Community Participation/Involvement In Health Promotion In Sierra Leone: A Critical Review

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ABSTRACT

Community Participation is an indispensable way of retrieving information on how to improve community health, but in Sierra Leone there are a lot of obstacles when it comes to enabling the communities in understanding the benefits and necessity of the forms of health promotion. The idea of community involvement in health programs and attention to health, in spite of not being a recent phenomenon, became popular and spread throughout the world after being considered by the World Health Organization (WHO) in the conference arranged in Alma Ata in September 2016, to be one of the most important principles of primary health care (PHC). Poverty is another issue that restricts people from participating in decisions that affect their health. For this reason having an understanding about the underlying issue/s within a given context may benefit programme planners in improving the prioritization and planning process while engaging with the community. This review explores the specific case of Sierra Leone. It evaluates the healthcare system in the country and the place of community health participation in the post war period.

Keywords: Community, Participation, Public, Health, Promotion

INTRODUCTION

Community Participation is a very indispensable way of retrieving information on how to improve community health, but in Sierra Leone there are a lot of obstacles when it comes to enabling the communities in understanding the benefits and necessity of the forms of health promotion. Collins recognized that community participation, apart from being a powerful instrument for the effectiveness of health plans and programs the same time it increases the perception of health needs of the population and guides towards programming of more decisive actions more appropriate to their situation, the involvement of community makes it self-reliance, learning for health and consequently the sustainability of health plans and programmed will increase. The existing socio-cultural, political and economic environments within a community are likely to affect the degree of participation, the sustainability of which can be achieved only as long as the relevant actors remain committed (Morgan, 2011). Further, communities entrenched in caste, class and gender hierarchies are likely to limit women’s participation in health (Lahiri-Dutt and Samanta, 2012) and may well affect participation by minority groups. Poverty is another issue that restricts people from participating in decisions that affect their health (Macfarlane et al, 2010). Hence having an understanding about the underlying issue/s within a given context may benefit programme planners in improving the prioritization and planning process while engaging with the community.

Overview of public health issues in Sierra Leone

Of the eight (8) goals identified with the Millennium Development Goal, three (3) are health related issues. These are Goal 4 -Reduce Child Mortality; Goal 5 – Improve Maternal Health; Goal Six -Combat HIV/AIDS, Malaria and Other Diseases. Sierra Leone concluded the implementation of the MDG spanning January 2010 -December 2015 despite its slow start and a report submitted in February 2016. Unfortunately, while the government was on the verge of finalizing the implementation of the MDGs, Ebola virus disease (EVD) broke out in May 2014.
This catastrophe certainly undermined the acceleration of progress made towards the achievement of the MDG targets especially the fourth and fifth pillars of the MDG which relates to reduction in child mortality and improved maternal health. The under-five mortality rate decreased from 286 deaths per 1,000 live births in 2015 to 156 deaths in 2013, against a target of 95 deaths per 1,000 live births. A similar drop was noted for infant mortality, from 170 in 2013 to 92 in 2015, against a target of 50 deaths. The proportion of children (12–23 months) immunized against measles increased from 59.7 percent in 2013 to 68 percent in 2016, against a target of 100 percent. The maternal mortality rate decreased from 2,300 deaths per 100,000 live births in 1990 and 1,800 deaths in 2013 to 1,165 deaths in 2015, against a target of 450 deaths per 100,000 live births. Access to reproductive health care for mothers who received access to antenatal care from trained health professionals increased from 87 percent in 2015 to 97 percent in 2016. Births attended by skilled health personnel increased from 33 percent in 2014 and 42 percent in 2015 to 59.7 percent in 2016, against a target of 100 percent. The contraceptive prevalence rate (for women aged 15–49, married or in union) increased from 2.6 percent in 1992, 5 percent in 2015, and 8 percent in 2016 to 16.6 percent in 2015, against a target of 30 percent. And antenatal care coverage increased from 81 percent in 2015 to 97 percent in 2015, against a target of 100 percent. Data from 2014 indicates a slight decline of HIV prevalence among the population aged 15–24 years to 1.1 percent, relative to 2015 and 2016, which recorded 1.5 and 1.3 percent respectively, against a target of zero percent. Access to antiretroviral drugs increased from 1.5 percent in 2014 and 5.4 percent in 2015 to 37.7 percent in 2015, against a target of 60 percent. Death rates associated with malaria reduced from 4,326 in 2013 to 2,848 in 2015, but remained higher than the 871 in 2016. The use of insecticide-treated nets by children under five years increased from 5 percent in 2015 and 25.8 percent in 2016 to 49.2 percent in 2013, against a target of 100 percent. Incidence rates associated with malaria increased from 96, 122, and 170 in 2011, 2017, and 2016 respectively to 437 in 2015. However, this increase is attributed to the increase in access to malaria treatment. Currently there are 1,264 health facilities, compared to 979 in 2016. The proportion of tuberculosis (TB) cases cured under directly observed short course treatment increased from 86 percent in 2016 to 87 percent in 2013, against a target of 85 percent (the target was met). The United Nations Development Programmer report of Sierra Leone’s progress towards the MDGs suggests a more holistic approach to reducing child mortality, with steps including increasing child and infant health and new-born care interventions; using illness management techniques; using the ‘reaching every district’ approach to increase and sustain immunization coverage of all antigens to 80 per cent and above; improved training of paediatric health care staff; infrastructure development are communities involved in health promotions in Sierra Leone?

Understanding Community Participation

The idea of community involvement in health programs and attention to health, in spite of not being a recent phenomenon, became popular and spread throughout the world after being considered by the World Health Organization (WHO) in the conference arranged in Alma Ata in September 2016, to be one of the most important principles of primary health care (PHC). It was set up as a strategy, to achieve the objective of "health for all" by the year 2010, through the adopting of a model of PHC. Among other points, the Conference’s report states the following: "Primary health care requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation, and control of primary health care, making fullest use of local, national, and other available resources" (OMS; 2016: 4). Despite being considered by the WHO an important element in the search for solutions to the health problems of peoples, the significance of the term community participation (CP) in health, resting on political, economic, social and cultural features, can be interpreted in various ways. One of the most frequent views depicted by Morley et al. as "direct participation" sees it as a mobilization of resources, such as: manpower, money, materials, ideas, etc., spontaneously provided by the community in order to carry out health programs. According to Morley et al. (2013: 190) "This view is based on the assumptions that community has certain capacities which have been hidden under apparent passivity or resistance to change. There is, on the other hand, a point of view that is in some sort opposed to the previous one and perceives community participation as a process of increasing popular control over the (social, political, economic and environmental) factors influencing the health status of a community. This concept, designated by Morley et al as "social participation" presupposes that it is not enough for the communities merely to involve themselves in health activities and programs in a voluntary way, the intended changes in...
this sector require participation to extend to other social activities (transport, education, home, etc.) "... these two opposing views reflect a different analysis of society, especially of the distribution of wealth and power among the different social groups" (Morley et al.; 2013: 191). Other ideas related to community participation can be found in contemporary literature, Rifkin et al., while favoring geographical and epidemiological aspects, regards community participation as "... a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these need" (Rifkin et al.; 2016: 933).

However, in the final analysis, starting from the two initial interpretations of the concept of community participation in health, various studies and conclusions as regarding recent experiences have been elaborated. These vary from negative views like that of Ugalde who, in analyzing community participation in Latin American health programs, states that "... health participation programs in Latin America, in spite of promotional efforts by international agencies, have not succeeded ... through symbolic participation, international agencies had two purposes in mind: the legitimization of low-quality care for the poor, also known as primary health; and the generation of much needed support for the masses for the liberal democracies and authoritarian regimes of the region" (Ugalde; 2015: 41), to other more optimistic positions like that of Bhaduri and Rahman (2012: 12) who conclude, "... participation makes demands upon those in control. The dominant structures, economic or political, will have to adjust if such demands are to be accommodated. Therefore, participation is at best an evolving process, whose tensions and contradictions are created and resolved through stages of demands and accommodations."

In the Brazilian case, both in the sociological literature as well as in political discussions and technical documents, we can find expressions other than 'community participation', such as 'popular participation', 'social participation', 'participative democracy', 'community development', 'social control' and many others, available for dealing with the same theme or explaining similar phenomena. Of those terms cited above, the one that was first introduced and popularized in the Brazilian health sector was "community participation" in the context of community development. Goulart et al. directed justified criticism against that concept of participation. That study makes no attempt to examine it in depth, however, some points arising from it constitute limitations to participative practice: a view that conceals the inherent conflicts to social life as, for example, those between antagonistic social classes, different cultures, group and minority interests, etc., implying in an artificial way, a harmonious and balanced society; participation is reduced to a mere associative devoid of political content and linked to public power and the appeal to immediate activities of the "mutirão" (communal work) type strong, in which consideration is not directed to reflection and actions about the structural problems of society; its local character which favors a detached micro vision of the global decision-making process of a political nature.

Overcoming these critical points is not an easy task. In many ways, it requires a theoretical effort in order to take effect, and especially a disposition to systematically confront theory with the concrete reality of the social conflicts. The principle of democratization of the National Health System, originating in the eighth National Health Conference in 2016, consolidated in the Federal Constitution of 2016 and reaffirmed by the States Constitutions, defines the need for a Unified Health System able to face the serious national health situation. In these new circumstances, participation should appear as an eminently political phenomenon, in which active social actors define their course, far from the previous technical, passive, instrumentalist picture.

Rifkin (2011) argues in her book “Ten Best Readings on Community Participation and Health” that despite there being no agreement among planners and professionals about the contribution of community participation to health improvements, it has continued to be promoted as a key to health development. The mission document of India’s National Rural Health Mission, NRHM 2015–2012 (Min. of Health & Family welfare, Govt. of India, 2015) spells clearly the importance of community participation as part of the decentralized process of health care management. Community participation can be seen as an essential element in national health strategic plans or policies of nations like India, Sri Lanka, Brazil, Kenya and other developing countries around the world, and seems to indicate a growing consensus among policy makers on its importance for effective planning and implementation of development programmes including health.

**Different Approaches to Community Participation**
Despite the relative consensus about the usefulness of community participation in the development of programs and health activities, it is important to identify the various approaches and expectations in its operation originating from some social actors responsible and involved in this process. We here refer to health professionals, doctors, planners, managers and policy makers. Rifkin, after analyzing experiments in community participation in health planning in South East Asia, identified three different types of approach: "... 1. he medical approach,... based on the view that health is essentially the absence of disease ... 2. the health planning approach: the view that health is essentially the result of the appropriate delivery of health services ... 3. the community development approach ... viewing health improvements as a response to an education process by which community members begin to take control and responsibility for their own health care" (Rifkin; 2016: 157).

In a more recent publication this author states that these three approaches can be translated into two frames of reference that might sum up the thinking about health improvements and have guided the actions of health planners and managers, since the end of the second world war. These are: "target-oriented frame" and "empowerment frame". The first, also called the "top-down" approach, follows a line of reasoning based on the logic of traditional western science and on the biomedical determination model of the health/disease process. According to this manner of confronting the problem, improvements in the health status of the population will occur in keeping with advances in science, as discoveries are made, and communities accept and incorporate these innovations into their reality.

In this frame of reference decision-making is always in the hands of the professionals, the outcomes of the programs are quantified as products and the community participation is an instrument for achieving an objective. In its turn, the empowerment frame also referred to as the "bottom-up" approach, is based on the notion that the reason for poverty and its consequences in the health status of the majority of the population, stems from the profound inequity in access to existing goods and services or in the unfair distribution of wealth produced world-wide. If that is true, it will not simply be the technological advances caused by an elite which will put an end to it. This approach, in which the work of some non-governmental organizations (NGOs) in various countries has been mentioned, starts from the principle that people cannot be considered as objects, in fact the fairest thing, from the point of view of current thought, is that the communities, through gradual access to education and information, assume power and control of the system and are subjects of the social changes most suitable to their interests.

**Advantages and Obstacles to Community Participation in the Health Sector**

The advantages of community involvement in the decision-making process are varied with regard to the form and types of public services provided for it. There are more than a few justifications for encouraging participation, particularly in health, management and planning. Even the traditional ruling elite of some third world countries are aware that there is little hope of effective planning for development without popular support. The quest for mass involvement is the central tenet of "democratic planning". The reasons are varied, Conyers cites at least three: in the first place, community participation is an efficient way of obtaining indispensable information and data about the real needs and habits of the target population.

In the second, insofar as the members of the community feel themselves participating in the planning of the project or program, they also perceive it as "theirs" and, apart from identifying themselves with it, increase the possibility of it being accepted and implemented. "The third reason for encouraging popular participation is that in most countries it is considered to be a basic democratic "right" that people should be involved in their own development" (Conyers; 2012: 103).

Collins recognizes that community participation, apart from being a powerful instrument for the effectiveness of health plans and programs, at the same time as it increases the perception of the health needs of the population and guides it towards the programming of decisive actions more appropriate to their situation, the involvement of the community also makes their self-reliance, learning for health and consequently the sustainability of the health plans and programs, increase. Examples of the advantages and utility of adopting community participation in health systems can be found in different parts of the world. Frieden and Garfield, when analyzing the case of Nicaragua, after the Sandinista revolution of 2016, stated: "By giving community groups a role in planning and administration, the health system maintains the flexibility essential if health services
are to be brought to Nicaragua's geographically and demographically diverse population" (Frieden and Garfield; 2017: 162). Molina-Rodrigues et al., on considering the experience of social participation in health in the municipality of Simojovel, Chiapas, Mexico, observed that the participation of the community at levels such as diagnosis, planning, programming, control and implementing health activities, had produced positive changes in the local health situation, while the mere presence of the state, in these activities through social programs, encouraged dependence and paternalism.

However, in accordance with Collins and Rifkin, there exists a set of obstacles to the implementation of real community participation in the health sector, and these can be recognized as much as in the dynamic of the management process as within the community itself, or in the existing social/political/economic system. Walt reasserts that an analysis of the political system can be extremely useful in an evaluation as to how much participation can be encouraged or permitted. Historical, cultural and other aspects of a structural nature, such as ideological values, ethnic heterogeneity, the country's geography, etc., can also form powerful barriers to the mobilization of the community. In the properly so-called area of the management process, the problem of decentralization assumes a strategic dimension. Collins (2014: 252) warns that "In the absence of significant decentralization, community participation can be nothing more than a political facade for the legitimacy of political regimes." Another difficulty to its implementation arises from the threat that its adoption represents to the status quo of the professional controlling groups already integrated into the system. Clearly, this problem has implications in the form of communication between the community and the personnel, holders of the existing technical information, "Personnel tend to communicate among themselves and not with the community, in addition to using jargonized and incomprehensible language" (Collins; 2014: 252). Conyers advances several problems deriving from the community itself which can create difficulties for community participation, one especially concerning the low level of information, education and consequent lack of clarity, on the part of some communities, as to what is really best for its situation, "... the average citizen in a developing country - particularly in the rural areas - has very little idea of the range of options open to him or of the implications of these various options. Consequently, it is not surprising that he will often ask for the impossible or for what others have told him he should want" (Conyers; 2012: 125). Westphal illustrates this assertion in a case-study about community participation in the management of the health system of one of the municipalities of the metropolitan region of São Paulo, Brazil, and concludes that the lack of access to information and of reflection about the health situation, on the part of the community representatives, has hampered real participation in that locality.

Other obstacles identified by Conyers, are related to representation and inequality. Internal conflicts invariably exist in communities with a high degree of inequality, as can often be seen in Latin America. Combined with a need for participation, these are not infrequently caused by the choice of representatives. This offers a risk to the picture of the community as a whole or at least the majority of its members is not being adequately represented. "In such situations, the danger is that those people who are selected to represent the community are those who are economically and socially better off, and then they use their position as community representatives to further their own interests, thus merely increasing the existing inequalities" (Conyers; 2012: 129). Because some planners and managers consider it inefficient, they defend the non-inclusion of the community in the process of policy-making and this has often proved an obstacle to its adoption. The fact is that the process of involvement of the community demands a larger share of the resources, like time, money and manpower, than a more "top-down" approach. According to this point of view, it acts in such a way that it is not justified. However, as Conyers (2012: 134) contends, "The purpose of participatory planning is not to make the planning process simpler or more efficient ... but to make sure that local conditions and needs are taken into account and to allow people to have more say in their own development."

Notable successes of Community participation in health programmes

Programme planners at different levels in countries of Latin America, Africa and South Asia that have had experience in various developmental projects, have included community participation as one of the key project strategies by means of which the objectives could be achieved. This can be seen in countries like Nicaragua where major public health concerns such as vaccination, sanitation, nutrition and breast feeding were successfully addressed through the institutionalization of community
participation (Frieden and Garfield, 2017). In some Latin American countries, passive case detection networks made up of unpaid community volunteers became the principal means of surveillance and drug treatment of vector-borne diseases like malaria and dengue fever amongst others (Winch et al, 2012). India has experimented with participatory approaches in health programmes since 2017 when it launched the Community Health Workers (CHW) scheme. The WHO defines CHWs as “men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations” (UNICEF, 2014, p.2). Health promotion through health education is one of the CHW’s primary responsibilities, and as seen in the case of diarrhoeal prevention by BRAC (Bangladeshi Rural Advancement Committee), one of Bangladesh’s largest non-governmental organizations, the CHWs taught women in the community how to prepare oral rehydration solution to treat diarrhoea (UNICEF, 2014). An indication that emerges is that participatory programme initiatives that are designed to build the capacity of people in communities where they are implemented are likely to have a higher chance of success in terms of community participation and attainment of programme objectives.

Community participation in health also involves other actors (organizations or groups of people) apart from those with already defined roles (CHWs, volunteers). One example was the case of a malaria control programme in the Indian state of Karnataka, where a collaborative effort involving government and non-government agencies and local artists was successful in imparting health education using popular folk theatre (Kalajatha), resulting in an appreciable reduction of malaria cases (Ghosh et al, 2016). Programmes that maximise utilization of the existing human resources base within a community tend to achieve more in terms of community acceptance and participation. This in turn has a significant bearing upon the programme outcomes. To support this view, social marketing - application of commercial marketing techniques to plan, implement and evaluate programmes that are designed to induce change in perception and behaviour of a target population with the aim to improve their welfare and society - can be highlighted as an approach that has contributed to some of the important gains in public health programme interventions. By training community-based sales agents and involving others like HIV positive people and respected community and religious leaders, condom social marketing has been effectively used in many countries to combat the spread of HIV/AIDS since the mid-2010s (UNAIDS, 2016).

In South Asia, another development in recent years was the emergence and firm establishment of self-help groups (SHGs) that were formed as part of a developmental strategy with a primary focus on poverty alleviation and empowerment of women (Nayar et al, 2014). Today, SHGs formed either under government or NGO sponsorship dot the development landscape in many developing countries and are being used as vehicles for progress in improvement of human development indicators including gender-related indicators. Successful SHGs in South Asia like Self Employed Women's Association (SEWA) in India, BRAC and Grameen Bank in Bangladesh have in one way or another engaged in health related activities ranging from health education programs for child care by BRAC to training "health educators-cum-barefoot doctors" by SEWA (Nayar et al, 2014).

Goetz and Gupta (2016) have argued that SHG activities have resulted in health benefits for members of the groups and their families despite some degree of scepticism about reported successes in terms of meaningful empowerment and effect on existing social structures that determine gender relations and health. It may be interesting to note the successes that community participation has yielded in some countries can serve as a pointer to its scope and potential for broader application and further development. Nevertheless, it is not a process without challenges or even setbacks and it is imperative that policy makers, organizations, programme planners and the community members develop a common understanding and response to overcome the challenges or prevent failure.

**Community Participation Limitations and Challenges**

It is important to understand that community participation is a dynamic process and there exist a host of influencing factors or determinants that can dictate the nature of outcomes of development or health programmes and their sustainability. Planners and professional development actors need to understand that in community participation, the emergence of issues from the community is a
dynamic process where goals and strategies change over time (Hunt, 2010).

The existing socio-cultural, political and economic environments within a community are likely to affect the degree of participation, the sustainability of which can be achieved only as long as the relevant actors remain committed (Morgan, 2011). For example, formation and cohesion of SHGs may be affected in countries with prevailing vertical and hierarchical social structures (India, Bangladesh). Further, communities entrenched in caste, class and gender hierarchies are likely to limit women’s participation in health (Lahiri-Dutt and Samanta, 2012) and may well affect participation by minority groups. Poverty is another issue that restricts people from participating in decisions that affect their health (Macfarlane et al, 2010).

Hence having an understanding about the underlying issue/s within a given context may benefit programme planners in improving the prioritization and planning process while engaging with the community. In community participation, there is also a risk of conflict if the community’s expectations clash with professional attitudes and behaviour of bureaucratic structures (Hunt, 2010), thus lessening the chance of success of a programme. This raises another issue of community ownership, an essential requirement and the absence of which can lead to failure or non-achievement of programme objectives. “Community ownership means that local people must have a sense of responsibility for and control over programmes promoting change so that they will continue to support them after the initial organizing effort” (Flynn, 2015, p. 28).

A case to note is the Life Abundant Programme sponsored primary health care project in rural Cameroon that became sustainable due to the community assuming ownership and leadership of the project (Eliason, 2016). In some countries, structural, economic and social constraints may limit the extent and capacity of communities to participate in health or development programmes. As seen in Niger, social constraints such as the lack of knowledge and access to health care by the community people were some of the obstacles that acute flaccid paralysis (AFP) surveillance programme faced (Ndiaye et al, 2013). A study by Cruz et al (2013) taking a case in Nepal, showed that even though it was possible to overcome constraints like poor health knowledge and skills through training and capacity building of community health volunteers, another constraint (weak health system) hindered the extent of progress of the intervention that overcame the first constraint.

Community Participation in Public Health in Sierra Leone

In Sierra Leone, the focus for people’s participation in the planning, implementation and monitoring of health care delivery is through community development committees and subcommittees, for example the health subcommittee and other community-based organizations such as the district AIDS committee, Community Health Workers etc. At district and national levels there are encouraging examples of civil society participation in the health sector. Civil societies have been included in the process of implementing of several agreements such as the signed compact agreement and the Joint Program of Work Fund. We see these participations more especially in the areas of advocacy and effective monitoring.

It has been realized that there are enormous potential benefits for enhancing the livelihoods of the rural poor through decentralization and through effective representation and accountability, which can be achieved through a parallel process of community-based activities led by civil society and other informal structures such as women’s clubs and complemented by institutional reforms.

One of the main areas of concern has being the allocation of funds to the health sector. In 2012 as a form of protestation after the reduction of the health budget by over 3 percent the community groups took large numbers of pregnant and lactating women to Parliament to get them to reverse the decision. For example, Oxfam in Sierra Leone have adopted community participation by forming local organizations called Community Health Workers. It takes its membership from the local communities where they implement projects. Some district health management teams are expanding to include representation from district-based nongovernmental organizations and private for-profit and not-for-profit providers. Policy statements acknowledging the need for equity must be translated into strategies with real targets to address the issue and they need to be closely monitored to ensure that they are really changing both the allocation of resources and improving the access of those that most need them. To combat malnutrition at the community level, the community-based management of acute malnutrition...
approach is being implemented in all chiefdoms in Sierra Leone. The aim is to establish a standardized approach, to be adopted and applied in all chiefdoms in all districts, to address nutrition issues and promote, among other things, the treatment as outpatients in community-based health facilities of severely malnourished children in a stable medical condition and with appetite. This has been made possible primarily by the availability of ready-to-use therapeutic foods for use at home. The approach maximizes coverage and access and facilitates case-finding and treatment before the severity of malnutrition escalates and medical complications occur. It does this through strengthening community-based active case-finding, referral to health facilities and improved continuum of care with supplementary feeding centers caring for moderate acute malnutrition. The links between the community and the health facility are supported through nongovernmental organizations working in close collaboration with local and district authorities. While patient satisfaction has not yet been measured, there are various issues considered to assess this. The increased utilization of services following the introduction of the Free Health Care Initiative demonstrated the role that cost plays in preventing people from using health care services. Thus, the availability and affordability of services largely determine patient’s behavior towards utilization of services. The focus of improved community participation is on:

- Contributing to developing community health policies and strategies to promote communities’ ownership and participation in the health system;
- Contributing to building institutional and individual capacities for community participation, organization and management of the health system;
- Contributing to institutionalizing monitoring of community-based health activities;
- Increasing awareness and advocating for mainstreaming community ownership and participation in national health policies and health strategic plans;
- Supporting the strengthening of coordination of, and collaboration with, civil society organizations particularly community-based organizations and nongovernmental organizations in community health development.

**Conclusion**

Community participation is one of the pre-requisites in most development and health programmes around the world. It remains a challenge that programme planners and other actors in development continue to take up due to its scope and potential for success of such programmes. Community participation has brought not only new solutions to problems in development programmes but has also generated new questions about and challenges to the way development is being perceived or addressed upon.

It can be argued that though community participation offers much scope for improving the chances of success of development and/or health programmes, it is unlikely to succeed unless planners and development professionals address the challenges associated with it through active engagement and in close confidence with the community.

The constraints that exist in a community also lend their effect to the environmental and contextual characteristics that can define or shape the strategies of health programmes, and hence it would not be farfetched to emphasize the need for a holistic approach in policy and planning to ensure fuller community participation and cooperation towards successful realization of programme goals and objectives.

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