.2 Participation in Implementation

In analyzing participation in implementation, it finds certain similarity to that for participation in decision-making. Implementation is a "*specified set of activities designed to put into practice an activity or program of known dimensions'*. (Fixsen, Mental, & Florida, 2005) (Wandersman, 2009 pp.5).

There are certain kinds of initial activities needed for implementation. It includes contribution of various resources such as to create infrastructure to build up other assets (knowledge and expertise) for the operation of a project. According to Cohen & Uphoff (1977) implementors mostly focuses on resource contributions, participation in administration and coordination and recruitment in program. The details are follows:

1) Resource mobilization

The most important aspects of participation in implementation are to recognize the approach it occurs among group and individual basis. Mainly what we wanted to find is who contributes their inputs to conduct or implement the project and how these contributions are made. Resource contribution is certainly important even fairly simple and straightforward (Cohen & Uphoff, 1977). Communities have wealth of unused resources and energy that can be harnessed and mobilize through community. It can be used by various techniques that people can engage and train and employ where appropriate to reduce the cost of providing services. Most implementation failure occurs when the theory utilized fail to operationalize in the real practice. Reason for such failure may include lack of resources, inexperienced personnel, and insufficient training (Wandersman, 2009). Resource contribution can be sub-categorized based on project/ program, contribution of material inputs and provision of information.

Community contribution for some projects such as rural works in mosque, health centers, irrigation and drainage system building or schools may require labor from local people. However it is important to know how much labor is provided and contributes their energy in the implementation. This is an area where community

members likely to participate indirectly without prior knowledge that they may not get any benefits from it (Cohen & Uphoff, 1977). The objectives are defined according to national or regional levels. The level or scope of the activities must be considered when defining the project objectives. According to Bamberger (1986) the three district kinds of local participation includes:

1. Beneficiary involvement in the planning and implementation of externally initiated projects or community participation,
2. External help to strengthen or create local organizations, but without reference to a particular, or local organizational development, and
3. Spontaneous activities of local organizations that have not resulted from outside assistance or ingenious local participation.

The first two are externally promoted participatory approaches used by government, donors, or NGOs, while the third is the kind of social organization that has evolved independently of (or despite) outside interventions. At a community level, there is a separation of community participation into two approaches: the community development movement and community involvement through co sanitization (Bamberger, 1986).

Many projects are planned without local inputs of funds, land or other physical resources. In some projects like building school or health center materials like timber or building stone are provided by rural communities; thus it is not included in any cost accounting. Therefore, participation indicators should be sensitive to the source of such inputs (Cohen & Uphoff., 1977). The same concern holds true for cash contributions which can be squeezed from local people in a manner inconsistent with the typical notion of what participation means.

Planning, implementation and evaluation of any development project require a great deal of information from youth, local leaders and elderly people in the community. Providing information is not just an object that can give from one person to other and is not easily dominated. It is often not considered as an 'input' and it cannot be considered as participation in implantation.

The actual importance of these three aspects of participation implementation will depend on the nature of the project. For example, a land reform project in a particular county may require only ownership and boundary information from local people and leaders. In rural works projects are likely to require large inputs of labor, contributions of land, and timber or stone may also be needed. In contrast local leaders provide community education in health development project like tropical disease control, immunization campaigns, family health and water supply sanitation. Methodologies for re-educating and re-orienting community leaders towards community involvement are an effective way to change their attitudes and resistance towards community participation. Community involvement in health development is unique in that it composes the only distinctive sectoral approach to promoting participation in project activities.

2) Administration and Coordination

The involvement of local people in administration and coordination can occur in various ways, the most commonly a member from project-related committees or in a particular positioned person in project. Recruit local people for the project staff as paraprofessionals, skilled workers or manual laborers. This serves to bring local residents more active role in channeling the local people and the project staff for

effective communication of ideas (Cohen & Uphoff, 1977). Community participation and inter-sectoral collaboration are core concepts in the present view on health promotion (WHO, 1986). Community participation is required to design programs that address the social determinants of health, and inter-sectoral collaboration has great potential for community action for health.

Effectively changing socioeconomic-political structures in the environment requires mobilization of many system factors, multi-sectoral in origin. These factors are important to adopt and maintenance of new health behavior of an individual social and physical environment (Guldan, 1996). In addition to mobilize the public sectors, community health promotion program organizers should also activate members of the private and commercial sectors.

Health and family welfare program cannot be implemented in isolation of other development programs. The activities of other sectors directly as well as indirectly influence health development. Therefore, primary health care has to become a part of the overall socio-economic development process. It demands coordinated and simultaneous efforts being made in such sectors as agriculture, irrigation, animal husbandry, education, social and development, cooperatives, industries and voluntary organization, etc.

Lessons from Project LEAN, a nationwide social marketing campaign to take the message of dietary fat reduction to the US public in 1989 to 1992, are valuable. This initiative was to be the first project that provides support and assistance of a broad coalition of 34 organization and agencies representing health and other professionals, voluntary associations, government agencies, and food associations.

The lessons obtained from this project includes partnership with other organization is an essential ingredient for success, collaboration with the private sector expands the campaign, building up of local programs strengthens and sustain the campaign, national campaign strategies and materials have important benefits for state and community programs and recognition of differing approaches to the development of health messages on the part of public health and advertising professionals can enhance collaboration (Samuels, 1993).

3) Enlistment in Programs

The third aspects of participation in implementation concerns the willingness of persons, often thought of as a member of the target population, to respond positively to the program offerings to the project. For example, in an animal improvement program, having one's herd inoculated against diseases like brucellosis. There might seem to be some ambiguity between such participation in implementation, and some participate and others in benefits. This type of enlistment in programs does not assure benefits, and that benefits in any case should be assessed on a different scale than that of program services received (Cohen & Uphoff, 1977).

3.2.3 Participation in Benefit sharing

Participation in benefits can be classified and analyzed in many ways. One can measure, if possible, the total amount of certain benefits, through persuaded that the distribution of benefits and their quality and quantity of benefit produced. Benefits that accumulate to individuals can be distinguished from those getting to the group or communities. In terms of economists "private goods" verses "public goods" are mostly dealt. Material benefits are such as increased income; whereas social benefits

are such as education, health and other services. A further sets of benefits called personal benefits' for better designation, which is difficult to measure, but very important for individual, self-esteem, political power and general recognition in the community to begin his/her destiny. Measurement types will depend on the nature of the project and kind of benefits it produces and the welfare goals for which it was formulated (Cohen & Uphoff, 1977).

Material benefits refer to tangible rewards which can be translated into monetary value include wages, increased poverty value and information. Material benefits can be analyzed in terms of compensation or income, where it can be claimed or represents a flow of material benefits. Income will most often be measured in terms of monetary income, but it can include goods and services received from a project.

An asset is also types of benefits that can be getting from a program or project. Assets represent a stock of material resources capable of producing an income flow over time. Example would be purchase of additional land, investment in on-farm production such as well, fences, implants livestock, trees, small workshop for crafts or other investment activities in rural capital market. Assets are commonly harder to ascertain than income because of their complexity and frequent concealment (Cohen & Uphoff, 1977).

Purposive/ social benefits are derived from supra-personal goals of the organization and include bettering the community, doing one's civic duty, and fulfilling the sense of responsibility. Most of the research suggests that active participants in voluntary organizations (e.g., leaders) are primarily motivated by purposive benefits such as working toward the improvement of the neighborhood or

community and desiring to make a contribution (Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Rich, 1980; Wellstone, 2003). In addition, it can be considered as the amount and distributions of benefits related to social overhead investments, usually characterized as services or facilities where provided by a project. There are quite variety of benefits that can be included under this heading; education are considered at the special place, it occupies in increasing productivity, welfare and power for the poor majority. These provide a person with information that can be considered as a great asset generally give way income, social status and sometimes political power. Other services and facilities include the facilities that provide on a project to the community to improve the quality of life. Example, health services, water supply, roads, transportation or better housing (Cohen & Uphoff, 1977).

Personal / Solidary benefit are largely derived from social interactions and include socializing, status, group identification, and recognition. The most active participants also appear to be motivated by solidary benefits such as friendship and socialization, and ego gratification (Perlman, 1976; Rich, 1980). These are things which are usually greatly desired though often not attained on an individual basis. They are attained on groups or sectors basis and are acquire social and political power through the operation of a project. Among the several possible project, three kids of benefits can be generated; namely self-esteem, political power and sense of efficacy.

Self-estem comes when an individual improves his/her status in accordance to whatever criteria to worthiness prevail in the community. It probably has to be measured in each case by locally determined standards, such as land ownership,

literacy, possession of belongings like wristwatch or bicycle. This benefit is frequently difficult to assess.

Political power is more difficult to determine than self-esteem, even though it affects how able a person is to avail he/she to the other benefits discussed here. It is mostly related to the enchantment of a person's ability to influence authoritative decisions, through electoral process, in official administrative channels, or through private negotiation with officials.

Some studies claims that centralized bureaucratizes and ministries tend to inhibit project effectiveness, although evidence on this is generally very weak. For instance, in review of community managed USAID projects hold that organizations that implement decentralized and nonauthoritarian for Community Based Development (CBD) / Community Driven Development (CDD) are found to be effective. White (1996) noted that power relations in the wider society within which participation occurs have to be taken into consideration before it is successful. In some cases, to be really successful the state may have to support broad-based redistributions in power for CBD/CDD. This recommends that CBD/CDD must be seen as part of shift towards a broad participatory and decentralized system of governance. However, it is unclear how to achieve this due to conflicts between local political interest and community organization. Thomas-Slayter (1994) noted that once the community gets strengthened they might pose a challenge for local political interests leading to competitive relations between the state and community organizations and withdrawal of state support. In such condition community support is very fragile in creating the right kind of "facilitating environment" for CBD/CDD (Mansuri & Rao, 2003).

An increase in the individual's recognition that he/she can play a role in the development process and that participation is an effective approach to improve well-being and security can be the end result of any development project. As this is towards attitudinal, as anything else, it can be measured through surveys getting at persons' sense of efficacy and confidence that they can affect their future.

3.2.4 Participation in Evaluation

The reason for community participation in health promotion research and interventions has been clearly articulated. First, communities shape behavior through a system of exchange and influence, second, communities themselves may be engaged or mobilized to act as a change agents to achieve social and behavioral outcomes. Finally, early and sustained participation by community members and leaders is needed to realize community ownership and sustain programs. The general experience of practioners from participatory evaluation suggest that when the researchers and organizers involve community member in their efforts, health outcomes are better realized and maintenance of programs enhanced (Bracht, 1999; Fawcett et al., 1997). Involving participation at each stage of evaluation generates innovative ways to measure process impact and outcome even though maintaining participations' enthusiasm and interest is challenging (Springett, 2003 cited in Wandersman, 2009).

As with participation in implementation, one should not look only who is participate, but also need to look into the empowerment input, as well as how formal and informal participation should be analyzed. According to Cohen and Uphoff (1977), three kinds of evaluation can be found and different perception can exist

about what is being evaluated and quite different standard used to measure it. Perceptions, preferences and expectations of the project by local residence need to be sought out and compared with those of donors, project managers and external evaluators.

a) Project-centered Evaluation

If there is any formal review process, first should know who participates in it and who continuously participate and with how much power on his/her suggestions. Most local residents do not have formal role in the review process or any formal power to get action on suggestions. According to Rifkin (2009), community in evaluation cannot be measured, because in many programs only lip service is given to monitoring and evaluation. Also, it can come through either informal project-centered consultation or political activity (Cohen & Uphoff., 1977)..

b) Political activities

Whatever local efforts and involvement in project evaluation, most probably there will be a certain amount of influence by political activities. Mostly the suggestions and complaints are channeled through locally elected officials such as parliament member. Participation in elections at local, regional or national level can provide some opportunity for local evaluations to be fed into policy process, through such inputs are likely to evaluate accomplishment of project rather gross, or simply satisfaction or dissatisfaction (Cohen & Uphoff., 1977).

c) Public Opinion Efforts

In participation in evaluation activities that aim at influencing public opinion there would be less direct with the desired ramification for continuation or possible modification of a project. Mostly media plays the role, for example, through a "letter to the editor," to promote favorable or unfavorable opinion of the project or suggestion for improvement. This is a very diffuse approach but it might be regarded as one possible ways of participation in evaluation than not participation at all (Cohen & Uphoff, 1977).

Evaluation can be accomplished as a social science activity directed at collecting, analyzing, interpreting, and communicating information about the workings and effectiveness of social programs (Wandersman, 2009).

Evaluation are conducted for a variety of practical reasons: to aid in decisions whether programs should be continued, improved, expanded or shortened; to assess the utility of new programs or initiatives; to increase the effectiveness of program management and administration; and to satisfy the program accountability requirements of program sponsors (Wandersman, 2009).

3.3 FACTORS THAT INFLUENCE COMMUNITY PARTICIPATION

The history of performance and possibilities depends on the physical and environment settings and the social system and distribution of power to local community. The purpose of this section is to analyze those factors in the task environment with a view from different developed and developing countries. Most of the mission chiefs and

project directors probably come to feel that the country they are working in and its development problems are unique in nature. When it comes to real environment, like anybody else, unless they have long varied experience in that country, they must draw on knowledge and models developed from somewhere else. The application of the analytical framework presented in chapter one Figure B in which was adapted from Murray's (2004)barriers to community participation in health promotion.

Community participation is a complex and fragile process. While the measures outlined below can substantially increase the probability of success for community health project utilizing a participatory approach, there are many factors that operate to diminish this success. The most basic are the nature of communities (Zakus & Lysack, 1998), which include factors such as geography, socioeconomic status, gender, occupational status and family income; as well as the structural, operational and community factors.

3.3.1 Social nature of community

(a) Geography

The likelihood of participation affects community members by their geographic location. Geography is associated with the life of voluntarism, since an increased number occurs in urban areas, most probably due to higher population density (Cohen, 1985). However, there is also evidence that the rural communities have higher number of voluntary associations if rapid urbanization occurring (Sills 1968, as cited in Boyce, 1997).

(b) Socioeconomic status

Pateman (1976) believes that the greatest predictor of participation is socioeconomic status; especially income, occupation and education. According to Sills (1968, as cited in Boyce, 1997) members among the voluntary association is a type of social interaction, that people who are deprived of a broad range of social interaction opportunities (e.g., rural, poor and elderly) due to social, geographical physical and economical barriers are less likely to participate. According to Guijt and Shah (1998, as cited in Morgan, 2001) many participatory development initiatives do not deal well with the complexity of community differences, including age, economic, religious, caste, ethnic, and particular gender. Further they argue, due to program planners the community relationships can isolate or even harm some individuals and groups. Therefore all the development projects should consider the impact that they have on reinforcing or undermining existing identities within stratified socioeconomic contexts.

Widmer, (1989) interprets several explanations for the low rate of participation in individuals of lower socioeconomic status. The needs approach suggests that the poor have unmet substance level needs which preoccupy their attention, while well off status persons have more resources and are free to seek self-esteem and selffulfillment through voluntary participation. In fact, poorer people tend to expect some sort of incentives or provide free consultation services or medication (Rifkin, 1986). Widmer notes that it is easy to demonstrate that individuals participate in response to incentives, but considerably more difficult to demonstrate why people do not participate.

c) Gender

A gender disproportion (female more than males) has been reported frequently for participation in volunteer activities. Lower workforce participation of women and thus their availability, is often cited as a structural reason. However, this claim predates the increase in women's employment rates and is thus unconvincing (Wells, DePue, Buehler, Lasater, & Carleton, 1990).

3.3.2 Structural factors

Human actions that are associated with social environment. Values, attitudes, activities, and relationships are greatly influenced by, factors in the organizations of society (Boyce, 2001). Structure is understood as a recursively organized system of rules and resources which are central to routine life. In a structural perspective, it is very important to highlight the various purposes of participation, especially empowerment, since the perspective focuses on resource utilization, organizational structures and power (Giddens, 1984).

The structural factors affecting community participation can be classified into three dimensions – organizational, socio-cultural and political-legal-economic dimensions. Any, or all, of these broad dimensions may affect participation in health promoting setting.

(a) Organizational dimension

The organizational dimension of structure includes administrative works, resources, mandates, and attitudes of planners that shape decision making roles. The major organizational structure is the governance of the group, for example direction by the professionals through service agency.

There are two elements of organizational structure (membership size formalization and functional specialization) which have been noted to affect participation strategies. According to Olson's (1968 as cited in Alfano & Marwell, 1980) theory articulated by using economists, that the development of a large membership base access public goods through a 'free-rider effect'. Since most of the participants are expected to behave rationally, few will make contributions, and the good will not be provided.

Secondly, the functional specialization and institutionalization decreases the number of participants. In contrast, (Oakley, 1991) it is necessary to maintain participant's interest with clear roles for members to function. He further mentioned that formalization of group structure is very important to manage organizational growth which is achieved through increased member involvement. These finding illustrate the reciprocal nature of structure and participation. As participation increases, structures are developed to manage it and subsequently may prevent further growth. Alternatively, structures may be introduced too early in the process, which then inhibits initial activity. In either case, the precise form of the organization and its fit to the participants' needs and context may be crucial. (Boyce, 1997)

(b) Socio-cultural dimension

The socio-cultural dimension of structure includes social relationships that have developed historically, such as economic dependency and marginalization of minority groups and women. Moreover it can be termed as 'structure of lifestyle' in disadvantaged group, for example lack of economic resources, social isolation of disabled persons and physical inaccessibility of services and restricted movement of women and norms of male right.

Communities are very heterogeneous in nature, not only in their demographic composition, but also with respect of their interest and concerns. This diversity has a profound impact upon every step of the community participation process (Zakus & Lysack, 1998).

First, verifying who is a genuine representative of the community is far from clear-cut. Who are willing to donate their expertise, time and energy are not always easy to find (Alford, 1975). When this is the reason the dominant majority dictates the health agenda with less input from those considered to be the target of community-based health interventions. (Tachamov, 1986, as cited in Zakus & Lysack, 1998).

A different set of problem arises when the minority group itself prefers professional handling the health issues and they kept themselves not engage actively in the participatory process. When they are familiarized of being by passed and then ignored (Berman, Gwatkin, & Burger, 1987). This type of avoidance has been observed in the international disability context where rural villagers refused to participate in community-based rehabilitation (CBR) projects (Lysack, 1996, as cited in Zakus & Lysack, 1998). Research in Indonesia has shown that villagers are suspicious of community participation because they fear that the limited professional medical services they do have will replaced with something less. In Central Java, for example this concern has taken in two specific forms; some thought that participation in CBR provides an excuse for local government to eliminate the local health centers and reduce funding and others fear that any health gains accomplished via a community approach work against their larger purpose of petitioning the national government to increase both the amount and quality of government health care (Zakus & Lysack, 1998).

A second major problem is that communities are rarely, if ever a homogeneous whole. Many segments of the population can be isolated from political and social organizations, including the organizational structures of the health system. Hence, some groups within the so-called community will be unaware of opportunities for participation or find it hard to break into the system (Zakus & Lysack, 1998).

c) Political-legal-economic dimensions

Lastly, the political – legal – economic dimension of structure includes ideology, political entitles, legislation, bureaucracies and economic system that facilitate participation. This might be difficult to observe due to less importance given to disadvantaged persons in health promotion projects, not an observable dimension and the structure may be operating through organizational networks, roles and resources may be highly influenced by existing political principles and bureaucratic biases (Boyce, 2001).

The third problem relating to the nature of community resolves around the matter of representation itself. Who has right to speak for 'the community'? Who are legitimate community representatives? As it pertains to the process of community participation, representation becomes an issue when community health workers need to be selected and when community leaders need to be identified. In both example, individual prejudices, stereotypes, and social and political ideologies can create problems that seriously impair the ability to organize in pursuit of better health (Rifkin, 1983). For example, in many parts of South East Asia, where the wives of prominent local businessmen and government officials often serves as CBR cades,

real conflicts between the local agenda of disabled people and the policies of government arisen (Rifkin, 1983).

Structural obstacles also include the tensions which can arise between the mechanisms promoted locally by the State in order to achieve centrally planned objectives and the spontaneous, informal development efforts at grass-roots level within development projects whose participants are excluded from these mechanisms (Oakley, 1991). The existing legal system within most country frustrates efforts to promote participation. This may be due to two ways. One way, the legal system often has an inherent bias both in the way it is conducted and in the way in which it maintains the status quo. The other way, many rural people are unaware of their legal rights and of the services legally available to them. Most of the legal systems share information to rural people, who thus remain largely ignorant and excluded from the effects of laws which are supposed to benefit them. In other instances the legal system acts as a direct constraint on the rural people's involvement in development activities.

3.3.3 Operational factors

(a) Resources for community participation

The ability of the community to mobilize resources both from within and the ability to negotiate resources from beyond itself is an indication of a high degree of skill and organization (Goodman et al., 1998). The experience of many programs has identified the ability of community groups to mobilize or gain access to resources as an important factor toward empowerment (Fawcett et al., 1995; Roberts, 1997). Rifkin (1990) concluded that there was little evidence to prove that resource mobilization alone will make community groups more empowered. The community must also have

a purpose and the skills and capacities necessary to achieve this purpose, as well as the required resources.

At the organizational level, it is self- evident that community agencies utilize financial resources to facilitate community participation through expenditures on staffing, rent, meeting coats, etc (Butterfoss, Goodman, & Wandersman, 1993). Limitations on agency funding have been shown adversely affect level of participation. In addition, funding conditions and short term grants create organizational uncertainty, diversion of purpose, staff turnover, and increasing bureaucratization, all of which affect recruitment negatively (Shragge, 1990).

At the individual level, studies of participatory programs directed to the general community have shown that 'solitary' incentives (group identification status) and 'purposive' incentives (achievement of goals) are more important than 'material' (monetary) incentives for participations (Butterfoss et al., 1993). There is evidence to suggest that where participation is linked to material benefits, readily available and dependable incentives are important in sustaining the participation (Oakley, 1991). According to Buijs (1979, cited in Oakley, 1991) states that the easiest way to persuade people to participate is by "offering money or material benefits".

(b) Health System Governance

Health is influenced by varieties of factors which cut across all aspects of life, including society, culture, spirituality and economics. Improvement in health status and quality of life are interlinked. To achieve improved health and quality of life, the concept and principles of health promotion are increasingly being adopted by countries around the world.

Governance is the exercise of political, economic and administrative authority in the management of a country's affairs at all levels. It includes complex mechanisms, process and institutions, through which citizens and groups articulate their interest, mediate their differences and exercise their legal rights and obligations. The principles of good governance are legitimacy and voice, direction, performance, accountability and fairness (UNDP, 1997 cited in WHO, 2007). Good governance is very much about good management.

The ultimate objectives of a well performing health sector are improved and more equitable health status, reducing financial risk, especially poor, greater patient and public satisfaction. Health System governance concerns the actions and means adopted by society to organize itself in the promotion and protection of the health of its population (Dodgson, Lee, & Drager, 2002). To achieve a system of good health governance, a number of areas need to be addressed. These includes improving the policy process through ensuring policy- making based on evidence and open, informed, fair and equitable involvement of key stakeholders. Community participation can be enhanced through increasing local information and leadership, and institutional incentives and openness of officials (WHO, 2007).

Information regarding product evaluation, equity and quality of health services remains internal to ministries or specific institution. Transparent criteria on how public sector resources are allocated to the various levels of health such as primary, secondary or tertiary; or promotive, preventive and curative care are lacking in most countries. Many ministries of health maintain a website where some information is available, but these sites are not regularly updated (WHO, country report, 2007).

(c)Political Will

The use of regulatory policies, procedures, and laws to protect the health of the community is one of the characteristics of public health. It has a dramatic effects on the health of the population (McLeroy, Bibeau, Steckler, & Glanz, 1988). For example the existing level of centralization or decentralization in government establishes definite limitation or opportunity for local participation according to the level of decentralization that exists as a general rule in that political system.

Policy development, public advocacy, and policy analysis have important implications for communities. Berger and Neuhaus (1977) argues that public policies should design to strengthen, rather than weaken the voluntary association which serves as mediating structures.

According to Milio (1986, as cited in McLeroy et al., 1988) the task for public policy becomes one of creating environments all of which have biotic and constructed socioeconomic and interpersonal aspects. Moreover she believes that mediating structures in a community serves as connections between individuals and the larger social environment. Mediating structure serves as appoint of access to and influence on, the policy making process (McLeroy et al., 1988).

(d) Coordination and Collaboration with other organization

Links with other people and organizations include partnerships, coalitions, and health alliances formed to address community-health needs (Laverack & Wallerstein, 2001). Coordination occurs as organizations attempt to attain their goals or carry out their programs and probably at the same time that they are trying to cope with their environment. Coordination can be formalized, as in computerized transmittal of routine information, or informal, as when a member of one organization telephones to

check some information with other organization. Connections with others reveal the ability to develop relationships outside the community, often based on mutual interests. The development of partnership is an important step towards empowerment and can also lead to an improvement in health outcomes by pooling limited resources and by taking collective action. From a comparison of healthy city projects in the UK and The Netherlands, found that intersectional collaboration tend to equate with interpersonal rather than inter-organizational collaboration (Harpham, Burton, & Blue, 2001).

In the present research, coordination is studied as it occurs under different bases of interaction. According to Aldrich (1976, cited in Hall, Clark, Giordano, Johnson, & Van Roekel, 1977) not enough attention has been giving to different bases of interaction as they affect the quality of interactions among organizations. Their observation in the set of organizations studies and consideration of the literature led us to develop a set of hypothesis about bases of interaction and coordination (Hall et al., 1977).

(e) Information and communication

Unimpeded internal communication among the membership and staff may be the most essential ingredient for enhancing the climate of participation. The quality of communication has been positively related to coordination and negatively related to conflict (Hall et al., 1977). Open communication helps the group focus on a common purpose, increases trust and sharing of resources, provides information about other programs and allows members to express and resolve uncertainties about planned activities (Feighery & Rogers, 1995). The participatory process is to initiate and support community through provision of information, resources and skills training

(Healey, 1998). Improving health literacy in a population involves more than the transmission of health information, although that remains a fundamental task. Helping people to develop confidence to act on that knowledge and ability to work with and support others will best be achieved through more personal forms of communication and through community-based educational research (Elhauge, 1991).

Social capital plays an important role in relations among persons and organization that facilitate cooperation and collaboration in communities (Gittell & Vidal, 1998). Studies suggest that such communal activity and community sharing translates into better community participation (Ratzan, 2001). Evidence suggests that communities with less social capital have lower educational performance.

(f) Political and bureaucratic support

Mostly, bureaucratic and political systems, and their funding process, restrict the possibility of community innovation and participation (Mega, 1999). If community-based groups are to operate effectively, as part of a participatory local sustainable community process, there must be recognition of the services and benefits they provide to the community through ongoing political and bureaucratic support for their effort. To a great extent of this innovation and effort is voluntary and needs to be acknowledged and appropriately valued by the public sector as it provides an important economic contribution to the society (Organization for Economic Co-opertaion and Development 2000). Moreover, United Nations Volunteers (1999) highlighted that these efforts have a second and equally important benefit in that 'volunteering helps in the building of strong and cohesive communities'.

While the public sector in a democracy is intended to support local community targets, needs and issues, Saul (1997) in exploratory research suggest that this support

is often lacking or completely missing. For example, key informant interview suggest that current participatory process are inadequate, suggesting that most people actually feel pretty powerless about the whole political process (community facilitator), the resources and he energy and support and the structures aren't there (environmentalist) and, there has been no chance for public input… we've been totally denied our rights to have anything to say (community activist). These comments suggest current status that, as a starting point, local governments will need to reform their organizational commitment to participate local community (Carson, 2001).

(g) Administrative Support

Centralized government encourage centralized administrative structure which, by their nature, are major obstacles to people's participation. These administrative structures retain control over decision-making, resource allocation and the information and knowledge which rural people will require if they are to play an effective part in development activities (Oakley, 1991).

Government planners are regularly professional group who do not compromise their practice to the local level. Most of the rural development planning takes place in ministries at central and rarely this takes place at local level (Oakley, 1991). The degree of member participation depends on the active roles that they spent in the organization.

3.3.4 Community factors

Community refers to mediating structures, or face- to-face primary groups to which individuals belong. This can be viewed as of community embraces families, personal friendship networks and neighborhoods. Second, community can be thought of as the

relationships between organizations and groups within a given area. Third, in terms of defined geographical and political terms, such that a community refers to a population which is conterminous with a political entity, and is characterized by one or more power structures (McLeroy et al., 1988). The importance of these varying definitions of community is that they have different implications for the development and implementation of health promotion intervention.

Community as mediator includes family, informal social networks, voluntary associations, and neighborhoods, which may be important sources of social resources and social identity. These structures are repositories and important influences on the larger communities' norms and values, individuals' beliefs and attitudes and variety of health related behaviors. Health promotion programs may use these mediating structures to deliver services within communities, or may attempt to develop or strengthen existing neighborhood organizations.

Community as relationship among organizations is referring to the relationship among organizations within a political or geographical region. In many communities, the total resources available for health and human services are limited. This may be due to rural areas and small towns and in some countries with facing fiscal crises. Many communities compete with each other for limited resources, including donations and volunteer time which may result in inefficient use of resources.

Community as a power plays a critical role in defining community health problems and allocating resources including funding, technical assistance, staffing, materials and official and unofficial approvals for their advancement. The most important roles are that they control the public agenda. Hence there might have political and economic implication due to powerful segments of the community. Health planners often overlook the political and economic implications of their

proposed interventions. Which leads to programmatic failure, as important community powers structures actively or passively block the effectiveness of the program implementation due to potential threats to political and economic interest (McLeroy et al., 1988).

(a) Stakeholder commitment to community health

The participants, or stakeholders, in the organization are individuals or groups "who can affect or are affected by the achievement of the firms objectives" (Freeman, 2010). Stakeholders can express interest and influence the practices of an organization through direct pressure or by conveying information. In terms of community involvement activities may be interpreted in a number of ways. In the perspectives of instrumental stakeholders, it may be that some community involvement activities arise as a direct response to pressures from specific company (Berman, Wicks, Kotha, & Jones, 1999). These may be designed to apply solely to the particular events or preferences of the specific stakeholders involved. However, other possibilities like when company-specific stakeholder pressures arise, the nature of corporate responses to them may result of other stakeholders (Brammer & Millington, 2003).

Participatory assessment motivates the stakeholders to identify and build on their strengths and to minimize their weakness through their own efforts, based on their own knowledge and experiences. Rifkin (1990) points out those stakeholders are more likely to be committed if they have a sense of ownership in regard to the problems and solutions being addressed by the program. Moreover she mentioned that programs that do not address community concerns and that do not allow the stakeholders to participate in the process of assessment have shown not to achieve their purpose. Capacity can therefore be built into the design of methodology by allowing both a participatory and empowering approach.

Participation allows the different stakeholders of a program to express their views, share their experiences and to challenge existing knowledge claims and patterns. Different stakeholders may have different opinions and a methodology should allow individuals to participate in an equal relationship between all parties (Arnstein, 1969). The technique should promote the involvement of each member through their discussion and interaction with the other participants.

(b)Trust

The most frequently mentioned challenges to conducting effective community-based research are lack of perceived lack of respect between members and researcher (Dockery, 1996; Hatch, Moss, Saran, & Presley-Cantrell, 1993; Levine et al., 1992). A long history of research with no direct benefit and no feedback from the community has contributed to this trust which develops it on anger and suspicion. Trust is most commonly under-stood to refer to confidence or belief in individuals or institutions under conditions of risk; where out-comes or intentions are fully known, trust need not come into play (Secor & O'Loughlin, 2005). Community members may hesitate to get involved even if researchers are proposed. Once trust is established, it cannot be taken for granted and it must be proven to the community (Treleaven, 1994).

© *Leadership*

Leadership is the process of persuasion or example by means of which an individual (or leadership team) induces a group to peruse objectives held by the leader or shared by his/her followers (Roussos & Fawcett, 2000). In most of the reviewed literature, leadership was the most often reported internal or organizational factor for a partnership‘s effectiveness in creating community and system change. In grassroots initiatives, the leader is often the person who organizes and mobilizes community

members around a common concern (Zapka et al., 1992). Loss of leadership may be adversely associated with rates of community change (Fawcett et al., 1997); in the other hand, on the arrival of stronger leadership may increase rates of environmental changes (Lewis et al., 1999).

Leadership is a central concern for those interested in community organization and development. Goodman et al., (1998)asserted that both participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Leaders play an important role in the development of small groups and community organizations, which are part of the continuum of community empowerment. Gruber and Tricket (1987) argue that participation without a formal leader who takes responsibility for getting things done, dealing with conflict and providing a direction for the group, often results in disorganization. In a context of a program, leaders are mostly participating as an external force because they are seen to have the necessary management skills and expertise. In most communities, leaders are historically and culturally determined and programs, which ignore this, have little chance of success of being accepted or utilized by primary stakeholders (Rifkin, 1990).

According to Constantino-David (1995, cited in Laverack, 2001) discussed in the experiences of community development in the Philippines and the success of utilizing local leaders. Competent leaders were developed by NGOs amongst poor people who offered a more insightful understanding of the community problems and culture. However, it was found that a lack of skills training and previous management experience of these people created limitations in their role as leaders. Leadership style and skills can therefore influence the way in which groups and communities develop and in turn this can influence empowerment (Laverack, 2001).

(d) Culture of participation

Anthropological research into community participation in health has emphasized the important of context. Muller (1991) asserts that participation is an ambiguous concept because it cannot be defined outside of social context. "Culture" emphasizes the importance of understanding what participation means within a particular setting, formal political system and institutional structure. Oakley et al. (1999) stated that culture is not an obstacle to community participation, but it must be understood before participation is externally imposed. Furthermore, culture has been reviewed by Stone (1992) in the participation literature. Stone found that most planners and health project personnel saw culture as a set of "beliefs" and "customs" which were potential "obstacles" to the introduction of new health measures and ideas. On the other hand, social scientist, saw "culture" in the territory of health as "local knowledge" (indigenous medicine) and at locally "strategies" for securing health care. In both views, Stone regarded local culture as fairly inert.

According to Barnouw (1979, cited in Giuliano et al., 2000) cultural factor refer to the way of life for a group of people, the configuration of the patterns of learned behavior that is passed down to generations through language and imitation. Cultural beliefs and perceptions influence participation in health screening, prevention trials, diagnostic tests, compliance, as well as treatment-seeking behaviors.

(e) Perception

Passy and Giugni (2001) argues that social networks also influence the intensity of participation indirectly, via their impact on the cognitive parameters related to participation. They further mentioned that the fact of having been socialized in formal organizations leads individuals to perceive the role of organized citizens as effective

in bringing about social and political change. At the same time, people become aware of the limitations of citizens to change political decisions. Therefore, a similar explanation could be advanced for the negative effect of recruitment by formal networks on the delegation of authorities/ legitimating of citizens.

(f) Time and resources

The community's ability to show high degree of skills in the ability of needed resources and their capacity reflects the amount of access resources and use them wisely. Resources can be either traditional capital (e.g., property and money) or social capital (e.g., the knowledge and skills of people, and cooperation to establish new association) (Goodman et al., 1998). Communities needed both kinds of resources to establish and sustain their participation. Capital resources include funding from community as well as outside agencies and existing foundations; competent professionals, such as lawyers and accountants; meeting place and facilities for program activities; media involvement and responsive mediating bodies, such as grassroots organizations and moreover technical assistance from outside the community. A community with rich resources any lack access to technologic, such as computers, photocopiers, and video cameras which can provide community with innovative ideas. If technology is not available locally, community may obtain it from outside source and to maximize to use such technology community may require access to communication channels within and outside community.

Social capital is facilitated by trust, if high level of trust exists in a community, new and varied social relationships emerge and in communities with lack of trust, relationship and cooperation occur only through rules and regulations. Trust is an

important component of community to involve people in health promotion program and bringing organization together.

(g) Expectation of participation

What kinds of expectations might arise in rural people as they participate in development and what incentives, if any will be required to sustain this involvement? It would appear that people understand expectation in two different ways. That is people participate most often with direct linked to some kind of immediate benefit. On the other hand, the incentive may be linked to more long term solution to poverty. Participation is seen as the process by which previously excluded people can begin to exert some influence and this "emergence from exclusion" could be more lasting solution. Nether perspective is mutually exclusive but they respectively suggest very different immediate and longer-term expectations on the people involved (Oakley, 1991). There is evidence to suggest that participation is linked to material benefit, readily quickly and dependable incentives are important in sustaining the participation. The third world is littered with projects which had sought to obtain people's involvement by offering immediate incentives (e.g. inputs or credit) only to see the participation evaporate when the incentive.

CHAPTER FOUR

FINDINGS: NATURE AND INTENSITY OF MALDIVIAN PARTICIPATION IN HEALTH PROMOTION PROGRAM

4.1 INTRODUCTION

This chapter presents the analyzed results of the survey on these three aspects (i) segments of Maldivian community who are participating and not participating in community health promotion programs (ii) types of health promotion program that they involved with; and, (iii) levels of community participation. These three aspects are response for objective number one and objective number two of this study (Infra, sub-section 1.3 of Chapter 1).

4.2 SEGMENT OF COMMUNITY PARTICIPATION IN HEALTH PROMOTION PROGRAMS

4.2.1 Age, gender and marital status

Distribution of respondents' age is presented in Table 4.1. A total of 1074 questionnaire were distributed to three provinces (Upper North, North Central and Upper South) in Maldives. Only 923 questionnaires were completed. Hence, this study involves 923 Maldivians of 18 to 65 years old of age. Table 4.1 describes the demographic characteristics of the study sample. 46.4% were between 18 and 33 years old, 35.5% were between 34 to 49 years of age and 18.1% are from the age of 50 to 60 years respectively. These data point out that younger adult has clear priorities for participating in community lifestyle change programs due to the fact that

the programs are designed by the younger people and they actively participate to implement the programs.

Table 4.1: Distribution of socio-demographic and economic factors

General characteristics of respondents		**Number of respondents**	**Percentage**
Age in years			
18 – 33		428	46.4%
34 – 49		328	35.5%
50 – 65		167	18.1%
Min = 18	Max = 65	Mean = 34	Std. Deviation = 11.8
Sex			
Male		251	27.2%
Female		672	72.8%

Majority of the respondents of this study were female, of who has better education background and employed. The vast majorities (72.8%) of subjects were women; compare to only 27/2% men involved in the projects or developmental activities. The gender disproportion in volunteering has been reported. Females may be more likely to volunteer for health promotion programs because they have more time (i.e. less likely than males to be in the paid workforce) (Gallup Survey on Volunteering, 1983). Women are largely housewives, with range of responsibilities that save little time for community activities. Maldivian women had always contributed economically as well as socially to the development of the society. Women play an important role in the development and promoting healthy lifestyle. Moreover, the women practically involved now and then to minimize inequalities among them in the community.

Table 4.2: Socio-demographic and economic factors

General characteristics	Number of respondents	Percentage
Marital Status		
Single	191	20.7%
Married	663	71.8%
Widowed	19	2.1%
Divorced	48	5.2%
Separated	2	0.2%

For the marital status, 71.8% respondents were married, 20.7% were single and 5.2% were divorced (Table 4.2). The distinction between married and single parenthood also is useful in explaining the amount of time devoted to volunteering. The bond of marriage have an effect of drawing the person into the community with or without children and regardless of the age of children (Sundeen, 1990). The family is seen as an interdependent system; hence it experiences a change in the role content of one specific position bring changes to all other mutual positions.

4.2.2 Educational background

Higher education attainment is also associated with the potential to earn a higher income, which buy health care and funds healthy habits. The formal education system in Maldives consists of Primary (grade 1 – grade 7), secondary level (grade 8 – grade 10), and higher secondary (grade 11 and 12). The number of years of formal education identified in this study corresponds to the education level attained by the general population which is common throughout the country. Most (45.2%) participants of this study attained primary education 39.7% attained secondary education and only limited percentage possessed higher levels of education (Table 4.3). This shows that most of the higher levels of educated people are away from

home town for different purpose like better jobs. The positive correlation between education and health is a well-known empirical regularity in several disciplines in public health (Glouberman & Millar, 2003). The result may not disentangle the mechanism that connects participation in health with education. Maldivian today hold many high ranking position within Non-Governmental Organizations (NGOs) like Society for Women Against Drugs (SWAD) and Care Society, both of which focuses on two very pressing matters within Maldives society.

Table 4.3: Distribution of respondent by education status

Educational Attainment	**Number**	**Percentage**
No Formal Education	57	6.2%
Primary Education	417	45.2%
Secondary Education	366	39.7%
Higher Secondary Education	48	5.2%
Vocational training /Certificate level	15	1.6%
Bachelor degree or higher	6	0.7%

While race and socio-economic class have been related to participation, they may have limited explanatory and predictive power. The social background loses much or most of its direct explanatory power in predicting participation in voluntary associations when intervening attitudes, personality, and suitable variables are controlled statistically (Smith, 1975). It is possible, for instance, that those groups who avoid participation in the larger social structure because of their perceived inefficacy, will respond with enthusiasm to an arena of concrete, visible concern such as their residential area (Wandersman, 1981).

4.2.3 Employment and income status

Maldives is a community, identified as “bedroom” communities, where majority of the residents commuted for employment. The “bedroom” community meant here that most of the people prefers to live in capital of the country, Male” where 12×9 square feet room shares 5-6 people or a whole family. Otherwise, farming, fishing, tourism and the service industries were described as the largest employers in rural communities. Quite number of respondent were civil servants (23.1%) and 20 percent works with non-governmental organization (carpentry, tourism, construction company and project based work). The occupations that were identified in Table 4.4 were considered as seasonal, generating incomes that were lower than capital average.

Table 4.4: Distribution of respondent by occupational background

Occupation	**Number**	**Percentage**
Government official	213	23.1%
Sales men	103	11.2%
NGO	185	20%
Farmer/ fishermen	27	2.9%
Unemployed / House wife	356	38.5%
Student	8	0.9%
Self-employed	31	3.4%

Unemployment and dependence on social assistance were identified as being as significant problem in virtually every jurisdiction, with some respondent describing it as the “biggest single health threat” in most communities. Among the entire respondent, 38.5% were considered unemployed as they do domestic chores at home (Table 4.3). Several commented on the “welfare dependence” on medical insurance and lack of employment was problematic for youth (school leavers), who often were forced to stay at home due to lack of jobs in their community. The unemployment rate

in Maldives increased from 10.2% in 2000 to 14.4% in 2006 (Office, 2009). Due to higher expatriate employment in the country, the Maldivian youth and women find difficult to find a job and which influence in their socioeconomic development. The impact includes low pay and high living standard in the country.

Table 4.5: Distribution of respondent earns income and level of income.

No. of people earn in family	**Number**	**Percentage**
1-5	544	58.9%
6-11	379	41.1%
Median = 2 Min = 1	Max = 11	Mean = 2.5
Average family income (RF)		
RF 15,000 and above	221	23.9%
RF 10,000- 14,999	186	20.2%
RF 5,000- 9,999	230	24.9%
RF 1,000-4,999	227	24.6%
RF 999 and below	59	6.4%

The size of the household reflects the availability of potential work force in a family. Household income status was defined using on area of residence, household income, family size and Maldivian average income. There is no single, nationally accepted poverty line in the Maldives. The various possible poverty lines are considered, and the distribution of the population under a reasonable "range" of poverty lines are examined by Asian Development Bank in 2004. Moreover the perceptions of poverty vary across the country. To capture hardship in Male' as well as in the outer islands, different poverty lines have been calculated. Practically, a low poverty line of Rf10 ($0.64) per person per day, and a high poverty line of Rf15 ($0.97) per person per day are commonly used characterize the income poor.

The income variables was the most difficult to obtain accurately because the respondents did not keep a record of their income and its sources. Some of them were unwilling to reveal this information. The researcher, however, was able to obtain this information by coaxing the respondents to give a rough estimate of how much they had earned monthly. The household income were classified if: (1) the lowest income was < US$64 (RF999); or their income was between ($64.9-324.2) Rf1,000 – Rf4,999; or (3) ($324.3- 648.5) Rf5,000 – Rf9,999; or (4) ($648.5-972.7) Rf10,000 – Rf14,999; or (5) the high intermediate income status categorized whose family income was ≥ ($972.8) Rf15,000 respectively.

The average number of person who acquires a job is two per household in this study. The survey result (Table 4.5) shows equal percentage distribution with level of income and with few 6.4% below Rf999 respectively. Some of this may be attributed to the fact of the family size. The income level that fell into lowest tend to be those in which fewer household members are employed and which do not receive remittances from family members working in resorts or in Male'. The probability of belonging to the poorest households is higher when engaged in agriculture, fishing and local manufacturing and lower when working in tourism or government. Participants reported that whereas there was an association between high income and well education, participation was not always predicted since some financially successful rural people had modest participation levels.

4.3 TYPES OF HEALTH PROMOTION PROGRAM THAT MALDIVIAN PARTICIPATE

There are several major groups including residents, helpers and government officials that may be involved in community organizations. The involvement of each of these groups varies with the aims and scope of the organizations; as shown in Table 4.6. Only 21.6% of the respondents involved in some sort of local organization whereas 77.6% considered not involved in any of the societal work and 0.9% were not formally involved in any organization. Notably, a higher percentage of volunteers participated through political party (46.6%), and 15% reported through island development committee respectively.

Table 4.6: Categories of participation

Types of local organizations	**Number**	**Percentage**
Non Participants	716	77.6%
Political party	97	10.5%
Private NGOs	26	2.8%
Island health volunteer	31	3.4%
Health task force	8	0.9%
Island development committee	27	2.9%
Youth association	8	0.9 %
Others – Volunteers	10	1.1%

Why political party involvements are more in Maldives? It is expected that in early 2011 the country has initiated a local governance system as stipulated in the law no 7/2010 on decentralized governance providing the elected atoll and island councils the power of local administration in that certain atoll and island (Hussain, 2008). The new government has come up with several policies and programs. Some of the policies advocated are corporatization of health services, public-private partnership, insurance schemes and decentralization. Several factors in the political-bureaucratic

milieu influence community participation (Wood, 1993). The main reason includes the multi-party systems which formulate new policies and excessively complicated administrative system by privatization of government services. The sources of stimulus to the bureaucracy include the president, parliament, courts, and larger political environment. That affects the entire health sector as a whole, on prevention and curative services. With Community participation is narrowly defined as it is often difficult to attract participants that reflect the diversity of the community. The participation process itself can discriminate against those in the community who are not well-educated, well-spoken, or well off. Due to overly directive administrative guidelines together with loose management style, inconsistence performance of health promotion programs focused on rural health promotion and sustainability. It needs to be noted that the study is being conducted at a time when Maldives is in transition; politically and socially.

Transitions in politically and socially socio-economic status affect the local people in the country. The young people, who constitute the largest population group in the country, involve in crimes, tobacco use, substance abuse and violence. As a result, the dependency rate increases in the country. Results of Global School Health Survey (GSHS, 2009) shows that prevalence of lifetime drug use among students is 5.4%, and tobacco use is 11.6%. About 30% of students were involved in physical fights and 17% of students were voluntarily involve to have sexual intercourse and 19.9% of students seriously considered committing suicide (Ministry of Education, 2011).

Volunteers are group of people to assist with public health emergency response activities. They usually assist the health department or assist local hospitals when they are overwhelmed during an emergency such as tsunami or natural disaster or an influenza pandemic. Volunteers help fill in the gaps during emergencies when there may be staff shortages of both medical and non-medical workers. According to the findings, 19 percent of respondent were from island health volunteer /health task force. Island development committees play very important role before new government has been elected in Maldives. Island development committees (IDC) were committees elected by Ministry of Atolls and Development every two yearly. The present island development committees were elected in 2004, and new election held on 2007 was postponed to be held a month after the national referendum to decide a system of government for an amended Constitution. Therefore the present involvement by the IDC was 13 percent respectively.

All the representatives were involved in some way with more than one voluntary sector organization. In Maldives, partners in health in collaboration with local communities and a wide range of Non-Governmental Organization (NGOs) contribute to strengthen public health so that future generations may regard these services. The NGO sector in Maldives has been historically weak. Before the advent of the multiparty democracy, in 2008, only two to three national NGOs of importance were in existence. Society for Health and Education (SHE) has remained in the forefront of population activities in the country. There are few other NGOs such as Care Society, Diabetic Society, Journey, Manfa-center of elderly population, Mothers against Drugs which are becoming popular. In this study 12.6 percent respondent participates through NGOs. According to NGO Capacity and Needs Assessment conducted by Rajje Foundation, Australian Government and UNDP, the existing

challenges to participate NGOs are due to low level of funding and inadequate human resources that are managed mostly by volunteers (Niraula, 2010).

Citizen participation in the community can take a variety of forms and has been studied in diverse literatures including community participation in voluntary action in voluntary associations (Smith, 1975), community power and decision making (Clark, 1975, as cited in Wandersman, 1981) , political participation (Alford & Friedland, 1975), federally mandated citizen involvement in governmental programs (Mott, 1977) and participation in community organization (Perlman, 1979). “Volunteers” generally refers to an individual who on his or her own initiative help others in a spirit of goodwill (Nakano, 2000).

Volunteering has emerged in Maldives since world embraced Primary Health Care as a core policy for the World Health Organization with the Alma-Ata Declaration in 1978. The commitment given by volunteer is the major positive achievements in health indicators today in Maldives. Volunteer who nominated by personal interest were the highest percentage (79.7%) of respondent who participated in this study. Result in positive perception towards volunteerism in the country. Some has been assigned by the committee that they have been involved is 12.7 percent respectively.

A few respondent participate voluntary activities not because they want, but they has been assigned or selected by certain influential person like island chief or

atoll chief or health worker. The number of respondent who participated in that manner is 2.4 percent and others 5.3 percent.

The active volunteers may have valuable knowledge about the organization, facilitating the integration of health promotion program. Possibly they would have varying history of activity and involvement in organization. The duration of being a volunteer occupies an important role in the organization. The result of this study shows that 93.7 percent of respondent participates 1- 10 years in voluntary service and 6.3 percent between 11 to 18 years. Most of them asserted they have registered only and minimal activities have been organized by the committees.

It is also interesting to speculate if volunteers in health promotion do volunteering because they perceive it as an opportunity for more successful behavior change for themselves. The incidence of participation among the respondents who does voluntary work were 39.8 percent, i.e. 3 to 4 times in a month and 33.5 percent do participate ones or twice a month respectively. As well as 21.4% or respondent do some kind of participation every 6 month and the rest of the respondent were not active as such.

Table 4.7 summarizes the result of respondents who involved in health promotion programs. The volunteers who add credibility to the society of participating in health promotion program were 61 percent and 35.6 percent do not participate directly in health promotion activities but they do other voluntary works for the community (sports and recreational activities). A few numbers of respondents

(3.4%) participate with specific manner of health promotion activities such as first aid program.

Table 4.7: Distribution of respondents involved in health promotion program

Characteristics	Number	Percentage
Are you involved in any health promotion programs in this community?		
Yes	74	35.6%
No	126	61%
Others – indirectly	7	3.4%
In what program you participate as a health promotion volunteer?		
- Communicable Diseases	41	23.8%
-Maternal and child health program (Nutrition program)	11	6.4%
-Mental health awareness program	10	5.8%
-Quit and win program (Anti Tobacco program)	10	5.8%
-Non-Communicable Disease prevention program	26	15.2%
-All of the above programs	64	37.2%
-Others- First Aid	10	5.8 %

The health promotion contribution programs participatory activities were organized around individual behavior changes in government priorities such as communicable disease prevention program, maternal and child health, mental health awareness, smoking and alcohol, non-communicable diseases and reflected a lifestyle view of health promotion programs. The respondents were asked to choose more than one program that they were participated. Table 4.7 presents the response categories with the number and percent of respondents in each category. In a sample of 207 respondents reported highest involvement of community members were in all of the above mentioned programs (37.2%); 23.8 % had participated in communicable disease prevention program and only 15.2% had participated in non-communicable

disease prevention program. The Maldivian government has to design the post Ottawa Charter to address community participation in health promotion project from an empowerment perspective to enhance more participation in rural areas.

The data from this study reveals that how societies shape the way people construct themselves and how self-identity is fashioned from range of available choices in the society. At province level, there were no health committee as such, only community health worker or family health worker do community health promotional activities. Traditional birth attendants (TBA) used as mobile source of maternity in the community. The TBA was supposed to give basic antenatal care, perinatal care and postnatal care to local women. However, some community had island development committee members who assisted to motivate villagers to bring their children to immunization clinic and pregnant mothers to antenatal checkups. There was a feeling that the community lacked information, regarding health promotion strategies and policies. Moreover respondent felt strongly that people in rural areas were neglected and only central and Capital Island only benefits from government activities. Health services were seen as the responsibility of the health services alone. Community participation was perceived by both professionals and community members as a means of mobilizing community resources for public task. The overall conclusion was that community participation in health promotion was not yet well developed in Maldives.

4.4 LEVELS OF COMMUNITY PARTICIPATION

4.4.1 Community participation in decision- making activities

This section focuses on communities' level of participation in selected several activities related to decision-making. A total of nine variables constituted in decision

making scores. The degree of involvement was measured by using these scales: never (zero times), occasionally (1-2 times), and always (3-5 times). The corresponding scale used was one, two, three and five points.

Finding from overall scores (Table 4.8) in decision- making participation reveals that slightly more than one-half (56%) had occasionally participated in decision making and 23.4 % had always participated and 20.6 % had never participated in any decision making process respectively. Overall, participation in decision making was relatively low. The overall mean score was only 26.6; which were moderately lower between the lowest possible score of 9 and the highest possible score of 45.

Table 4.8: Distribution of Community Participation in Decision- Making Activities

Participation level	**Frequency**	**Percent (%)**
Decision making		
Always participate (> 38.3)	29	23.4%
Occasionally participate (14.8-38.2)	71	56%
Never participate (<14.9)	26	20.6%
Mean=26.6 Max= 45 Min= 9 SD= 11.7		

A recent study conducted in Ontario analyze the tendency to participate in public policy making and implementation suggests that the government initiated participatory strategies put forward only certain kinds of information from consumers and do not live up their democratizing promises (Aronson, 1993). Previous research in the United States suggested a similar pattern (Checkoway, 1982; Lipsky & Lounds, 1976).

Assessment of citizen participation in Quebec suggests that despite more than two decades of efforts to enhance participation in health care decision-making, the

presence of citizens on the boards has not succeeded in empowering the community in such a way as to significantly influence health (O'Neill, 1992). The problem stems from the power relationships among lay individuals, administrators, and health professional. In decision making, health professionals and administrators are motivated to participate because they have a concentrated interest related to employment and income (Brown, 1981). Therefore, the benefits of participation are likely to out weight the costs. Local participant interests tend to be broader and diffuse than health professional. The root of the problem is the imbalance of resources among citizens, providers, and administrators which citizens encounter when participating in shared decision making process (Church et al., 2002).

Table 4.9: Composite scores of participation in decision- making.

Participation in decision making			
	Always (>38.3)	**Occasional** (14.8 – 38 .2)	**Never** (<14.9)
Attend all the general meetings	48.4	27.0	24.6
Participate in decision by asking questions and recommendations.	43.7	30.2	26.2
Involve in problem and need assessments.	46.8	28.6	24.6
Involve in making action plan.	38.1	32.51	29.4
Participate in decisions regarding program implementation.	42.1	27.8	30.2
Participate in decisions regarding distribution of benefits.	34.9	31.0	34.1
Participate in developing operational plans.	34.9	31.7	33.3
Participate in decision regarding managing conflicts in the group.	40.5	30.2	29.4
Participate in delegation, representing the group to dialogue with the program officer.	38.1	27.8	34.1
Overall scores	**23.4%**	**56%**	**20.6%**
Mean = 26.6 **Max = 45** **Min = 9** **SD = 11.9**			

The decision- making were measured by the following nine items:

(1) *Attending all the general meetings* - Table 4.9 reveals that 48.4 % or nearly half of the respondent attended general meetings, 27 % were occasionally attended meetings and 24.6 % never attended any meeting that was organized by the committees or any local organization. This result reveals that the proportions that have been participated in health promotion are attentive to attend general meetings.

(2) *Participate in decision by asking questions and recommendation*_-participate in questioning and recommending at the process of decision-making were considerably high (43.7%), occasionally participated 30.2 % of respondent and 26.2 % never participated. Compared to the participants attendance at group meeting and suggesting their views are quite higher. This shows that if they attend meeting usually participate to share their thoughts and views. Commonly in Maldives organizing committees do participate in meetings and local members are being notified latter. Mostly women are house wives and less likely to attend meetings and involve in domestic work at home.

(3) *Involvement in problem and need assessments* - the data in Table 4.9 also presents the summary of involvement in problem identifying and need assessment process. 46.8 percent of the participants from the community always participated at an average level. On the other hand, 28.6 percent occasionally and 24.6 percent never participated in need assessment process. As mentioned above if they took part in meeting they do open up with problem identifying.

(4) *Involvement in making action plan* - as seen in Table 4.8, one third (38.1%) of the participant always involve in making action plan. In addition, another 32.5 percent participated occasionally and 29.4 percent never participated in planning process.

(5) *Participate in decisions regarding program implementation* - participant were asked if they had contributed any decision regarding implementation, nearly half (42.1%) of the respondent always participated in decision related to implementation process, as for never participated 30.2% and only 27.8 % occasionally participated respectively.

(6) *Participate in decisions regarding distribution of benefits* - it has been noted that most of the project are implemented not for any financial or material benefit. Mostly it is good for community and do voluntarily, therefore respondents felt difficult to answer this question. Out of respondent who answered, 34.9 percent always participated and 34.1 percent had never participated and 31 percent occasionally participate in deciding benefit sharing.

(7) *Participate in developing operational plans* - most operational plans were made by the project planner or program organizer. Out of all respondents who participate in health promotion, one third (34.9 %) of the participant always participate and 33.3% never participated and 31.7% occasionally participates in developing operational plans. Mostly, plans are made by health professionals at central and the local committees will know little about plans.

(8) *Participate in decision regarding managing conflicts in the group*- conflict resolutions among group members shows 40.5 percent of the respondent always participates, 30.2 percent had occasionally and 29.4 percent had never participated in managing conflicts among the group.

(9) *Participate in delegation, representing the group to dialogue with the program officer*- the Table 4.9 shows that 38.1% of respondents always participate in delegating work and discuss with health professionals during community activity. On the other hand 34.1% never participate in this process and 27.8% occasionally participates.

The overall conclusion, the involvement of communities in decision-making about health priorities had been neglected, however, and the community representatives' themselves were not confident about expressing their views and questions. It was taken for granted that the health workers knew the priority problems of the population. On the other hand, few participatory community surveys had

undertaken environmental health activities, such as community cleaning campaigns and vector born disease control programs.

Although moderate statistical power clearly has contributed to the difficulty in detecting the actual community participation in health promotion activities, it should be noted that number of reasons have been detected during the survey. Explanations found in the comments were fall into the following areas; unorganized health promotion programs, limitation of the interventions, limitation of theory of community involvement and egoist thinking of the health professionals. So far few programs have been implemented and it has not been completed due to finance and inappropriate program planning.

4.4.2 Community participation in implementation activities

The mechanism of implementation in health promotion programs may differ from project to project making it adaptable to the local situations, perspectives and conditions. Adoption of recommended health promotion practices and contribution to project made up variables employed in the measurement of composite participation scores in implementation. The former comprised ten variables in order to measure level of implementation. The scale was constitutes as mentioned above in decision-making level scores. Lack of involving potential beneficiaries in the design, implementation, and management of a project, as highlighted by Koretn (1983), may lead to the inability to reach a broader target audience, failure to sustain local activities, and creation of dependencies on the implementing agencies.

The overall study result (Table 4.10) disclose that the level of implementation found that more than one-half of the respondents (57.9%) moderately participate in

program implementation, 21% were not involved at all and 20% participated always in implementation process. The overall composite mean score was 28.6 which were lower between the lowest possible score of 10 and the highest possible score of 50. Reports from The Ottawa Charter, The Adelaide Recommendations on Healthy Public policy, and The Jakarta Declaration on Leading Health Promotion into the 21st century shows that the implementation of health promotion and related approaches in the region has traditionally been spearheaded by the health sector although the participation of individuals, communities and non-health sectors is gradually increasing.

Table 4.10: Distribution of Overall score of Implementation

Participation level		**Frequency**	**Percent (%)**
Implementation			
Always participate (> 40.5)		26	20.6%
Occasionally participate (16.6-40.4)		73	57.9%
Never participate (<16.7)		27	21.4%
Mean=28.6	**Max= 50**	**Min= 10**	**SD= 11.9**

Participation in implementation was measured by the following ten items:

(1) *Mobilize community resources to implement community improvement program* - what participation under this heading has been in the provision of work of the project (labor) or the contribution of material inputs (case or in-kind). Resource mobilization in implementation process detected no consistent, measurable differences between participant who always participates and who does not participate at all. The data shows almost equal number of 34.9 percent had always participate and 34.1 percent had never participated at all and also 31 percent had occasionally participated. Since this information is based on overall aspects of

implementation in mobilizing resources it reveals that one-third of the respondent participates.

Table 4.11: Composite score of Participation in Implementation.

Implementation process			
Composite Scores	**Always** (>40.5)	**Occasionally** (16.6 - 40.4)	**Never** (<16.7)
Mobilize community resources to implement community improvement program	34.9	31.0	34.1
Worked collaboratively to improve water and sanitation condition	42.1	23.8	34.1
Help publicizing information of disease situation through home visiting in the community.	34.9	32.5	32.5
help in health campaign to improve healthy lifestyle in community	34.1	34.1	31.7
Assist health personal in giving vaccination	30.2	28.6	41.3
Organize physical activities in the community. E.g. group exercise	41.3	26.2	32.5
Persuade community for exercise.	35.7	38.9	25.4
Do home visiting for health education and rehabilitation	36.5	36.5	27
Identify and inform risk group in the community to attend checkup. E.g. antenatal, elderly group and under five group, malnourished children.	35.7	39.7	24.6
I inform community about health center services	33.3	38.1	28.6
Overall scores in implement.	**20.6%**	**57.9%**	**21.4%**
Mean = 28.6 Max = 50 Min = 10		**SD = 11.9**	

(2) *Worked collaboratively to improve water and sanitation condition* - Table 4.11 reveals that larger percentage of participants worked to improve water and sanitation condition in community. Out of all, 42.1 percent had always participated and 34.1 percent had never participated at all and 23.8 percent had occasionally participated. Practically community does give greater contribution in labor works. But compared before is can be said that the contribution is diminishing. The reason behind this might be due to

unavailability of youth work force at island level and foreign laborers do unskilled manual works.

(3) *Help publicizing information of disease situation through home visiting in the community*- as depicted in Table 4.11, publicizing information through home visiting is being done by the health center staff. Mostly family health workers and TBAs do home visiting to inform antenatal mothers to antenatal checkups, vaccination and diabetic and hypertensive patient for regular follow ups. Doctors and nurses involved community visits sometimes in some communities to consult bedridden patient and disabled patient in the society. As a result the study reveals one-third of respondent (34.9 %) do always and 32.5 percent occasionally and 32.5 percent never participated in publicizing information in the community. The proportion that has been always participated was among committee members and hospital staffs that are questioned in this survey.

(4) *Help in health campaign to improve healthy lifestyle in community* - health campaign are organized in the country with an outbreak of a diseases or prevalence of a disease in community. Campaigns are mostly organized by government and NGOs who actively work in the community. For example Red Cross and Red Crescent of Maldives worked the complete elimination of measles and also organized rubella vaccination as part of this campaign. Recently HPA organized a campaign to control dengue as the number of people that fall victim to the disease increases during specific time of year. The campaign was designed for whole country to participate with assistance from relevant health institutes and NGOs participate in information sharing with the public. The data result concluded that same number of 34.1 percent had always participated and occasionally participated in campaigns that are

organized by health facilities. Only 31.7 percent never responds to the campaigns organized by health facilities are questioned in this survey.

(5) *Assist health personal in giving vaccination* -as shown in Table 4.11 overall, most of the respondents found participating in giving vaccination is the responsibility of the health care workers therefore they did not feel it is important to participate. The result reveals that 41.3 percent had never assisted, 30.2 percent had always assisted and 28.6 percent occasionally assisted in vaccination. Furthermore, when asked at the end of this question what sort of assistance were given in giving vaccination, most of the women reported that they go and tell the neighbor to go for vaccination and explains the importance of giving vaccine to their children.

(6) *Organize physical activities in the community* - most of the island organizes physical activities in the community, with occasions and without occasions. Most of them reported that they organize during special day celebration, like World Health Day, Eid Days and etc. The result concluded in this study reveals that 41.3 always participate, 32.5 percent had never participated and 26.2 percent had occasionally participated in organizing physical activities. This shows that have tendency to be active in the society, but they only can participate with passion to celebrate some important days only. The reason reported by most of the respondent was that they don't have much time during school days and once only they get a holiday they can participate actively.

(7) *Persuade community for exercise* - as shown in analyzed data, most of the respondents persuade community to participate in exercising. One third (35.7%) of the respondent always participate, 38.9 percent occasionally

participate and 25.4 percent never participate respectively. The result concludes that they persuade community to engage in exercise programs.

(8) *Home visiting for health education and rehabilitation* - one third (36.5%) of the respondent participates always and occasionally participates in home visiting and 27 percent never participate at all.

(9) *Identify and inform risk group in the community to attend checkup* - among the respondent who answered in identifying and inform risk group 39.7 percent of the respondent occasionally participate to spread information in the community and 35.7 percent always does and 24.6 never participated in dissemination of information regarding healthy community. The result reveals that this information are only can be given by health care workers, to antenatal, elderly group and under five group, malnourished children.

(10) *Inform community about health center services* - in this component the highest number of respondent occasionally participate that is 38.1 percent, then 33.3 percent as always and 28.6 percent had never participated in information sharing. Mostly health information is being shared by the health professionals in Maldives. In a rare situation community do home visiting regarding a specific topic or a disease condition. Example, community health volunteers activate in an epidemic of communicable disease.

4.4.3 Community participation in benefit sharing

The third component of community participation in this study constitutes benefit sharing in health promotion programs. Community participation in benefit sharing is a process; not a product in the sense of sharing project benefits. For example, acquisition of economic assets through a project. (e.g., land, house etc). Community

participation in health promotion program in benefit sharing is different from activities that have incomes, generated benefits and stimulated economic growth. According to Paul (1987) community participation viewed as process provides a dimension that goes beyond benefit sharing is connected to the issue of project sustainability. Analyzing the amount and distribution is difficult because benefits include collective as well as individual gains, indirect as well as direct effects of project activity and non-material as well as material benefits.

This study focused on four types of benefits, were included, namely increase income, material benefits, social benefits and personal benefits. A five point scale was employed to determine the extent of benefits community perceived they received. The overall study result level of benefit sharing found that more than one-half of the respondents (62.7%) moderately participate in benefit sharing, 20.6% were not involved at all and 16.7% participated always in benefit sharing. The overall composite mean score was 11.6 which were lower between the lowest possible score of 4 and the highest possible score of 20. The mean score 11.6 which is average score as shown below in Table 4.12.

Table 4.12: Overall score of Benefit sharing

Participation level	**Frequency**	**Percent (%)**
Benefit sharing		
Always participate (> 16.4)	21	16.7%
Occasionally participate (6.7-16.3)	79	62.7%
Never participate (<6.8)	26	20.6%
Mean=11.6 Max= 20 Min= 4 SD= 4.8		

As shown in Table 4.13, the respondents were asked about whether their personal income has been increased when they participated in health promotion programs. Most of the respondent refuses to answer this question since they rarely perform community work for income benefits. Most of the respondents participate as a voluntary contribution and for the benefit of whole community. The result concluded that most 38.1 percent had occasionally participated, 33.3 percent never participated and only 28.6 percent had always agrees that their household income increases.

Table 4.13: Composite scores of Participation in Benefit Sharing.

Participation in Benefit Sharing			
Composite Scores	**Always** (>40.5)	**Always** (16.6-40.5)	**Always** (<16.7)
My household income increases by participating in Health promotion	28.6	38.1	33.3
I got benefits directly from a project that I participated	35.7	36.5	27.8
Get social benefits by improving health care in this community	38.1	37.3	24.6
Do get personal benefits by increasing popularity in community and thereby people recognize in this society.	37.3	35.7	27.0
Overall scores	**16.7%**	**62.7%**	**20.6%**
Mean =11.6 **Max = 20** **Min = 4**		**SD = 4.8**	

For the material benefits from the project, 36.5 percent of the respondent only occasionally received material benefits and 35.7 percent had always got benefits. In addition, another 27.8 percent had never got any benefits from the projects that they participated. Reciprocally, the response for the “always” and “occasionally” level only gets some sort of project benefits like building a community building and agricultural projects.

Then, for the social benefits by improving health care in this community, one third of the respondent always participated in community projects and inquire more about health information from it and 37.3 percent had occasionally participate and 24.6 percent had never agrees with the social benefits getting by involving in community programs.

Most of the respondent seeks information regarding healthy habits and disease burden in the community regarding participation. They were overwhelmed by knowing what the facilities they have and what the current status of their community is. Moreover they get short term training from some long term and short term projects which they can be used in daily life. For example, PD Hearth program in nutrition. From this perspective, the individual does not view participation and contribution as a cost that needs to be compensated; rather these activities are enjoyable in and of themselves.

Finally, for the composite of personal benefits by increasing popularity in community and thereby people recognize in this society, result shows that one third of the respondent (37.3%), agrees that they always gets personal benefits and 35.7 percent had occasionally gets personal benefits and 27 percent had never gets any personal benefits by participating in community.

4.4.4 Community participation in evaluation activities

The fourth and the last component of community' participation in this research constituted a study of the extent of community participating in health promotion activities in general. The activities included five selected variables: monitoring, discussion of progress with group members, discussion with family members, discussion of progress in meetings and suggest ideas in discussion. The overall study result level of evaluations found that more than half of the respondents (54.0%) moderately participate in program evaluations, 23.8% were not involved at all and 22.2% participated always in evaluation process. The overall composite mean score was 13.5 which were lower between the lowest possible score of 5 and the highest possible score of 25.

Table 4.14: Composite score of participation in evaluation

Participation level			**Frequency**	**Percent (%)**
Evaluation				
Always participate (> 20.5)			28	22.2%
Occasionally participate (6.4 -20.4)			68	54.0%
Never participate (<6.5)			30	23.8%
Mean=13.5	**Max= 25**	**Min= 5**	**SD= 7.0**	

Obviously, evaluations would range from very supportive role to negative attitude or critical ones. Nearly half (42.1%) of the respondent only occasionally participates 30.2 percent had never participate and only least number of respondent 27.8 percent had always participate in the monitoring process. Some respondent responds

negatively towards this question by telling that they were rarely given the opportunity to discuss.

In light of this study finding, it appears that the result was a bit reverse for the aspect of encouragement from family members and friends. One third of the respondent (35.7%) never discussed with their family members about the progress of the program. On the other hand one- third of the respondents always discuss with their family and 31 percent had occasionally discussed with their family members respectively. Family and friends plays an important role in encouragement activities to participate in voluntary work. It's like a social gathering. Internal promotion is another needed community building activity.

Table 4.15: Composite scores of Participation in Evaluation.

Participation in Evaluation.			
Composite Score	**Always** (>40.5)	**Occasionally** (16.6-40.4)	**Never** (<16.7)
I involves with health officials to identify progress of the programs	27.8	42.1	30.2
Discuss with group members to identify progress of the program	27.81	38.9	33.3
Discuss with family members about progress of the program	33.3	31.0	35.7
Discuss on program progress in committee meetings	31.0	34.1	34.9
I contribute suggestions/ ideas in discussions.	33.3	35.5	30.2
Overall scores in evaluation	22.2%	54%	23.8%
Mean =13.5 Max = 25	**Min = 5**	**SD = 7.0**	

For the aspect of discussion of program progress among the group, as shown in Table 4.15, the results reveals that 38.9 percent had discuss occasionally with group members and 33.3 percent had never discussed with group members. In addition,

27.8 percent always discuss with group members regarding progress of the program. By sharing progress facilitates integration of the outcome into the community.

The results shows 34.9 percent rarely or not involved and 34.1 percent had occasionally involved in discussion about program progress. Only 31 percent always discuss in committee meeting. The respondents admit that few people attend general meeting to discuss the outcomes of the programs and mostly involved in implementation process.

Then, for the contribution of suggestions/ ideas, about one-third (36.4 percent) had occasionally participated and 33.3 percent always participated and only 30.2 percent never participated in contributing their ideas in discussion.

The equal distribution of percentage among the three levels shows that communities are not much aware of health promotion programs and less likely to bother to find information.

4.5 CONCLUSION

The social characteristic of a community refers to the composition of the population in the community, social network, norms and traditions of the community, and the functioning of the community. In Maldivian communities an average number of respondents inhibits or facilitates participation. Many studies related to demographic variables with participation have found low correlations. A study conducted by Wandersman and Florin concluded that five cognitive social learning variables predicted willingness to participate better than a group of 16 demographic and personality variables (Wandersman, 1981).

Thus, characteristics of the community population as a whole may have an influence on the press for participation in community which is distinct from the influence of these characteristics on an individual level. Social network and network analysis is an important conceptual tool for relating individual behavior to the community. Political party is the inhibiting characteristics that community participates in formal community organizations.

It is necessary to point out that these findings also conclude that the programs in an island community are not sequential phases in the participatory approach. It can be observed that most of the communities participate in implementation phases and rarely the projects have planned for other types of participation. The types of participation can be regarded as a key determinant to answer to the question 'how?' (Cohen & Uphoff., 1977) identified four types of participation in rural development and moreover Rifkin classified five types about community participation in health field, namely, planning, monitoring and evaluation, implementing, activities and benefits.

Whatever the types of participation that a health system of a county wants to adopt there is question of how does community participation happen in practice? In summing up, the preceding analyses and discussion shows that the local participants who participated more actively in implementation activities were those young age, with secondary education, married respondents without any formal occupation, with medium family, and with political organizational memberships. In general, the above description holds minimum level of participation in decision-making, implementation benefit sharing and evaluation. Only a small proportion of the respondent highly participated in four types of participation. Most respondents participated voluntarily

and indirectly, but mainly under influence of a political party, rather than through their own.

CHAPTER FIVE

FINDINGS: FACTORS AFFECTING MALDIVES COMMUNITY PARTICIPATION IN HEALTH PROMOTION PROGRAMS

5.1 INTRODUCTION

Community participation is recognized as a success factor underlying health and sustainable community health promotion programs. However, achieving participation can be a major challenge. There are many potential barriers or factors that influence community participation. This chapter describes the findings on factors affecting Maldivian participation in health promotion programs.

5.2 BARRIERS TO COMMUNITY PARTICIPATION IN HEALTH PROMOTION

Participation as an individual social behavior is influenced or shaped by various social, psychological, and environmental factors. Murray (2004) identified many potential barriers to community participation. He further mentioned that community participation in public health planning projects and their implementation requires overcoming barriers at a number of levels, namely the participants, the community, the operational and the structural level.

The most common form of participation is through democratically elected representatives from the community. Ideally, this should represent the interests of the community and should be in constant communication with the communities, as well. However poor public participation in health promotion programs in Maldives can be

documented. This could be due to former traditional centralized governance, where care was provided for and not with the people. Other possible causes could be lack of individual and community empowerment, failure to operationalize the policy on public participation in health, lack of commitment and time.

Barriers to community participation towards health promotion have been debated by many scholars. Murrey (2004) concluded four levels of barriers to participation in development of community health programs; namely the structural, the operational, the community and the participant level. It should be distinguished that such areas of barriers are not mutually exclusive. Although, there is no specific reason beyond this classification, it is supposed that it will facilitate understanding of barriers to community participation in health promotion programs, at least at theoretical level.

5.2.1 Structural factors

Structural factors are usually associated with institutional, power structures, legislative and economic system. A major new focus in the practice of community involvement in health is the potential of local health development structures at the district health system level to facilitate community involvement. Such structures include local health committees, health councils or boards, community-based organizations and advocate groups.

A study conducted by Boyce (1997) suggested that structural factor is an assumption that human actions are to a large extent determined by the social environment. Findings from this study can suggest that there is a need for professional

support by skilled personal to support policies and plan an appropriate health care system that enable to further involvement. Social system links the individual to structure and recursive, that is, they are both medium and outcome of social interaction. Values, attitudes of professionals, lack of experts, lack of appropriate legal system, lack of trained human resources, lack of financial resources and relationships are believed to be the result of, or greatly influenced by, factors in the organization of society (Boyce, 1997; Murray, 2004; Steven & Jennifer, 2002).

Structural factors were assessed under three items, namely structure of health care system, availability of local trained human resources and capacity of resources to community participation. In terms of structure of health care system, there is still unwillingness to decentralize the administrative structure and to make the government program and peoples government to people. As a result, most local people are not aware of health structure of the country. The overall finding of structural factors concludes as shown in Table 5.1. The result shows more than half of the respondents (74.6%) are not sure structural factors affecting community participation.

Table 5.1: Composite scores of Structural Factors

Participation level			Frequency	Percent (%)
Structural Factors				
Agree (> 39.6)			15	11.9%
Uncertain (39.5-20.7)			94	74.6%
Disagree (<20.8)			17	13.5%
Mean=30.2	**Max= 55**	**Min= 11**		**SD= 9.4**

An effective means of assessing the ability of community to facilitate genuine participation in health promotion programs, were assessed by the following statements; presented in Table 5.2.

Table 5.2: Structure of Health Care System and level of Community Participation

Structure of Health Care System			
Participant level	**Agree (>39.6)**	**Uncertain (39.5 – 20.7)**	**Disagree (<20.8)**
Current structure of Maldives health care system motivates grass-roots community development action	36.5	36.5	27
Number of health care providers is sufficient to provide services for this community	29.4	48.4	22.2
Decentralization of health services strengthens district health system which serves best for community	35.7	45.2	19
Overall structural scores (%)	**11.9**	**74.6**	**13.5**

As shown above in Table 5.2, one third of the respondent agree that the current structure of health system permits grass-root community involvement in development actions and same percentage of respondent are not sure of this policy and 27 percent are against with the structure and grass-root community involvement. As a result, real community participation does not take root, and the benefits of health care programs are not properly distributed and remain accessible only to the privileged few. Most of the respondents involved in this study have indicated that they feel there is lack of access to information about government programs and services. Rural Maldivians have also reported that the present information regarding policy permit, government programs and services is difficult to obtain and interpret.

Table 5.3: Availability of trained local human resources and level of community participation

Availability of trained local human resources			
	Agree (>39.6)	**Uncertain (39.5 – 20.7)**	**Disagree (<20.8)**
Island has enough trained health promotion officials to provide services to community	32.5	44.4	23
We have a specific person to provide health promotion programs	28.6	48.4	23
The appointed health promotion officer regularly communicates with voluntary	23.8	50	26.2
Support of NGOs can provide additional resources in developing community involvement in health.	27	46	27
Overall structural scores (%)	**11.9**	**74.6**	**13.5**

The availability of technical assistance which includes training and support needs are lacking to either implement or sustain health promotion program in Maldives. Most of the respondents are not sure of the human resource (44.4%) and whether a specific person is assigned to community health promotion (48.4%) respectively (Table 5.3) such assistance is provided by professionals outside a partnership but sometimes with specific skilled person from central system. There are certain difficulties that slow down this assistance, include presumptions about existing levels of staff or community capacity and inappropriate or insufficient support from the province level.

Another information challenge is the fact that little research has been conducted concerning rural communities and the policy making process. Further, this research often is difficult to obtain support. There is a noticeable lack of expertise in health sector and other barriers like lack of information; of trained human resources, low level of awareness and lack of an appropriate legal system are factors that can be

as important obstacle for community participation in health development as shown in Table 5.3. The main reason is that the desired reorientation and reorganization of health care delivery system have not yet occurred and all facilities are concentrated in urban areas.

Table 5.4: Capacity of resources for community participation and level of participation

Capacity of resources for community participation (%)			
Participant level	**Agree (>39.6)**	**Uncertain (39.5 – 20.7)**	**Disagree (20.8)**
The government provides a community center for us to conduct a meeting about health activities	27	40.5	32.5
We have an expert person to organize HP programs in this community	27	50.8	22.2
We have a community leader appointed to deal with health facilities	26.2	52.4	21.4
Our community manpower contribution to health program s are more than other developmental activities	26.2	50.0	23.8
Overall Structural scores	**11.9**	**74.6**	**13.5**

5.2.2 Operational factors

Good governance is a cornerstone for a health administration to address people's health needs affectively. The structure of the central health department and the health infrastructure are provided in Chapter 2, Figure 2.1 p 73. The result concluded that most of the respondents were not aware of number of service providers and strength and weakness of health administration at local level. Rather what is needed is a

system of governance that fosters effective partnerships and coordinates initiatives to create synergies and avoids destructive competition at all levels. The overall findings on operational factors conclude as shown in Table 5.5.

At the same time, there is insufficient transparency with respect to intergovernmental organizations and central decision-making. Transparency literally means open governance, free flows of information and civic participation. These are values that support accountability and are widely believed to be hallmarks of good governance (Gostin & Mok, 2009). There are overlapping aspects in health system of Maldives which could lead to uncertainty with operational features to most of the respondent. According to Eldis (2007, cited in Kumar, 2010)), accountability in health sector is a key element in improving health system performance. Buse (2006) further describes that accountability encourages people and non state actors to be participated in health system through sharing information.

Table 5.5 Composite score on Operation Factors (OF).

Participation level			**Frequency**	**Percent (%)**
Operational Factors				
Agree (> 86.3)			18	14.3%
Uncertain (86.2-47)			82	64.1%
Disagree (<47.1)			26	20.6%
Mean=66.7	**Max=115**	**Min= 23**		**SD= 19.6**

There is also modest evidence that the creation of health authorities has focused attention on public demands for greater responsiveness of health professionals and policy makers to communities (Frankish, et al. 2002). The data reveals that the government at the time of data collection permits to health sector policies and frameworks to initiate community participation by agreeing nearly half of

the respondents. These agreements are associated with call for greater accountability for health resources.

Emerging quantitative data also suggest that each of these concerns remains a significant threat to meaningful citizen participation. There is strong evidence that the system of Maldives health sector are continuing to operate as if health professionals are the legitimate and superior decision makers respectively. It has been suggested that citizen participants may have less skills or knowledge that those responsible for carrying out the decisions (Brownlea, 1987). Furthermore Lomas, (1998) stressed that much remains to be done in terms of training and capacity-building to support citizen participation. Sensitizing and orienting the community for promoting primary health care is very crucial to a country like Maldives, which is geographically separated by the sea.

Table 5.6: System of health governance and level of participation

	System of health governance (%)		
Participant level	**Agree (>86.3)**	**Uncertain (86.2 – 47)**	**Disagree (<47.1)**
Many people have been placed in the community in charge of health promotion activities	27.8	49.2	23
Government promotes better transparency and accountability of health system	30.2	47.6	22.2
Health sector strengthen partnership with civil society to empower their active participation in health development	34.1	46.8	19
Overall Operational Score	**17.5**	**64.3**	**18.3**

Some studies found evidence of policy change to which collaborative partnerships for community health contributed, for example, new modified policies to

reduce harm related to smoking and alcohol, increase the amount of time students spend in physical education classes and improve access to health care service (Roussos & Fawcett, 2000).

Health and family welfare program cannot be implemented in isolation of other development programs. The activities of other sectors directly as well as indirectly influence health development. Therefore, primary health care has to become a part of overall socio-economic development process. It demands co-ordinates and simultaneous efforts being made in such sectors as agriculture, education, social and development, environment and voluntary organizations, etc. At present, extension workers and functionaries of these sectors/departments are operating in the field with minimum linkages or coordination among them as summarized in Table 5.6. Often the health personnel are not aware of various projects and schemes under other sectors of development which have relevance to health.

Table 5.7: Political will and level of community participation

Political Will			
Participant level	**Agree (>86.3)**	**Uncertain (86.2 – 47)**	**Disagree (<47.1)**
The present policy permits to health and safety of the people.	58.7	24.6	16.7
The present government develops health sector policies and frameworks that promote community participation	48.4	29.4	22.2
The present government works with external partners to promote greater participation	20.6	35.7	43.7
The present government develops people's managerial capabilities to take responsibilities for a process like community involvement in health.	19	36.5	44.4
The present government incorporates human health criteria into all policy sectors	20.6	37.3	42.1
Overall Operational Score	**17.5**	**64.3**	**18.3**

For mobilization of resources and cooperation of other sectors towards promotion of health, alertness, initiative, persistent efforts and persuasion of community participation would be crucial. Collaborative partnership in public health takes in many forms, including coalitions of community members and groups, and grassroots and broader advocacy efforts and incentives. The structure of partnerships can vary and may include formal organizations with a financial stake or interest (e.g. consortium of health care providers) as well as individuals and grassroots organizations that have formed around a recent event or local concern.

Two broad conclusions can be drawn about public literature on collaborative partnerships for community health improvement: collaborative partnership has been popular but only limited empirical evidence exists on their effectiveness in improving

community-level outcomes. For example, such as substance abuse, crime and violence and adolescent pregnancy (Roussos & Fawcett, 2000).

Table 5.8: Coordination and level of community participation:

Coordination			
Participant Level	**Agree (>86.3)**	**Uncertain (86.2 –47)**	**Disagree (<47.1)**
Health care facilities has good linkage with other sectors such as education, island office, island committee and other government sectors for the purpose of improving health care in the community	33.3	42.1	24.6
Advocate stakeholders in order to assure sufficient support to community development	32.5	47.6	19.8
Better local-level intersectional co-ordination so that the underlying basis of poor health can be identified and understood	357	45.2	19.0
Overall Operational Score	**17.5**	**64.3**	**18.3**

The result show moderate linkage (42.1%) among community and stakeholder. Moreover moderately (47.6%) advocate stakeholder in order to provide support to community respectively as shown on Table 5.8. Several assumptions underlie the strategy of collaborative partnership: the group cannot reach goal by one individual or group working alone, participants should include a diversity of individuals and groups who represents the concern and geographic area or population, and shared interests make consensus in different circumstances; for example, a single intervention in one setting may be sufficient to accomplish more modest goals for health improvement, and advocacy may be necessary when there are conflicting interests.

Table 5.9: Composite score of Operational factors

Collaboration and communication			
Participant Level	**Agree (>86.3)**	**Uncertain (86.2 –47)**	**Disagree (<47.1)**
Community Health Worker (CHW) organizes health and safety sensitization meeting regularly.	37.3	38.1	24.6
CHW collaborates with communities to identify potential risk to health.	34.1	41.3	24.6
CHW collaborate with communities to plan and implement health programs.	30.2	45.2	24.6
CHW collaborate with communities to identify environmental health and safety issues.	31.7	48.4	19.8
CHW collaborate with community to plan, implement and evaluate health promotion programs.	37.3	40.5	22.2
CHW speak to community groups on related health-topics.	34.9	44.4	20.6
Overall Operational Score	**17.5**	**64.3**	**18.3**

Communication and logistical networks must be strong enough to engage and mobilize intended beneficiaries at the base of society. The result shows that moderate and low collaboration and communication with stakeholders to community involvement in promotional activities (Table 5.9). Unimpeded internal communication among the membership and staff may be the most essential ingredient for enhancing the climate of participation. The quality of communication has been positively related to coordination and negatively related to conflicts (Hall, Clark, Giordano, Johnson, & Van Roekel, 1977). Open communication helps the group focus on a common purpose, increases trust and sharing of resources, provides

information about one another's programs, and allows members to express and resolve misgivings about planned activities. The present study concludes that moderately interact among CHW and local population regarding community involvement in health promotion programs.

Lack of coordination and cohesion within the highly fragmented health sector is well-known problem to destination planners and managers. The literature on inter-organizational partnerships is filled with examples of the difficulties inherent in sustaining successful relations among diverse partners (Duhl, 2000). Community health partnerships face qualitatively different challenges from those confronting individual organizations in either the public health or the private sector (Shannon & Shortell, 2000). Here collaboration is a "process of joint decision making among key stakeholders of a problem domain about the future of that domain" (Gray, 1989).

This study incorporated measurement of collaboration and communication with health sector and local stakeholders. Research indicates that achieving consensus in community organizations whose mission is to integrate community actors often begins with specific groups. The analysis reveals that less effort has been made by health sector to collaborate with local stakeholders in overall process of planning and implementation of health programs. However most of the respondent agrees that community health workers collaborate with communities to improve water and sanitation facilities at their respective community. Promotion itself can be broadly defined as communication strategies that inform, persuade, and influence beliefs and behaviors relevant to the products. Simplistically, promotion also can be categorized

as the use of media-based or interpersonal channels of communication; however, most promotions uses a number of media-based an interpersonal strategies concurrently or sequentially (Winett, 1995). Furthermore (McKinlay, 1993) argues that most effective public health interventions involve changes in policies and regulation, because these can cover entire populations.

The most important administrative unit for organizing and implementing PHC is the province level that policies will be put into practice. Weak, inactive and poorly organized health systems will inevitably mean a lack of basic health care for a country's population. The province management's ability to maintain member interest is very important to foster links between the partnership and external community, and communicate membership benefits is critical to the success and sustainability of community health participations. Data in Table 5.10 concludes that the greater number of local administration, island office, and health facilities encourages volunteerism in the community and provides healthy lifestyle training to volunteers. The result concludes that local administrative support will encourage volunteerism in the community (39%) agrees and also government commitment is more important to sustain community health care (38%) among the rural population those who are more vulnerable. There is a neutral agreement regarding health care facilities and island office that foster participation in the community (38.9%) agrees and disagrees regarding their role in encouragement of local community. Regarding the question asked about in-service training to VHVs, most agrees (37.3%) that some sorts of training are provided to them. Still there are barriers regarding information sharing from top to grass root level, which indicates that majority 42.9% disagrees with this clause.

Table 5.10: Administrative support and level of community participation

Administrative support	**(%)**		
Participant Level	**Agree (>86.3)**	**Uncertain (86.2 –47)**	**Disagree (<47.1)**
Local administration, island office, health facilities encourage volunteer groups for health promotion activities.	9.7	9.4	0.2
Government authorities help to overcome barriers, and health care organizations do their respective roles.	8.9	1.0	0.2
Island office and Health facilities encourage local citizen's participation in health promotion in this community.	8.9	2.2	8.9
Island office and health facilities provide opportunity to participate in health promotion activities.	0.4	6.2	3.7
Health facilities provide in-service training to VHVs	7.3	4.1	8.6
Island office and Health facilities share information about policies and regulation with VHVs	7.0	0.2	2.9
Overall Operational Score	**7.5**	**4.3**	**8.3**

5.2.3 Community factors

The factor 'commitment to community health' was measured by using the gratitude and values of dedication towards various health promotion programs. The overall result concludes that most of the respondents accept volunteer's dedication in providing community services (Table 5.11).

Table 5.11: Composite score of Community Factors.

Participation level	**Frequency**	**Percent (%)**
Community Factors		
Agree (> 69.1)	23	15.9%
Uncertain (69-35)	84	66.7%

Disagree (<35.1)			22	17.5 %
Mean= 52.1	Max= 90	Min= 18	SD= 17	

The general wisdom holds that participation tends to remain durable when the commitment of individual members is strong (Cohen, Baer, & Satterwhite, 1990). Member groups have different level of commitment that result in varied investments of time, effort and resources (Prestby and Wandersman, 1985). Furthermore Brown, (1984) and Neuson, (1989) as cited in Butterfoss, Goodman, & Wandersman, (1993) suggest that member Commitment may be increased by formalizing a system of accountability and developing criteria for judging whether member commitments are honored.

Table 5.12: Commitment to community health and level of community participation.

Commitment to Community Health		**(%)**	
	Agree (> 69.1)	Uncertain (69-35)	Disagree (<35.1)
District medical officers and their teams often appreciate and value of community participation.	3 9.7	39.7	20.6
Community members accept the community volunteer services.	46.0	38.1	15.9
Member ideas and views are as valid and excepted by health facilities.	42.1	40.5	17.5
This community is dedicated to community work	35.7	46.8	17.5
Mean= 52.1 **Max= 90** **Min= 18** **SD= 17**			

There were concerns that community representation on both the government and the volunteer groups were not as good as it should be. Some mentioned that community groups were sometimes as set up groups to address particular concerns or problem in the community. In this study commitment to participate in community

activities shows their willingness and enthusiasm. According to this study most of the responded agrees with the appreciation and volunteerism in the society. Community members accept the community volunteer's service agrees almost half of the respondent that 46 % and their views and ideas accept 42.1% of the respondent. Regarding the dedication of their volunteerism m most of the respondent are not sure 46.8%. This might be that most of the respondents are not aware of what sort of programs are conducting through health care workers in their society.

5.13: Trust by community and level of community participation

Trust by community			**(%)**	
		Agree (> 69.1)	Uncertain (69-35)	Disagree (<35.1)
Community people trust VHV's ideas and contribution towards HP program		22.2	44.4	36.5
The people are the principle actors in running the HP programs		23.8	44.4	31.7
Community health worker depend on us to any type of work regarding health		22.2	37.3	40.5
Mean= 52.1	**Max= 90**	**Min= 18**	**SD= 17**	

Empowering individuals by getting them directly and actively involved in addressing problems that affect their lives there by creating social bond amongst the community. Trust by community towards volunteers was assessed in this study. The result concludes that the respondent were not sure or uncertain about trust worthiness of their contribution. The trend in the country concludes that they only trust health care workers rather than health volunteers. As such there are no trained health volunteers in Maldives. Therefore creating synergy is very important when a

collaborative process successfully combines in sharing knowledge, skills and resources of a group of diverse participants.

Table 5. 14: Leadership within community and level of community participation

Leadership within community			
	Agree (> 69.1)	Uncertain (69-35)	Disagree (<35.1)
Community takes initiative to solve health problems in community.	35.7	38.1	26.2
Community leaders motivate and inspire other people to involve development activities.	37.3	36.5	26.2
All the members are a leader in this community.	43.7	28.6	27.8
Mean= 52.1 Max= 90 Min= 18 SD= 17			

Strong central leadership is an important ingredient in the implementation of any developmental program. When the leaders are attentive to and supportive of individual members concerns, and are competent in negotiation, collecting resources, problem solving and conflict resolution, the participation tend to be more cohesive in reaching peripheral members and maintaining program operations. Among the reviewed studies, leadership was the most often reported internal factor for partnership's effectiveness in creating community and system change. In grassroots initiatives, the leader is often the person who organizes and mobilizes community members around a common concern. Loss of leadership may be adversely associated with rates of community change (Fawcett et al., 1997); on the other hand strong leadership may increase rates of environmental change (Lewis et al., 1999). The result reveals that Maldivian community takes leadership in community (43.7%); the only

reason was that someone has to motivate and inspire grassroots members to involve in community development activities (Table 5.14). For example, community health worker, less is known about how partnerships develop and transfer leadership. Different leadership skills may be more useful during different stages of partnership development. These factors cause disillusionment.

Attitudes were assessed by using set of 8 affective statements. These statements were intended to measure control over events that impact life, which can affect participation (Table 5.15as presented below).

Table 5.15: Attitude of community towards health promotion programs and level of community participation

Attitude of community towards health promotion programs	**(%)**		
	Agree (> 69.1)	Uncertain (69-35)	Disagree (<35.1)
In this community have committees who mostly contribute support to health issues.	29.4	49.2	21.4
Communities have too many health promotion programs.	28.6	51.6	19.8
The School in this community takes initiative towards Health Programs.	36.5	44.4	19.0
Only doctors and health care workers should have responsibility for the health program in the community.	25.4	42.9	31.7
In order to sustain a healthy community must raise their voice on behalf of entire island.	30.2	43.7	26.2
The community should mobilize their own resources for the people.	32.5	46.8	20.6
The social needs of the citizens are the responsibilities of themselves and not of the community.	31.7	42.1	26.6
Only those who have most time should assume the responsibility for health promotion programs.	20.6	42.1	37.3
Overall operational scores (%)	**18.2**	**65.1**	**16.7**

In brief attitudes towards participation are the views of favorability or un-favorability about participation in the community. Attitudes towards health promotion programs are the attitude about the health care planners, program implementers and

politicians concern for the individual participation. The data in table shows low level attitude of community towards health promotion programs. There might be a related problem that voluntary organizations suffer from lack of continuity and financial assistance. These factors cause disappointment and resentment and hinder the promotion of participatory activities and attitudes towards participation.

5.2.4 Participant factors

The participant factors were measured by using culture of citizen participation, comfort of being a participant, perception of participants, time and resource availability, responsibility and expectation of participation as a participant. The overall result concludes that most of the respondents (70.6%) are not sure of with participant factors that affecting participant's participation in health promotion as shown in table 5.16.

Table 5.16: Composite score of Participant Factors.

Participation level			Frequency	Percent (%)
Participants Factors				
Agree (>97.4)			16	12.7%
Uncertain (97.3-55.3)			89	70.6%
Disagree (<55.4)			21	16.7%
Mean=76.4	**Max= 125**	**Min= 25**		**SD= 21**

5.2.4 (a) Culture of active citizen participation

Different culture have different ways of seeing the world, and acting in that world. Culture reflects and serves both the community and the individual needs, because it at once assures us of who we are and inspires us with intimations of the goals we may reach. The culture of participation in any development program has been practiced long back in the Maldives. For example, island chief mobilize community for DDT spraying under supervision of Health Workers. At present the trends has been changed but still do voluntary works at rural islands but it is quite difficult to mobilize

urban communities. The study result reveals that moderately encourages local citizen's participation in health promotion activities (Table 5.17).

Table 5.17 Composite scores of participant factors in affecting participation

Culture of active citizen's participation (%)			
Participant level	**Agree (>97.4)**	**Uncertain (97.3 -55.3)**	**Disagree (<35.1)**
This community involves representative range of local population in community health promotion programs in this community	41.3	46	12.7
This community encourages volunteer groups for health promotion in this community	35.7	48.4	15.9
This community helps to overcome barriers, health care organization do their respective roles	34.9	50	15.1
This community encourages local citizen's participation in health promotion in this community	34.9	50	15.1
This community provide opportunity for citizen participation in health development	34.9	49.2	15.9
Government authorities provides in-service training to VHVs	35.7	48.4	15.9
Overall community scores (%)	**12.7**	**70.6**	**16.7**

5.2.4 (b) Comfort with being as a participant

Since the adoption of Primary Health care in developing countries brought a new interest in the influence the cultural factors in community health programs. In the same concept the Maldivians do voluntary participation in certain prevention programs in the country. The participants notably participate in terms of health promotion in prevention of locally endemic disease. According to this study the majority (47.6%) of the respondent are happy to provide voluntary services to the

community and 42.9% were satisfied with volunteers and also 58.7% gets family and peer support to involve in community voluntary works. Furthermore the study suggest that public services are clearly valued their contribution. One or the other way representative contribute their participation in voluntary organization in the country.

Table 5.18: Comfort with being participant and level of community participation

Comfort with being participant (%)			
Participant level	**Agree (>97.4)**	**Uncertain (97.3 - 55.3)**	**Disagree (<35.1)**
I am happy to provide voluntary services to this community because people appreciate service	47.6	36.5	15.9
I am satisfied with volunteer services	42.9	41.3	15.9
I get support from my family to participate community work.	53.2	29.4	17.5
Overall community scores (%)	**12.7**	**70.6**	**16.7**

5.2.4 (c) Perception of participants

The general perceptions of volunteers are good among the participants in health promotion programs as shown below.

Table 5.19: Perception towards community participation

Perception of participants (%)			
	Agree (>97.4)	**Uncertain (97.3 - 55.3)**	**Disagree (<35.1)**
Man and woman are equal in developmental activities	58.7	24.6	16.7
Participation in health promotion programs will benefits me and my family.	48.4	29.4	22.2
Participation in health promotion programs will cost a lot of my time and resources.	20.6	35.7	43.7
Rich people do not need to participate in health promotion programs	19.0	36.5	44.4
Health promotion is the responsibility of government	20.6	37.3	42.1
Overall community scores (%)	**12.7**	**70.6**	**16.7**

Poor services at facilities also affect community perceptions and utilizations. Every island health center is closed to the community, but they have complained that advanced health care services are only provided at province and central level. This is the case that some respondents criticize that health services are poorer in their society/community. Finally, men and women think that they should carry same amount of responsibilities towards volunteerism. Women are preferred to take an equal role in community involvement in health not always in other social activities.

5.2.4 (d) Time and resources

Community-based health promotions programs are often large in scope, have extended time frames and require many resources. Local community may show dynamic and internally differentiated outcome due to environmental priorities and resources. According to Brachat (Estabrooks, Lee, & Gyurcsik, 2003) states that there must be an accurate understanding of community's needs, resources, social

structure, and values, and early citizen involvement, in order to build collaborative partnerships and facilitate broad community participation. In this study the researcher analyzed time and resources availability by using three questions. The three negative question scores have been calculated reversely. Most of the respondent moderately (41.3%) believes agree with lack of availability of time to participate in community activities and one third (44.4%) of the respondent agree that they have minimum resources to participate in HP (Table 5.20).

Table 5.20: Time and resources and level of community participation

Time and resources (%)			
Participant level	**Agree (>97.4)**	**Uncertain (97. 3 - 55.3)**	**Disagree (<35.1)**
Lack of time to participate in community development programs	22.2	41.3	36.5
Minimum resources to participant	23.8	44.4	31.7
I need to develop my own business rather than spending time on community work.	22.2	37.3	40.5
Responsibility of participation (%)			
To create awareness in this community	50.8	33.3	15.9
To identify priority area to improve healthy lifestyle in this community	49.2	35.7	15.1
I speak to the needs to develop more effective and efficient community base health care	51.6	33.3	15.1

5.2.4 (e) Responsibility of participants

Although the lead on public involvement a consultation was firmly allied to health authorities in the original document, clearly provider organizations also have a significant role to play in promoting and developing public consultation and involvement. The half of the respondent (50.8%) agrees that their main responsibility

is to create awareness and identify priority area to improve healthy life style in the community (Table 5.20).

Community involvement can be built in to the role of providers in a number of ways. Some of these are initiatives that could be encouraged by volunteers;

- Encourage positive attitudes.
- Explores with providers the impact of poor-quality services and alienating the style of service delivery of people's willingness to get involved and give their views.
- Build community development and community involvement into contract specifications.
- Work to support and develop the provider capacity of voluntary and community organizations, and seek to contract with them.
- Provide or encourage training and staff development program to build up skills in community involvement.

5.2.4 (f) Expectation of participants

Indicators of what was expected of the participating "community" can be found in the literature on health for all in WHO European Region, which demonstrates that, a wide variety of activities fall within the scope of participation in health. At individual level WHO encourages expressing "their views" on health issues and "expressing opinions" in order to influence political and managerial decisions. In addition, communities expect to get certain amount of training and practical help from other agencies. The Alma-Ata deceleration (1978) suggested that "appropriate education" was needed to develop the "ability of communities" to participate. The Ottawa Charter (1987) stated that "full and continuous access to information, learning opportunities for health, as well as funding support" were required.

Table 5.21:Composite scores of participant factors in affecting participation

Expectation of participants			
Participant level	**Agree (>97.4)**	**Uncertain (97.3 -55.3)**	**Disagree (<35.1)**
I expect to know most of the programs	57.1	28.6	14.3
I expect to have a decentralized health care system and have a greater NGO and private sector involvement in service deliver	59.5	27.8	12.7
I expect to know lots of information about health of this community.	60.3	26.2	13.5
I expect to inform health hazards in this community	61.1	25.4	13.5
I expect to get incentives to this voluntary work	46.0	30.2	23.8
Overall community score	**12.7**	**70.6**	**16.7**

The issues raised in this study are closely related to the sustainability and improvement of programs, and the health of the communities served. Most of the respondent (59.5%) expected coordinated action and collaboration among governments, health, social and economic sectors, NGOs and voluntary organizations and media to promote individual and community health participation. In general, these rural communities indicated that they expected the MOH to provide decentralized health care system and promote NGO and private sector involvement and free door-to-door services. 46% of respondent expected to get an incentive to their contribution towards community. For example; token of appreciation and easier way to consultation (Table 5.21).

The types of community participation indicate how, when and where participation is taking place. In general, the way respondent involved themselves on a voluntary basis and with some sort of other commitments. Most of the time it is posted to local communities by a sponsoring agency with fund and other forms of

support. Ideally, local communities should be encouraged to involve voluntarily. In some cases participation was forced type, not due to policies and regulations, but because of their deprived socio-economic status with the hope of getting more development to their community.

In summing up, the preceding analysis and discussion shows that the local residents who participated more actively in implementation activities were those with younger age, female who are married, with primary education, without any occupation and mostly housewife, having average income and with mostly political parties. The analysis also shows that the majority of the respondent had medium level of participation in all activities. Moreover out of total respondent small proportion of the have participated in health promotional activities. Most respondents participated under the influence of a political party's decision, rather than their own will.

5.3 TYPES OF COMMUNITY PARTICIPATION ASSOCIATED WITH FACTORS AFFECTING COMMUNITY PARTCIPATION

The chi-square analysis was carried out to determine whether any association between types of community participation and structural factors affecting participation. The association between structural factors and decision making was performed by using chi-square and it did not showed significant with associated factors as shown on Table 5.23 below. The association between structural factors and implementation process, data reveals chi-square value of 15.00 which was significant at the 0.05 level (P = 0.005). It can be concluded that there is a significant association between structural factors with implementation process.

Table 5.22Association between type of community participation and structural factors affecting in participation

	Overall type of community participation (%)				
	Agree	**Uncertain**	**Disagree**	***Chi-square***	**p-value**
	Overall factors affecting participation (%)				
Structural Factors		**Decision Making**		5.59	0.23
Always	6(40%)	8(52.3%)	1(6.7%)		
Occasionally	18(19.1%)	55(58.5%)	21(22.3%)		
Never	5(29.4%)	8(47.1%)	4(23.5%)		
Structural Factors		**Implementation**		15.00**	**0.005**
Always	8(53.3%)	4(26.7%)	3(20%)		
Occasionally	17(18.1%)	58(61.7%)	19(20%)		
Never	1(5.9%)	11(64.7%)	5(29.4%)		

*P <0.05 **P<0.01

Table 5.23 Association between type of community participation and structural factors affecting participation

Overall types of Community Participation and Factors Affecting Participation					
	Agree	Uncertain	Disagree	*Chi-square*	p-value
Structural Factors		**Benefit Sharing**		10.55*	**0.032**
Always	6(40%)	9(60%)	0(0%)		
Occasionally	14(14.9%)	58(61.7%)	22(23.4%)		
Never	1(5.9%)	12(70.6%)	4(23.5%)		
Structural Factors		**Evaluation**		12.45**	**0.014**
Always	7(46.7%)	7(46.7%)	1(6.7%)		
Occasionally	18(19.1%)	55(58.5%)	21(22.3%)		
Never	3(17.6%)	6(35.3%)	8(47.1%)		

*P <0.05 **P<0.01

Statistical analysis on community participation and factors affecting participation shows significant association benefit sharing and evaluation in Table 5.23. The result concludes a chi-square of 10.55 and was significant at 0.05 (p=0.032). This means there is an association between structural factors and benefit sharing. A similar analysis was carried out to determine whether there is an association between structural factors and evaluation shows significant at 0.05 (p=0.014).

Table 5.24 Association between types of community participation and operational factors affecting participation

Overall types of Community Participation and Factors Affecting Participation					
	Agree	**Uncertain**	**Disagree**	***Chi-square***	**p-value**
Operational Factors		**Decision Making**		1.04	0.904
Always	4(22.2%)	10(55.6%)	3(22.2%)		
Occasionally	15(18.3%)	50(61%)	17(20.7%)		
Never	10(38.5%)	11(42.3%)	5(19.2%)		
Operational Factors		**Implementation**		8.722	0.068
Always	6(33.3%)	9(50%)	3(16.7%)		
Occasionally	13(15.9%)	53(64.6%)	16(19.5%)		
Never	7(26.9%)	11(42.3%)	8(30.8%)		
Operational Factors		**Benefit Sharing**		10.52*	**0.03**
Always	5(27.8%)	12(66.7%)	1(5.6%)		
Occasionally	8(30.8%)	53(64.6%)	21(25.6%)		
Never	8(30.8%)	14(53.8%)	4(15.4%)		
Operational Factors		**Evaluation**		5.99	0.200
Always	4(22.2%)	12(66.7%)	2(11.1%)		
Occasionally	17(20.7%)	43(52.4%)	22(26.8%)		
Never	7(26.9%)	13(50%)	6(23.1%)		

*P <0.05 **P<0.01

The chi-square analysis was performed to find association between operational factors and types of participation was performed as shown on Table 5.24. The result shows that only operational factors and benefit sharing are significantly association at chi-square value 10.52 at 0.05 (p = 0.03). The rest of the factors did not show any significant association as shown on Table 5.24

Table 5.25 Association between types of community participation and community factors affecting participation

Overall type of community participation and community factors (%)					
	Agree	**Uncertain**	**Disagree**	***Chi-square***	**p-value**
Community Factors		**Decision Making**		6.55	0.162
Always	9(45%)	8(40%)	3(15%)		
Occasionally	15(17.9%)	52(61.9%)	17(29.2%)		
Never	5(22.7%)	11(50%)	6(27.3%)		
Community Factors		**Implementation**		12.345**	0.015
Always	9(45%)	8(40%)	3(15%)		
Occasionally	14(16.7%)	53(63.1%)	17(20.2%)		
Never	3(13.6%)	12(54.5%)	7(31.8%)		
Community Factors		**Benefit Sharing**		7.046	0.133
Always	8(40%)	11(55%)	1(5.0%)		
Occasionally	12(14.3%)	55(65.5%)	17(20.2%)		
Never	1(4.5%)	13(59.1%)	8(36.4%)		
Community Factors		**Evaluation**		10.27*	**0.04**
Always	7(35%)	8(40%)	5(25%)		
Occasionally	19(22.6%)	50(59.5%)	15(17.9%)		
Never	2(9.1%)	10(45.5%)	10(45.5%)		

*P <0.05 **P<0.01

The chi-square analysis was carried out to find association between types of community participation and community factors as shown in Table 5.25. The result revealed that community factor and implementation shows significant association at chi-square value of 12.35 which was significant at the 0.05 (P = 0.015). Moreover

with community factor and evaluation shows significant association at chi-square value 10.27 which was significant at 0.05 (P = 0.04).

Table 5.26 Association between types of community participation and participant factors affecting participation

Overall type of community participation and participant factors (%)					
	Agree	**Uncertain**	**Disagree**	***Chi-square***	**p-value**
Participant Factors		**Decision Making**		4.70	0.32
Always	6(37.5%)	7(43.8%)	3(18.8%)		
Occasionally	17(19.1%)	55(61.8%)	17(19.1%)		
Never	6(28.6%)	9(42.9%)	6(28.6%)		
Participant Factors		**Implementation**		2.39	0.67
Always	5(31.3%)	7(43.8%)	4(25%)		
Occasionally	16(18%)	55(61.8%)	18(20.2%)		
Never	5(23.8%)	17(52.4%)	5(23.8%)		

*P <0.05 **P<0.01

The chi-square analysis was carried out to determine whether any association between types of participation and participant factors affecting community participation as shown on table 5.26 .The analysis does not show any relationship between participant factor and types of participation.

Table 5.27: Association between types of community participation and participant factors affecting participation

Overall type of community participation and participant factors (%) (cont..)					
	Agree	**Uncertain**	**Disagree**	***Chi-square***	**p-value**
Participant Factors		**Benefit Sharing**		5.47	0.24
Always	1(6.3%)	14(87.5%)	1(6.3%)		
Occasionally	17(19.1%)	51(57.3%)	21(23.6%)		
Never	3(14.3%)	14(66.7%)	4(19%)		
Participant Factors		**Evaluation**		6.56	0.16
Always	7(43.8%)	5(31.3%)	4(25%)		
Occasionally	16(19%)	53(59.6%)	20(22.5%)		
Never	5(23.8%)	10(47.6%)	6(28.6%)		

*P <0.05 **P<0.01

Table 5.28 shows the association between participant factor to benefit sharing and evaluation. Analysis using chi-square method did not show any association between these factors. Therefore it can be concluded that there aren't any association in participation community health promotion programs due to participant factors.

The overall result concludes same as structural, operational and participant factors. More than half (65%) are not sure of community factors and 18.2 percent agrees with the statements to measure community factors.

(Murray, 2004) summarized common barriers to participate in public health planning projects and implementation. To overcome barriers at number of levels, namely the participant, community, the operational and structural level. Many of these barriers to participation were evident in this study:

1. No clear definition of objectives due to lack of assessment of consumer needs and lack of organizational agreement;
2. Insufficient funding to increase participation of grassroots community members;
3. Poor identification of key target audiences, including subgroups at highest risk;
4. Influence from political and professional objectives above consumer needs;
5. Influence of staff intermediaries between target group members and planners; and situations of urgency which result in short project time lines.

Communities with self-identified interest or target issue groups may have strong potential to participation and may be effective with general populations. This analysis will enable to explore the notion of how health services may achieve better outcome, including investing their efforts in increasing community participation and developing partnerships with existing groups and organizations.

The notion of 'uncertain' may itself is ultimate barriers to participation. In this appeal the participation of rural community groups may be significantly difference from participation of mainstream community members in terms of motivation, constraints and strategies which are necessary to make it meaningful and effective. Therefore this find needs further exploration.

CHAPTER SIX

ALTERNATIVE MODULE FOR ACTIVE COMMUNITY PARTICPATION IN HEALTH PROMOTION

6.1 INTRODUCTION

The purpose of this chapter is to review a wide range of experience in health promotion programs, with the aim of determining whether it is possible to single out the factors and conditions that encourage effective community participation module based on the study findings.

6.2 BEST POSSIBLE WAYS TO FACILITATE HEALTH PROMOTION PROGRAMS

There is an increase, in effectiveness of community participation and improvement of health outcomes, leading to improve more responsive care. Facilitate people's involvement in treatment decisions and improve quality and safety. Moreover, it can help to reduce political risk, hold professionalisms and bureaucrats accountable, encourage clinical management, identify workforce issues and foster more responsive and equitable services.

First of all why community participation is is important for health improvement. Refining the arguments of WHO, the UNICEF and Christian Medical

Commission, all of which played influential roles in the formulation of PHC (Rifkin 1981, Rifkin 2009), following can be concluded:

1) People are more likely to use and respond positively to health services if they have been involved in decisions about how these services are delivered, thus helping to make the services sustainable;

2) People have individual and collective resources (time money, materials and energy) to contribute to activities for health improvements in the community.

3) People are more likely to change risky behaviors when they have been involved in deciding how that change might take place;

4) People gain information, skills and experience in community involvement that help them take control over their own lives and challenge social system that have sustained their deprivation.

Now WHO is calling for PHC to be revitalized and renewed? The world health report 2008 is entitled *Primary health care: now more than ever.* The demand for revitalization is from all member states including health professionals and as well as political arena. Due to globalization most of the countries are under stress, and health systems are not clearly functioning in contemporary society. The demand and impatient with limited health services to deliver different levels of national coverage that meet minimum standard of care are changing. With this failure to provide services the only way that is corresponds to the needs of their expectations. The demand is getting higher day by day and the health system needs to respond better- and – faster- to the challenges of a changing world (WHO 2008).

The Primary Health Care values to achieve health for all require health systems that "put people at the center of health care". What people consider desirable ways of living as individuals and what they expect for their societies? This study also concluded some of the important indicters that need to be in place. PHC remains as a benchmark for most of the countries' discourse on health precisely because the PHC movement tried to provide reasons, evidence- based and preventive response to the health needs of the people (Katherine Gottlieb, Ileen Sylvester et al. 2008); (Kerssens, Groenewegen et al. 2004). In this assessment echoes this perspective as the right to attain quality health care at all levels by minimizing inequality and solidarity among the nation.

Moving towards health for all requires that health systems respond to the challenges of a challenging world and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate in society today and this reforms constitutes the revitalization of PHC (WHO, 208).

6.2.1 The social environment and health

Today the whole world, people are getting healthier, wealthier and live longer than 30 years back. According to WHO, (2008) report if the children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths. This can conclude that difference of 6.2 million is equivalent to 18329 children's lives being saved every day (WHO 2008). Maldives have made tremendous progresses in health indictors from 1999 to 2008 as shown in Table 6.1. This table shows that progress I possible. It can be accelerated. The only

way that can be accelerated by improving health and transforming health literacy in a better educated and empowered society is crucial for the better health of the nation.

Social environmental factors influence health predicting mediators such as disease pathways and quality of life, and in the long term health comes such as health expectancy (Marmot 2005). The concept of social capital "the process and conditions among people and organizations that lead to accomplishing a goal of mutual social benefit" (Green and Kreuter 2005) is also referred to social support and social participation. Many researchers agree that social capital has a role in the promotion of health (Kawachi, Kim et al. 2004).

Table 6.1 Health indicators from 1999 to 2008

Health indicators	**1999**	**2008**
Infant mortality (per 1000 live births)	20	11
Under 5 mortality (per 1000 live births)	28	14
Crude birth rate (per 1000 pop)	19	22
Crude Death rate (per 1000 pop)	4	3
Maternal mortality ratio (per 100,000 live birth)	115	57
Life expectancy in years (Kegler, Steckler et al.)	72.1	72.5
Thalassaemia registered cases (per 100,000 population)	387	669
Tuberculosis incidence (per 100,000 population)	73	60
Leprosy incidence (per 100,000 population)	23	5
HIV incidence (per 100,000 population)	19	15

The influence of the environment on health has been widely recognized and demonstrated by the rapidly growing and evolving literature on the relationship between health and the social and physical environment (ISEPICH, 2007). In these

developments, current health promotion practice seeks to bring about environmental changes that, along a varity of transitional outcomes that are intended to lead to better health. In recent years, the government of Maldives has taken steps to integrate a human right approach to health in its national development policy; the Seventh National Development Plan states that "*the health policy of the government is targeted to ensure access to Primary health Care to all citizens in an equitable manner*". (Ministry of Planning and National Development, 2007. Pp 144). The government has pledged to reduce the disparities in the quality of life and disease burden.

Decentralization is one important tool in improving governance. Decentralization of health-care services has the potential to improve efficiency of health services and equity of outcome. It is an opportunity to improve public health services with private sector involvement as well as regulation of private sector. Furthermore, civil society empowerment to participate in policy formulation, implementation and monitoring is necessary to ensure transparency, accountability and efficiency. The community can play an important role in light of the changing burden of disease and the aging population. Implementation of decentralization of health-care services is most suitable way for community participation in a small country with geographically dispersed population like Maldives.

Decentralization of health-care can contribute to the four areas of PHC. That is Universal coverage reforms that leads to better health equity, service delivery reform as it will be people- centered health services, public policy reforms to secure healthier communities and leadership in more inclusive manner, participatory and accountable in health governance. A change of roles at both central and local levels should take place.

A combination of ministry and community representative can make the organization subordinate to ministerial planners. These can carry out health planning and delivery functions, and also composed of representatives from popular organizations' such as women's associations, the federation of health workers and neighborhood bodies. The functions of stewardship – legislation, standards setting, supervision, monitoring and evaluation should remain with the central government (World Health Organization 2010).

In 2011, Local Government Authority (LGA) were established under the act of decentralization of the Administrative Division of the Maldives is to monitor and formulate operational regulation for City councils, atoll councils, and island councils. The responsibility for councils is participating in the deliver of most local public services along with state government. In late 2011 there was a national initiative to overhaul the primary health care system through the adoption of a new national health policy, in the context of federal governments issues directives in giving LGAs fill power over the delivery of PHC services. Therefore, the services have been transferred to MOHG to deliver PHC services only through Health Protection Agency (HPA).

The current national policy is jurisdiction over the Public Health Act 10/2010,indicates that government are expected to provide PHC services to the people of Maldives. It also mentioned that in order to facilitate island and city councils to escalate their responsibilities in implementing this Act in their regions and to give legal authority to the process, the minister has authority to appoint power. All responsibilities under this Act also has to delegate at the island, atoll or city councils in writing with roles and responsibilities clearly stated.

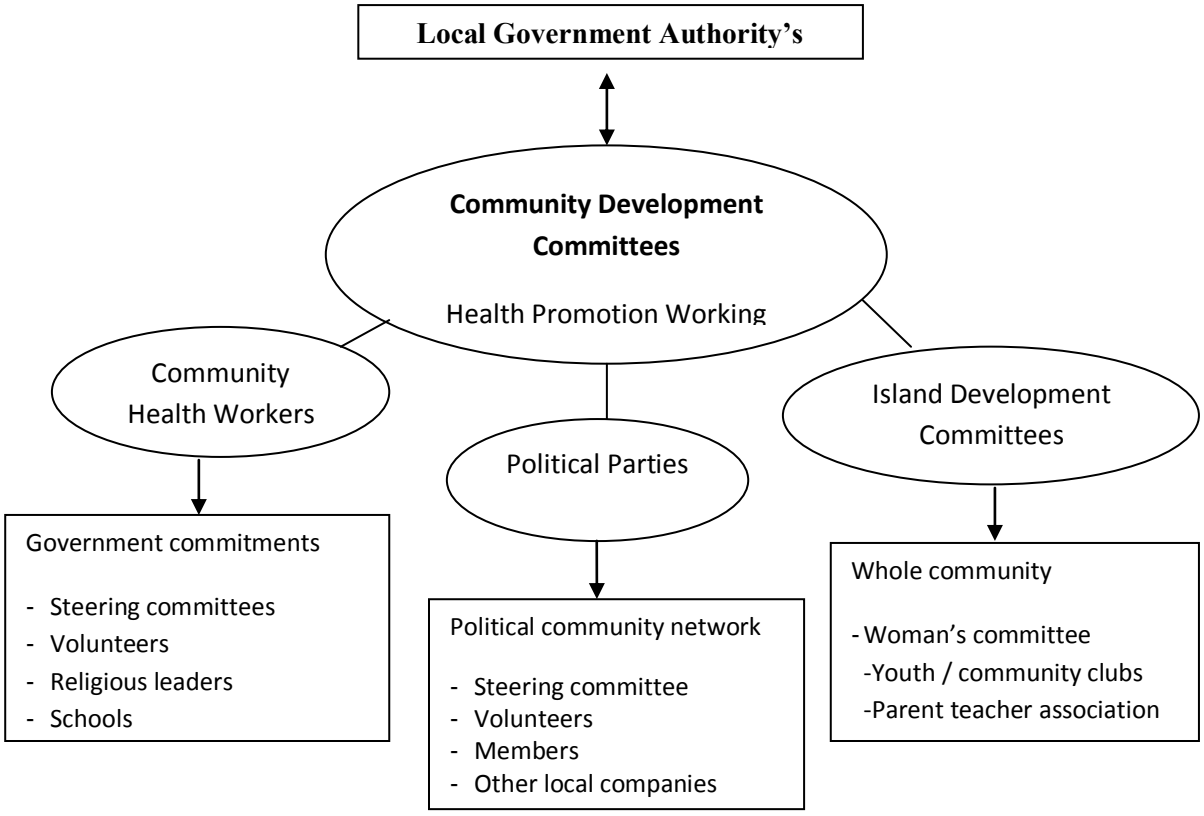
LGA has the equal responsibility in implementing public health services, with the general guidance, support and technical supervision of state Health Ministry, under the aegis of LGA Councils shall facilitate the process to meet the needs of the local community.

This implies that according to constitution, it is the state governments that have principle responsibility for basic services such as a primary health and primary education, with the extent of participation of LGAs in the execution of these responsibilities determined at the discretion of individual state governments.

There are various opportunities for community participation in health promotion. Most of the opportunities can be created by health promotion working groups or action groups in respective community as mentioned in this study. Community members can be involved in many ways, including individually, in groups or as a member of committees. The inclusion of community views and experience is very important and it cannot limit on working groups. Other means used to promote community engagement include surveys, interviews, focus group discussion, forums, planning groups and evidence based analysis. It is necessary to determine what types of participation are going to achieve the best results for a particular situation (ISEPICH, 2007).

Under Decentralization Act, the responsibility of councils is to motivate community development committees and facility head and staff that were indicated as principle decision- makers. However, there are striking differences in the sharing of responsibly between LGA and community development committees in the country.

Figure E: Framework that can be practice for community involvement in health promotion programs.



A great varity of groups may activate at one time or another be involved in community health promotion. In a local society with relatively small population and simple organization, such as an open country neighborhood, associations engaging in community activity are relatively easy to recognize. An excellent example is the community club or youth club. In this one association all the members in the area may coordinate to the interests of their common problem. By contrast, in a big city a number of organized groups may be operating in interest of their area. In this situation it is not easy to identify the organized activity which lies in the community field, but it is possible in favor of informal network.

The efficiency and moral of community participation are very important, and it depends on the genuineness of the individuals and groups representing the community of interest. In theory, community representative are able to provide insight into the norms, values, experiences and appreciation of the community they represent. Technically in many communities the great interest to public health are mostly of those members who have technically limited skills, knowledge and access to power and has less capacity to empower others. Empowerment relates to a person's ability to perform well in the society. Increasingly the efforts of public health is to empower local communities, and support of community members who will then have specialized knowledge, skills and abilities to carry out his/her roles and responsibility. Capacity building creates a cadre of individuals who both understand and values of the community as only members can understand the theories and method of public health.

Community representative ideally serve as bridge between their respective communities and the public health professionals with whom they work and professionals back to their communities. However, in the same way that public health professionals often define communities based largely on the reason for engaging specific groups, professionals often identify community representatives in light of the purpose they are expected to serve. Even sincere efforts to include community representation in public health activities may result in tokenism if the primary purpose is satisfied.

To be more effective in strengthening community actions in the future, the following mechanism must develop and incorporate into health promotion practice: 1) the engagement of communities to share priorities; 2) build community capacity; 3) mechanism for flexible and transparent funding and; 4) creative to replicate or scale-up successful local initiatives.

6.2.1.1 Engage communities to share priorities

A major step to strengthen community action in the future is to better engage with communities to accommodate local engages within national programs. Key to approach this is to use standardized approaches for community engagement during planning process to identify issues and then incorporate these within the design of the programs. The primary goal to engage communities to share priorities, first develop communication channels with the partners and government agencies to share success stories. Also identify and promote opportunities for local communities to participate in realizing the mission and vision of the organization and contribute to build a vibrant emirate. Promote capacity development opportunities for the community to provide feedback and raise their voice for additional needs.

Engage key informant in setting priorities and solving problems in the community. When the inspired people engage in community activity they will play in forging significant, long-lasting community change.

6.2.1.2 Build community capacity

Successful health promotion programs have a clearly defined strategy of how they will build capacity at a local level. Without this focus, the community can become dependent on an outside agency to provide support and resources without themselves

taking responsibility for action and greater control. Community capacity building is asserted by various authors (Goodman *et. al.,* 1991) as a process that escalates the assets and attributes that a community is able to draw upon. For a health promotion organization or health promoter, the task is not to create new program called 'capacity building'. Rather, the task is to examine how its practice can support increasing knowledge, skills and competencies of the community (Laverack and Nastaran, 2011).

Community capacity building is normally undertaken to achieve a specific purpose of community development work. In brief it is to bring about a collective change and justice, by working with communities that are targeting. It can also be defined geographically defined population of interest. It can be started by identifying their needs, opportunities, rights and responsibilities. Plan training program, organize and take necessary action. Lastly, evaluate the effectiveness and impact of action. Community capacity building can also strengthen the skills, competencies and abilities of people and communities in developing societies so they can overcome the causes of their exclusion and suffering.

Providing facilitator training is an additional component of successful health promotion programs.

6.2.1.3 Mechanism for flexible and transparent funding

Capacity building involves the provision of resources to support local initiatives. To meet the varied demand of community needs, funding agencies must be flexible in the type and timing of resources that they are prepared to provide. In a program context resources are often designated to a specific budget category, for example, health education session or screening services, which may not meet the needs of a

community initiative. The capacity building to tackle problems related to flexible and transparent funding needed and it takes place on an individual, an institutional level and society level.

- At individual level it enhances existing knowledge and skills. It also entitle for the establishment of conditions that will allow individuals to engage in the "process of learning and adapting to change".
- Institutional Level should involve aiding pre-existing institutions, developing countries.
- Societal level should support the establishment of a more "interactive public administrators that are responsive and accountable.

6.2.1.4 Creative to replicate or scale-up successful local initiatives

Health promotion must be more creative in the future to replicate or scale up successful initiatives that address local concerns. Obviously, this requires the right level of political commitment along with scaling-up of community action has to be achieved. For example walk to office every Monday in Maldives, the safer parks schemes in New Zealand and walking school buses in Australia are such initiatives.

Reviewing the current literature on health promotion interventions reveals that, similar to health promoting interventions in other settings such as schools, there is an inadequate understanding of communities. Context- and time dependent social settings have unique characteristics that changes overtime. Engagement with, capacity building of, transparency and being creative with local communities requires a partnership that is equitable, fair and open. A major challenge for the future is

therefore how health promotion agencies can develop and maintain the trust of communities, especially the socially marginalized in the society. In the long term, the planning, implementation, benefit sharing and evaluation of culturally appropriate interventions to reduce inequalities across different ethnic, geographically distributed areas and sectors should become an essential part of health promotion.

6.3 BEST ALTERNATIVE MODULE FOR ACTIVE PARTICIPATION FOR MALDIVIAN CONTEXT

Review data suggest that community participation in health cannot be sustained in health services alone; the literature examines health as part of wider community development programs. A review by Hossain and colleagues, on community participation and its impact on health in South Asian experience brings together evidence that community development programs have made an important contribution to health improvements (Hossain, Bhuiya, Khan and Uhaa, 2004). In this review it details some of case-study in relations to community participation in planning and implementation of health promotion programs. They concluded that it is possible to show the impact of some community development programmes at the community level, but not at the national level. The factors that improve health and links between those factors and the process of implementation have yet to be identified and explore more.

Most of the public and private health services in Maldives have concentrated on establishing large hospitals and clinics that have been able to cater to only a small privileged fraction of the population.

For very long time, and even today, people have believed that the health system is able to improve the health of the population and reduce disparities in mortality rates. Recently endorsed Public Health Act, promulgate in 2013, states that community participation at all levels of public health programs reduces inequalities in health and it can be achieved through proper and informed health promotion. Since, world embraces health promotion as priority agenda, Maldives also encourage several community based approaches to health care which was discussed in chapter 2 and 3. This entails training local people, building awareness, and providing health education. Moreover, this follows an integrated concept of health, which goes beyond the mere curative aspect and encompasses both preventive and promotive dimensions. Therefore the most appropriate models of community based health promotion are integrated and comprehensive model.

6.3.1 How do Maldivians can be empowered to participate in health promotion programs?

This model involves combining training of local volunteers with health education and rural development health activities emphasizing self help and use of available resources at island level. It is intended to assist health promoters to systematically accommodate empowerment goals within their normal approaches to programming.

Community – based health promotion base on the above mentioned model particularly can be delivered with the commitment from state government. In practice, community assessment and priority setting are most important components in health planning that certainly affect each other. Formal assessment based on the overview of the community to find out the feasibility of the project and benefit can be measured. Public health planners need to be balanced their professional responsibility to use attractive, interesting method and meaningful participation of the community.

People participation in phase1; in the way described in inquiry phase the people from the community itself decide what health programmes they think should be undertaken. Need assessment can be done from the community leaders, key informant, teachers and health workers. Government to provide the expert knowledge and resources to enable the activities to pursued. Based on the assessment make accost estimation for the project by tapping the available resources. Choose the best way of mobilizing those resources which include materials, money and personnel, to satisfy community priorities.

At the designing pahse-2, clearly define the objectives, group process and roles and responsibilities. People have both the right to know the information so they can participate in decision making. Such involvement provides a basis for increasing self- confidence and self-reliance. It will give also a practical force to the idea of health as a human right and an element in social justice issues.

Module 1: Community- based intervention on health promotion.

Phase 1- Inquire **Identify the target group, purpose, goals and vision for the community**	
Key question to explore	**Supporting activities**
Target group: who are targeting for? Identify important stakeholders. **Purpose**: what is this community's primary purpose? What are the benefits to the stakeholders? What specific needs will the community be organized to meet?	- Conduct a need assessment through informal discussion, formal interview and focus group discussion**.** - Define benefits of the community for all stakeholders, including community leaders, religious leaders' community as a whole and sponsors. - Create a mission and vision statement - Identify major topics and exploration - Create cost estimation for facilitation

	and support - Begin recruitment of key stakeholders to run the program
Phase 2- Design Clearly define the objectives, activities, group process and roles and responsibilities	
Activities: What types of activities will maximize participation and support? What will the community rhythm be in talking the existing problems? **Communication:** How will member communicate on an ongoing basis to accomplish the primary goals? **Training and learning:** What are the learning goals? And how can collaboration learning are supported? What kind of training needed and mode of training? **Collaboration:** How will community members collaborate with each other to achieve shared goals? **Time:** How much time can be spending on this at initial development? And latter how much time can put to make it a success? **Roles and social structure:** How will community roles can be defined at individual level, groups, leaders and administrative level. And who will take lead on them?	- Identify the tasks of the community. - Develop scenarios and describe and demonstrate. - Identify face-to-face meeting opportunities for community members. Explain how this can happen and which form - Lay out tentative program for the community (time frame). - Create a directory - Determine facilitator roles and recruited community facilitators.

Phase 3- strategic approaches Pilot the communities with a select group for stakeholders to gain commitment, test assumption, refine the strategy and establish a success story.	
What are the short term goals that will help to establish the community as visible and valuable entity? What technologies can be used to support the pilot community's social structures and core activities? How can they be shared success of the program?	- Select the most appropriate community-oriented technology to support the goals of the project. - Design community environment friendly tools - Implement the community prototype and give access to the core team and pilot audience. - Facilitate events and activities to exercise pilot. - Measure success of the program and report the result to sponsors and the stakeholders.
Phase 4 – Implementation Roll out the project to a broader audience in the community in new members can join and get the benefits**.**	
How many members become oriented to the community environment? Based on the orientation given from pilot project what kind of energy can be generated to support the newly join group? Based on insights, how will roles and structure of the community can be benefited over time? How will success be measured?	- Using experience and result from the pilot project design and implement to the community. - Establish the community charter or road map which includes their vision, mission goals etc. - Recruit new members and orient them. - Finalize and publicize the road map - Set up a communication channels
<u>Phase 5 – Benefit sharing</u> - Why should someone join the community project? - What are the benefits they are getting? - How do members get recognized and reward for their	**Benefit measurement** - Material benefits - Social benefits - Personal benefits - Harmful consequences

contribution? - How do members create their own identity and presence?	
Phase 6 – Evaluation and Sustain Evaluate the program outcome and grow the project. Networking events that meet individual, group and organizational goals that create cycle of participation and contribution.	
- Outcome evaluation	Evaluation of program - Evaluation of the techniques used in the program - Create and share success stories of individual as well as community - Conduct focus group discussion to measure the success - Facilitate discussions about community motivations for participating in the community. - Develop policies and process for harvesting and sharing knowledge outside the community - Encourage publication to news paper at central or local level. - Review participant goals and domain, watch for shifts in expectations and needs.

In Phase 3- strategic approaches; Pilot the communities with a select group for stakeholders to gain commitment, test assumption, refine the strategy and establish a success story. Successful health promotion programs should have a clearly defined strategy of how they will build capacity and go forward. Without this force, community will be too much dependent of outside NGO or other agency to provide support.

Capacity building is an action that they themselves take responsibility for action and greater control. The program establish a steering group made of stake holders from the groups of leaders, teachers, health professionals with task oriented to manage and implementation.

Phase 4 – Implementation; Roll out the project to a broader audience in the community and new members can join and get the benefits. In this process strengthen the program objectives and increase number of members in to the project. Review the current status of health promotion interventions. Success strategies can be defined and share best practice to schools and other work places. Communities can be empowered to achieve the social and political changes needed to address their power in the society. Empowerment influences community participation as it measures the interactions between capacities, skills and available resources at both individual and organizational levels.

In Phase 5 – Benefit sharing; think about how community people economically motivated. The benefits might vary from member to member; group to group therefore analyze the expectation of the participants. Some project work for food which they can have both short and long term benefits. The food, no doubt motivates community to participate in the effort more than the expectation for other things. The

reason for considering this factor is not to suggest incentives but do more voluntary work for the community.

In Phase 6- Evaluation; Evaluate the program outcome and grow of the project. As with other kind of participation, it is very important to evaluate the pattern of participation, the scope, and the power of participation involved. The process can be surveyed with a written questionnaire to measure the outcome of the project. Or else community key informant interviews or focus group discussion can conclude the project out come.

Networking is also important for sustainability, events that meet individual, group and organizational goals that create cycle of participation and contribution promotes sustainability of the program.

CHAPTER SEVEN

CLOSING REMARKS

7.1 INTRODUCTION

Since primary health care is concerned with using scare resources at any setting that brings the greatest possible health benefits to the greatest number of people. Community or citizen participation in health promotion is well-recognized as an essential means to a healthier and sustainable development in the health and environment field. In this chapter, discus about the practicality of implementing proposed module in the climate of Maldives. Followed by major obstacles and challenges in the process of planning, implementing and financial constraints is highlighted. Finally, in light of the finding recommendation and direction for further research are proposed.

7.2 INTEGRATED COMMUNITY-BASED HELATH PROMOTION MODULE

The most important step in implementing community- based health promotion module in to basic health services is through the PHC approach. Health Protection Agency is the mandatory agency to provide health promotion activity in the Maldives. The recently passed *Act on Public Health* defines how polices will be established and implemented. Including, identifying roles and responsibility of island, atoll and city councils in protection of public health. Based on these responsibilities the most appropriate gateway to implement community-based intervention module on health promotion is through councils. To implement this module establish a system for the work of public health programs in the regions representing councils. Make it

compulsory for all health care services facilities and centers to implement public health programs through community involvement with of the councils to follow the aims, standards and procedures accordingly with the guidance of Health Protection Agency.

The major possible challenges in implementation of health promotion programs based on the finding suggest that poor definition of expected outcomes, specific factors and conditions to be influenced through health promotion programs, lack of health promotion policies and guidelines for coordination of different methods and approaches and inadequate capacity (especially in human resources) to develop, implement and evaluate health promotion programs and activities. The following will foster participating at any level in the community:

- The policies and guidelines for community participation should be in place and training need to be provided to fill the gap of inadequate human resources.

- The Opportunities for citizens to participate in health planning has to be patient and unblock the friction between health care professionals and council members and shape the policy to the right of the people.

- The system of health governance, political wills coordination and collaboration and communication, and administrative support.

- Insufficient transparency with respect to intergovernmental organizations and central decision-making has been noted. Moreover there are overlapping aspects in health system of Maldives which could lead that most of the respondents as uncertain about the operational features of the government.

The overall implementation can be activated by considering above mentioned strategies. The community commitment, trust with in community, leadership

skills and attitude of community towards health promotion programs are very important factor that influence participation in health promotion programs.

7.3 IMPLICATION FOR POLICY DEVLOPMENT

An important area is producing an inventory or a database of community groups in the region. This will allow an analysis of the community structure within the region and also it will permit to identify role of existing groups, which usually have a mix mode of functions. As this mechanism increase community participation in civil and society activity and explore the ways in which health and other government sectors might provide financial support to implement health promotion activities.

Budget allocation is in need to pilot this module and followed by rolling out to other regions. Initially government could support and in second face of implementation international donor support will seek. Principles of participation can be expressed at various forums to increase awareness among whole country.

In relation to this interest in modifying the current practice, a number of practical recommendations for strengthening community participation in health promotion can be suggested with identified study findings.

7.4 PROPOSED RESEARCH

Further studies using similar measures will permit comparisons of participation levels in different communities around the country. This will be an important step to increase understanding for the ways in which participation levels differ in different context and cultures. Given that the level of social capital is being seen as an outstanding indicator of a health community. Therefore, understanding the patterns

underpinning social and civic participation will be important to social healthy policy debates. .

Developing community participation can be a difficult endeavor and what is evident is that practitioners need to understand what level of participation is meaningful to the approach being taken to guide implementation decisions and assessments. Clarifying with local stakeholders what the purpose of community participation is; who should involved and how or what level this participation should occur, will further strengthen and contribute to the development of health promotion programs in Maldives.

Community participation is without drought the greatest hope for access to effective health care for most people in living on islands. There is clearly a need to develop competency in knowledge, skills and inculcating the right and positive attitudes for island health, with hope of developing rural leadership in health care.

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QUESTIONNAIRES

This questionnaire is prepared for the purpose of collecting primary data for the degree of PhD in Social Administration (public health). The study is conducted to assess community participation in health promotion programmes and to identify the factors affecting Maldivian participation. I would very much appreciate your participation in this study. Your response will be kept strictly confidential. Therefore, please feel free to answer the questions. Thank you very much for your kind and honest answers.

Name: Asma Ibrahim Suleiman
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Department of Administration and Social Justice receipt
Metric no: AHA 090030
University Malaya

Serial. No: .....

Name of interviewer: .....

Date:...../...../.....

SECTION A

Instruction: Please fill in the blank or put mark √in the box [ ] of the most appropriate answer.

I. RESPONDENT PROFILE.

1. Gender

    a) [ ] Male

    b) [ ] Female

2. Age.....years

3. Marital status
    a) [ ]Single

    b) [ ] Married

    c) [ ] Widowed

    d) [ ] Divorced

    e) [ ] Separated

4. Education…….. total no. of years

    a) [ ] No education

    b) [ ] Primary school (grade 1-6)

    c) [ ] Secondary school

    d) [ ] High secondary school

e) [ ] vocational training center

f) [ ] Higher degree and above

g) [ ] Other, please specify
……...

5. Occupation ……..(Field of occupation)

a) [ ] Government official

b) [ ] NGO

c) [ ] Private business

d) [ ] Farmer

e) [ ] Unemployed

f) [ ] Student/Pupil

g) [ ] Housewife

h) [ ] Other (specify).....

6. Number of family members: ……persons.

7. How many people earn money for family's monthly consumption ……

8. Average monthly income in family: …….. (monthly)

a. [ ] 15,000 and above

b. [ ] 10,000- 14,999

c. [ ] 5,000 – 9,999

d. [ ] 1,000 – 4,999

e. [ ] 999 and below

9. Are you currently involved in any local organization?

a. [ ] Yes

b. [ ] No (go to last Q)

c. [ ] Others

10. Are you a member of the following local organizations in this community?

a) [ ] Youth association

b) [ ] Island development committee

c) [ ] Health task force

d) [ ] Island health volunteer

e) [ ] Private NGOs

f) [ ] Political party

g) [ ] Others, please specify……

11. How did you become Community Health Volunteer (CHV) ?

a) [ ] Nominated by myself or personal interest

b) [ ] Committees elected me

c) [ ] Island chief / health officer appoint me

d) [ ] others, specify ----------

12. How long you have being as Community Health Volunteer (CHV) ?

…….... month ……..…….. years

13. How often do you play the role of CHV?

a) [ ] monthly 3 – 4 times

b) [ ] monthly 2 -1 times

c) [ ] none

d) [ ] others, specify ----------

SECTION B: Involvement /participation in health promotion programmes.

14. Are you involved in any health promotion programs in this community?

a. [ ] Yes (If 'Yes' go to Q.10)

b. [ ] No (If 'No' go to section C)

c. [ ] Others, please specify…….

15. In what program you participate as a health promotion volunteer?

(*Put mark √in the box [ ] can provide more than 1 answer).*

a) [ ] Communicable Diseases

b) [ ] Maternal and child health program
(Nutrition program)

c) [ ] Mental health awareness program

d) [ ] Quit and win program
(Anti Tobacco program)

e) [ ] Non-communicable disease prevention program

f) [ ] All of the above programs

g) [ ] Others .Please specify…….

SECTION C

TYPES OF COMMUNITY PARTICIPATION

Please fill in the blank or put mark √in the box [ ] of the most appropriate answer.

Always – all the time whenever happened

Most of the time – more than half of the total time happened

Occasional – half of the total time happened

Sometimes – less than half

Never – no participation

	Activities	Never	Sometimes	Occasional	Most of the time	Always /frequent
C I - Participation in decision making process/activities						
15.1	I attend all the general meetings					
15.2	Participate in decision by asking questions and recommendations					
15.3	I involve in problem and need assessments.					
15.4	I involve in making action plan.					
15.5	I participate in decisions regarding programme implementation					
15.6	I participate in decisions regarding distribution of benefits.					
15.7	I participate in developing operational plans.					
15.8	I participate in decision regarding managing conflicts in the group.					
15.9	I participate in delegation,					

	representing the group to dialogue with the programme officer.					
C II- Participation in implementation process/activity						
16.1	Mobilize community resources to implement community improvement programme.					
16.2	I worked collaboratively to improve water and sanitation condition.					
16.3	I help publicizing information of disease situation through home visiting in the community.					
16.4	I help in health campaign to improve healthy lifestyle in community					
16.5	I assist health personal in giving vaccination.					
16.6	I organize physical activities in the community. E.g. group exercise					
16.7	I persuade community for exercise.					
16.8	I do home visiting for health education and rehabilitation.					
16.9	I identify and inform risk group in the community to attend checkup. E.g antenatal, elderly group and under five group, malnourished children.					
16.10	I inform community about health center services.					
C III - Participation in benefits						
17.1	My household income increases by participating in Health promotion.					
17.2	I got benefits directly from a project that I participated					
17.3	I get social benefits by improving health care in this community.					
17.4	I do get personal benefits by increasing popularity in community and thereby people					

	recognize in this society.					
C IV- Participation in evaluation activities						
18.1	I involves with health officials to identify progress of the programmes					
18.2	I discuss with group members to identify progress of the programmes					
18.3	I discuss with family members about progress of the programmes					
18.4	I discuss on program progress in committee meetings					
18.5	I contribute suggestions/ ideas in discussions.					

SECTION D

FACTOERS AFFECTING PARTICIPATION

D I - Structural factors

Instruction: Please mark √ in the box [ ] that you choose.

Strongly Agree- 5
Agree- 4
Uncertain- 3
Disagree- 2
Strongly Disagree-1

	Activity	**Strongly Agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
19. Structure of health care system						
19.1	Current structure of Maldives health care system motivates grass-roots community development action.					
19.2	Current no. of health care providers is sufficient to provide services for this community.					
19.3	Decentralization of health services strengthens district health system which serves best for community.					
20. Availability of trained local human resources						
20.1	This island has enough trained health promotion officials to					

	provide services to community					
20. 2	We have a specific person to provide health promotion programmes.					
20. 3	The appointed health promotion officer regularly communicates with voluntary groups.					
20.4	Support of NGOs can provide additional resources in developing community involvement in health.					
21. Capacity of resources for community participation						
21.1	The government provides a community center for us to conduct a meeting about health activities					
21.2	We have an expert person to organize HP programmes in this community					
21.3	We have a community leader appointed to deal with health facilities.					
21.4	Our community manpower contribution to health programmes are more than other developmental activities.					
D II - Operational factors						
22. System of health governance						
22.1	Many people have been placed in the community in charge of health promotion activities					
22.2	Government promotes better transparency and accountability of health system.					
22.3	Health sector strengthen partnership with civil society to empower their active participation in health development					
23. Political will						
23.1	The present policy permits to health and safety of the people.					
23.2	The present government develops health sector policies					

	and frameworks that promote community participation.					
23.3	The present government works with external partners to promote greater participation.					
23.4	The present government develops people's managerial capabilities to take responsibilities for a process like community involvement in health.					
23.5	The present government incorporates human health criteria into all policy sectors.					
24. Co-ordination						
24.1	Health care facilities has good linkage with other sectors such as education, island office, island committee and other government sectors for the purpose of improving health care in the community.					
24.2	Advocate stakeholders in order to assure sufficient support to community development.					
24.3	Better local-level intersectional co-ordination so that the underlying basis of poor health can be identified and understood.					
25. Collaboration and communication						
25. 1	Community Health Worker (CHW) organize health and safety sensitization meeting regularly					
25. 2	CHW collaborates with communities to identify potential risk to health?					
25. 3	CHW collaborate with communities to plan and implement health programs.					
25. 4	CHW collaborate with communities to identify environmental health and safety issues.					
25. 5	CHW collaborate with community to plan, implement and evaluate health promotion programmes.					

25. 6	CHW speak to community groups on related health-topics.					
26. Administrative support						
26. 1	Local administration, island office, Health facilities encourage volunteer groups for health promotion activities.					
26. 2	Government authorities help to overcome barriers, and health care organizations do their respective roles.					
26. 3	Island office and Health facilities encourage local citizen's participation in health promotion in this community.					
26. 4	Island office and Health facilities provide opportunity for citizen participation in health development.					
26. 5	Health facilities provide in-service training to VHVs					
26. 6	Island office and Health facilities share information about policies and regulation with VHVs					

D III- COMMUNITY FACTORS

Instruction: Please mark √ in the box [ ] that you choose.

Strongly Agree- 5
Agree- 4
Uncertain- 3
Disagree- 2
Strongly Disagree-1

	Activity	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
27. Commitment to community health.						
27.1	District medical officers and their teams often appreciate and value of community participation.					
27.2	Community members accept the community volunteer services.					
27.3	Member ideas and views are as valid and excepted by health facilities.					

27.4	This community is dedicated to community work.					
28. Trust by community.						
28.1	Community people trust VHVs ideas and contribution towards HP programmes.					
28.2	The people are the principle actors in running the health promotion programmes.					
28.3	Community health worker depend on us to any type of work regarding health.					
29. Leadership within community.						
29. 1	Community take initiative to solve health problems in community					
29. 2	Community leaders motivate and inspire other people to involve development activities					
29.3	All the members are a leader in this community.					
30. Attitude of community towards health promotion programmes						
30.1	In this community have committees who mostly contribute support to health issues.					
30. 2	Communities have too many health promotion programs.					
30. 3	The School in this community takes initiative towards Health Programs.					
30. 4	Only doctors and health care workers should have responsibility for the health program in the community.					
30. 5	In order to sustain a healthy community must raise their voice on behalf of entire island.					
30. 6	The community should mobilize their own resources for the people's health.					
30. 7	The social needs of the citizens are the responsibilities of themselves and not of the community.					
30. 8	Only those who have most time should assume the responsibility for health promotion programs					

D IV- PARTIICPANTS FACTOR

Instruction: Please mark √ in the box [ ] that you choose.

Strongly Agree- 5
Agree- 4
Uncertain- 3
Disagree- 2
Strongly Disagree-1

	STATEMENT	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
31. Culture of active-citizens participation						
31.1	This community involves representative range of local population in community health promotion programs in this community.					
31.2	This community encourages volunteer groups for health promotion in this community.					
31.3	This community helps to overcome barriers, health care organization do their respective roles.					
31.4	This community encourages local citizen's participation in health promotion in this community.					
31.5	This community provide opportunity for citizen participation in health development.					
31.6	Government authorities provides in-service training to VHVs					
32. Comfort with being participation						
32.1	I am happy to provide voluntary services to this community because people appreciate service.					
32.2	I am satisfied with volunteer services					
32.3	I get support from my family to participate community work.					
33. Perception of participants						
33.1	Man and woman are equal in developmental activities.					
33.2	Participation in health promotion programmes will benefits me and my family.					
33.3	Participation in health promotion programmes will cost a lot of my time					

	and resources.					
33.4	Rich people do not need to participate in health promotion programs.					
33.5	Health promotion is the responsibility of government.					
34. Time and resources						
34.1	Lack of time to participate in community development programmes					
34.2	Minimum resources to participant.					
34.3	I need to develop my own business rather than spending time on community work.					
35. Responsibility of participants						
35.1	To create awareness in this community					
35.2	To identify priority area to improve healthy lifestyle in this community					
35.3	I speak to the needs to develop more effective and efficient community base health care.					
36. Expectation of participants						
36.1	I expect to know most of the programmes.					
36.2	I expect to have a decentralized health care system and have a greater NGO and private sector involvement in service delivery.					
36.3	I expect to know lots of information about health of this community.					
36.4	I expect to inform health hazards in this community.					
36.5	I expect to get incentives to this voluntary work.					

37. Please comment on anything that did not cover in the questionnaire that you think is important to increase participation in HPP among Maldivians.

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Thank you