Community participation through the community health association in the communities' health effort: the case of the community health center in the rural commune of Tousséguela in Mali

By Amadou BAMIA

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ATTESTATION

I do hereby attest that I am the sole author of this project/thesis and that its contents are only the result of the readings and research I have done.

Amadou Bamia (UNISE 1801IT)

DEDICATION

In memory of my beloved late grandmother, Naminata Samassi

TITLE OF RESEARCH:

Community participation through the community health association in the communities' health effort: the case of the community health center in the rural commune of Tousséguela.

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ABSTRACT

Community involvement is a social process in which members of specified groups with common needs who live in a defined geographic region actively seek to identify those needs, make decisions, and build methods to address them. While community involvement in health improvement exists in Mali, little is known about how the community views this involvement. Similar to this, the influence of community involvement in public health on the delivery of healthcare is compromised, and the waiver system intended to encourage community involvement in health development in the delivery of healthcare remains unassessed. The study focused on the role played by the community health association and the management committees as well as all the personnel involved in the smooth running of the community health center's activities.

The results of this analysis were drawn from surveys conducted in seven (7) of the thirteen (13) villages in the Tousséguela health area. The interview with the beneficiary communities reached a sample of 663 people after eliminating inaccurate questionnaires, with wrong answers and voluntary omissions. The first hypothesis, formulated above, is indisputably verified because the populations participate in the health effort in the Tousséguela health area through the activities of the health association. The second hypothesis is also true because most of the target populations are not only aware of the ComHA but also receive feedback from their representatives within the ComHA, which allows the beneficiary communities to measure their performance.

Development is therefore not the burden of a single actor in the field. All the actors must invest a lot so that the actions of the associations are wanted and supported by all.

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LIST OF ABBREVIATIONS

BCC	Behaviour Change Communication
BI	Bamako Initiative
ComHA	Community Health Association
ComHC	Community Health Center
ComHW	Community Health Worker
ECC	Essential Care in the Community
HCDC	Health Center Development Committee
HV	Home Visit
MDHS	Mali Demographic and Health Survey
MPA	Minimun Package of Activity
NIPHR	National Institute of Public Health Research
NHL	National Health Laboratory
NFComHA	National Federation of Community Health Associations
NSPECC	National Strategic Plan of Essential Care in the Community
NGO	Non Governmental Organisation
PH	Public Hospitals
PHC	Primary Health Care
RefHC	Health Centres of Reference
RFComHA	Regional Federation of Community Health Associations
TDC	Technical Director of the Centre
VHC	Village Health Committees
W.H.O	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Community involvement is a social process in which members of specified groups with common needs who live in a defined geographic region actively seek to identify those needs, make decisions, and build methods to address them (Singh *et al.*, 2017). Individuals and groups, for example, can exercise their right to participate actively in the development of suitable health care. The process of establishing a partnership between the government and local communities in the planning, implementation, and utilization of health activities is known as community participation in health development (Yuan *et al.*, 2021). Community participation in health development guarantees that circumstances for long-term improvement in health are in place, as well as supporting community empowerment for health development. As a result, community participation in health development improves healthcare coverage, efficiency, efficacy, and equity while also encouraging community self-reliance (Oakley, 1991).

There are five levels of community participation: (i) communities participating in project benefits without making any contributions; (ii) Land, labor, and financial contributions from the community to healthcare programs. (iii) Communities take part in the implementation of health programs and are given managerial duties by health planners, to whom they turn for guidance, oversight, and approval. (iv) The community keeps track of and reviews programs in which it makes changes to the goals. (v) With professional knowledge and resources given by health personnel, agencies, and/or governments, communities participate in designing programs that the community prioritizes (Sacks *et al.*, 2017).

Needs assessment, leadership, organization, resource mobilization, and management are the five aspects that impact community engagement (Singh *et al.*, 2017). These indicators can be used by

different planners and participants at different times to assess participation in a given program. This aids managers in comprehending the process of community involvement in health projects. It aims to depict change by determining how broad or narrow involvement is at any particular time and comparing it to participation at other times or as seen by another group. It's a participatory method of analyzing community participation that can be utilized by both the district health team and community organizations to evaluate their own initiatives (Sakeah *et al.*, 2014).

The external agency (government health service or any outside organization); community health workers (development groups or identified target populations); and the education process that tries to provide a foundation for people's continuous involvement are the three fundamental parts of community participation in health development implementation (Eyre and Gauld, 2003). Partnerships at all levels between the community and institutions enable the sharing of experiences, skills, and resources needed to achieve 'Health for all.' The direct and indirect participation of the community in the promotion and maintenance of their own and their families' health is at the heart of community-centered development. Such approaches necessitate the deployment of self-sustaining development projects that are administered and owned by the community. To guarantee comprehensive execution, everyone must step up their commitment (Paul, 2011). There may be opposition from health care professionals in communities where community participation in health and development has not been used, and in order for it to be effective, health care providers' perceptions and attitudes regarding it must be considered. This holds true for the entire community (Oakley, 1991). When communities are asked to participate in health development programs, socioeconomic and demographic factors are known to influence their knowledge and perception (Sacks *et al.*, 2017).

In 1990, the Government of Mali adopted a Sectoral Health and Population Policy, with the overall objective of improving the health of the population so that they can participate in the economic and social development process. It is based on the principles of primary health care and the "Bamako Initiative" for wider health coverage with strong community participation. In the context of its implementation, the state has had recourse to other actors, including the ASACOs, which create and manage the community health centres (CSCOMs), the base of the health pyramid.

Mali's health sector policy was built on a pyramid structure of health whose first level is the community health centre (CSCOM), the second level is the reference health centre (RefHCs), and the third and fourth levels are the regional and national hospitals respectively. There are currently six hundred and eighteen (618) ComHCs. The management of these centres is carried out by community health associations and more specifically by the management body, which is the management committee.

The implementation of decentralisation from 1994 onwards has often called into question the health map drawn up and created problems that concern the population, elected representatives and health technicians. At the national level, Mali has taken several measures to better establish its health policy, and various ten-year health and social development plans have been drawn up. Mali, like many African countries, adopted the district health system in the early 1990s, through the implementation of the Bamako Initiative (BI).

We conducted this study, based on data collection in rural areas, in order to understand and better gauge the level of involvement of the ComHCs in Mali's health management policy, the need to bring the health map into line with the decentralization policy, the reality of the functionality and

autonomy of the ComHCs, and the prospects in this rapidly changing economic, social, and political environment.

The Community Health Centre (CSCOM) is a first-level health facility created on the basis of the commitment of a population defined and organised within a Community Health Association (ASACO) to respond effectively and efficiently to its health problems. (Order 94-5092 of 21 April 1994, Article 3)

In Mali, very few studies focus on the determinants of community participation in health. Hence this study which aims to answer the following question : what is the level of involvement of the populations in the participation not only in the health effort but also in the decentralised management of community health centres (Mali) ?

The study will attempt to understand the opinions of health actors and beneficiary communities on the process of involvement in the health effort and in the management of community health centres. This information will not only be useful for the revision and implementation of health policies and programmes, but will also facilitate the raising of awareness among communities that have a very low level of contribution to the socio-health development of their localities.

1.2 Research questions and hypothesis

We postulate that communities play a necessary role in their own social and health development. Are similar health needs within communities the basis for mobilising these communities in the health effort?

The specific questions are:

- Do communities really participate in their own health self-development through health associations?

- What are the shortcomings of community participation that may hinder the proper functioning of community health centres?
- What role do they play in the process of developing and ensuring the proper functioning of the community health associations that are responsible for managing the community health centres?

1.3 Statement of the problem

The mass adoption of community participation in health development in third world countries has coincided with the realization that governments cannot afford to fund health services on their own. In most nations, authorities have viewed community participation as a means of gaining access to resources that would otherwise be unavailable to the formal health care system. Manpower, materials, and financial contributions are all examples of these resources. The inability of cost-sharing funds to cover the recurrent budget of health facilities has increased the need for community participation in health development. The purpose of rural health facility management committee is to bridge the gap between the Community participation in health development and the local community.

The rural health facility management committee is expected to increase community participation in decision-making especially in the planning and development of appropriate infrastructures. The plan to include rural health facility management committee in the management structures of the Ministry of Health is implemented throughout the country. A genuine partnership involves partners to take joint action and make decisions together, as well as equal capacity to participate actively in participatory efforts. The community has access to community resources and has experience mobilizing itself for development projects, whereas the health professional has technical health expertise, government resources, and managerial experience. Because

participative relationships are about power sharing, neither partner should be in charge. The community's management abilities haven't been improved, and health staff haven't been retrained for their new leadership role. Although communities and health care providers have formed a partnership in the delivery of health services, health care professionals' roles and interests have not altered. Failure to undergo this re-orientation may result in anger and antagonism from the community and health-care professionals toward this cooperation.

In Mali, there is a paucity of literature on community participation in health development. Many resources and energy have previously been expended in the implementation and subsequent failure of community-based health-care projects. This scenario necessitates research into community perceptions of their involvement in health-care delivery, as well as the perceptions and attitudes of rural health-care workers concerning community participation in health development.

More research is needed to determine the criteria utilized at rural health institutions to grant user fee waivers to the community, as well as whether any training has been provided to educate the community on their role in health development. Any limiting reasons will be mentioned in the same tone, and appropriate remedial steps will be advised for implementation.

1.4 Research Objective

1.4.1 Overall objective of the study

The overall objective is to assess the level of community participation in the health effort and in the establishment of a health system in the context of the current policy of decentralization of community health structures in Mali.

1.4.2 Specific objectives

Specifically, we plan to:

- Examine the resource mobilisation and management capacity of ComHCs in rural areas ;
- Examine the impact of the local economy on the accessibility of populations to community health services and the improvement of their performance ;
- Assess the impact of ongoing decentralisation on the management and future of ComHCs;
- Make a critical analysis of the evolution of the quality of management strategies in the ComHCs on the basis of the objectives of Mali's health policy and the results obtained;
- Based on the results of the analyses, make proposals to the ComHC management body to guarantee access to health care for the most disadvantaged social strata; but also, based on these results, highlight possible improvements in relations between the health centres and potential partners;
- And finally, to formulate suggestions to meet the real and current needs of the target communities in the field of community health in rural areas.

1. 5 Nature of study

Given the scope of this research we found it necessary to conduct a mixed study, i.e. to conduct qualitative and quantitative data research in order to get an overview of the different parameters of the target population's participation in the management of community health problems.

Qualitative research is a set of investigative techniques that are widely used.

It allows us to gain an overview of people's behaviours, attitudes and practices, and to study their views on the management of community health problems, which in turn allows us to collect as many ideas and hypotheses as possible that can help not only to gain a deeper understanding of, but also to propose solutions to, different health problems.

Qualitative research is characterised by an approach that aims to describe and analyse the culture and behaviour of humans and their groups from the perspective of those being studied. Therefore, it insists on a complete or 'holistic' knowledge of the social context in which the research is carried out. Social life is seen as a series of interrelated events that need to be fully described in order to reflect the reality of everyday life. Qualitative research is based on a flexible and interactive research strategy. (www.ernwaca.org, 2011).

1.6 Assumptions

1.6.1 The assumptions of the study

The implicit assumption is that even if similar health needs are the basis for the creation of ComHCs, management methodologies determine their capacity to respond to said needs.

A second hypothesis is that, due to a policy of decentralisation and a lack of resources necessary for the proper conduct of ComHC activities, the beneficiary communities contribute to the mobilisation of resources necessary for the proper conduct of health activities in their community.

A third cross-cutting issue will be analysed to take into account the adequacy between the policy of creating and managing community health associations (ComHAs) and the health development policy of decentralised communities with the concerted participation of local authorities, NGOs and other partners. The community implications of the ComHC management policy must be understood and analysed in order to make proposals to enable the community health centres to achieve their objective.

The analysis of health problem management issues, namely the mobilisation of financial, material and human resources by the beneficiary communities in the efficient use of these resources, is central to the study of the level of involvement of these communities in the

management of health problems. These points should be taken into account in order to better gauge the level of participation of communities in their own health development.

1.6.2 Scope and delimitation

1.6.2.1 Limitations

The objective of this research is to identify the role and place of the community (health association) in the social and health development process of the rural commune of Tousséguela. To do this, we have anticipated the theme by posing two postulates that we will naturally verify. However, in order to better carry out this reflection, we made use of the experience of some associations. This research work was not carried out without difficulties.

With this research, we intend to make our contribution to the many reflections on the crucial question of the raison d'être of community activities in the development process.

Are similar health needs within communities the basis for the creation of community health centres?

In order to answer this question, we have divided this thesis into two main parts which deal respectively with the theoretical and practical aspects of the question.

The development of any community starts with itself, because it knows its needs and ambitions better than anyone else, and through its own human and material resources it can meet some of its needs. In order to improve the socio-economic living conditions of the population in general and of rural populations in particular, some governments are introducing innovative policies to support the rural world, which is much more marked by a higher level of poverty than urban areas.

The starting question was formulated as follows:

How do community health associations collaborate with the beneficiairy communities for social and healthdevelopment?

The specific questions are:

- Do communities really participate in their health self-development through health associations?
- What role do they play in the process of developing and running community health centre?
- What are the shortcomings in community participation that may hinder the proper functioning of community health centres?

1.7 Justification

In Mali's rural healthcare facilities, there has been a widespread management difficulty. It became clear in the late 2000 that the community participation in health development was being hampered by decaying public health facilities. Demand for services increased while total financial allocation in the health sector remained unchanged, resulting in chronic underfunding of the sector (Johnson, Faure and Raney, 1999). This has expressed itself in persistent shortages of medications, linen, and other health utilities, broken-down medical equipment and trucks, poor staff morale, and evident dissatisfaction amongst the customers of the health services. Cost-sharing was implemented in 1989 in an attempt to bridge the gap between the level of funds provided by the government for health care and the level required to meet service needs (The World Bank, 2019).

Despite this strategy, a plethora of challenges continue to bedevil the provision of quality health services by the government to its citizenry. Consequently through the Health Sector Reform

programs, the government started to operate rural health facilities in partnership\swith the appropriate local communities through community participation in health development, since 1990s. However, it's unclear whether this strategy is achieving the goals it was designed to achieve. No studies have been carried out to determine the status of community participation in health development within the community health center in the rural commune of Tousséguela in Mali, hence the outcome of community participation in health development program is unknown. Data and information from ongoing community participation in health development activities are required if the appropriate authorities have to chart and plan the path forward is based on informed decisions. As a result, this and further investigations are required.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Since the early years of independence (1960), the Malian government has implemented a health policy that facilitates access to health care for the majority of the population while involving them in its application. Since then, a number of strategies have been put in place to involve the beneficiary communities (population) in the decision-making process and the management of health problems. All these experiences had in common the establishment of village health agents (community health agents, matrons, traditional birth attendants) forming a team. Currently, the entire system is based on the community health worker (ComHW), and then gradually moves up to the top.

2.2. Community health development theory

The essential element of community ownership of local development is the participation of all its members regardless of gender, age and religion in their own development both locally and globally. Community development, according to one participant, is based on the strengths of the people. (J. Barnsley and D. Ellis). The participatory approach to local development emphasises the importance of people's participation and empowerment in all development actions. The concept of participation is at the origin of current concerns about 'local'.

The roots of community participation in health development can be traced back to the 19th century public health movements that swept Europe and North America (World Health Organization (WHO), 2019). To begin with, there was growing dissatisfaction with "western" medicine, which emphasized curative hospital-based health care. A health crisis followed, prompting a change toward preventive, decentralized community care based on epidemiological priorities. Prior to 2000, international health policy emphasized the provision of health education, but this gradually devolved into merely disseminating information with only minor

benefits in health (Assefa *et al.*, 2019). It became clear that communities needed to be involved in the planning of health care (Health *et al.*, 2021). Second, it was recognized that health was an important component of economic progress. Basic needs, social justice, and people's engagement began to include health concerns. The convergence of these two trends gave rise to the concept of Primary Health Care (PHC), which is essential health care that is made universally accessible to individuals and families in the community through means that are acceptable to them, with their full participation, and at a cost that the community and country can afford (Cai and He, 2021).

The UN pushed community development in Africa as a mass education technique for the rural poor in the 2010s (Article, 2022). The community development movement was hampered by incorrect assumptions, which needed to be addressed if PHC was to be developed successfully. The following assumptions were made: I communities are homogeneous. (ii) community leaders behave in the best interests of their people (iii) government and community workers share the same aims for community development (v) and community development activities did not generate conflicts for planners (Humola and Amkop, 2021). Decentralized decision-making and local participatory planning for health, which encourages partnerships in service delivery, helps to guarantee that community needs are met. Cornmunirv's ownership of health services is strengthened, and their use is increased as a result (Humola and Amkop, 2021).

The trend in health-development in industrialized countries has been to increase national spending on community-based primary care. In the United States, this is the foundation for public policy aimed at delivering primary care to underserved people (Cometto *et al.*, 2018). Similarly, in the United Kingdom, the focus is on shifting resources from secondary to primary care in order for spending to follow activity (Pennebaker *et al.*, 2019). The industrialized world

has had to adapt to shifting economic conditions, first through cost-cutting tactics and then through health-care reforms aimed at better organizing health services and involving more consumers (WHO, 2018). In Sub-Saharan Africa, CPHD has been geared toward community funding, with a focus on cost recovery through fees for services and medicine sales (WHO, 2018).

The Bamako Initiative was created in 1987 when UNICEF sponsored a gathering of African health ministers in Bamako, Mali. The Bamako Initiative is a cost-recovery system based on the sales of critical pharmaceuticals, equity, and easy access to health services, leading to better use and care quality. The Bamako Project served as a gateway to PHC, which was utilized to enhance the health of women and children who were identified as the family's most vulnerable members. Communities were given healthcare responsibilities (Scott *et al.*, 2018). Communities were made aware of current health concerns and the prospect of enhancing their healthcare through the Bamako Initiative (Singh *et al.*, 2017). The Bamako project has been significant in organizing villages to participate in various health-care initiatives, based on the premise that citizens become more active when they make financial contributions (David-Chavez and Gavin, 2018).

Every local member must be involved in small groups and larger organizations if the concept of participation is to evolve in a continuous manner.

People can affect the direction and implementation of a program through their contributions and active engagement, but this is not the same as community empowerment. The difference between empowerment and participative techniques is that the former has a clear goal of bringing about social and political changes, which is expressed in its sense of liberty and fight (Pindus *et al.*, 2018).

2.3 The theory of health burden sharing

The concept of participation in the health effort appeared in a context where the centralized management policy of the State showed its weaknesses in certain aspects of community development. Hence the involvements of local actors in social and health development initiatives, who have a better, grasp of their needs than anyone else in terms of health development initiatives. The latter considered that the development policy of a community should take into account the needs and aspirations of the said communities. "Some governments have been successful in linking population programs with health, education, and rural development projects and, in addition, have implemented them as part of broad socio-economic programs in villages or regions." (United Nations 1987 "Brundtland Report")

A second is the need for local planning, monitoring, ownership and participation in social and health development activities. The essential element of community ownership of health development activities is the participation of all its members, regardless of gender, age and religion, in their own social and health development. The participatory approach to local development emphasizes the importance of participation and empowerment of the population in all development actions.

For Harou et al quoted by Lambert (2007) "It is the contribution of citizens to the construction of responses to the needs of the community and/or the different groups that make it up. Its importance lies in the role that communities must play in their own development."

Community members come together to discuss their concerns, evaluate options and draw their own conclusions. They may seek advice from "experts"; however, they consider this advice along with other sources of information and their own experience to make decisions that best meet their needs. (http://www.ohcc-ccso.ca) Thus, in the context of health development, health

equity is conceived as the totality of financial, material, and/or technical contributions that can or may be made by individuals and groups. The main idea behind community participation is to empower the local population in the management of the health problems they face. The beneficiary communities must be able to think about how to organize themselves with local health actors in order to take charge of their own promotions at all levels: villages, health areas, health districts, to name a few. We follow the logic of this statement in this research to analyze the different levels of participation of the beneficiary community in the health effort and its impact on the health development process of the communities in our study.

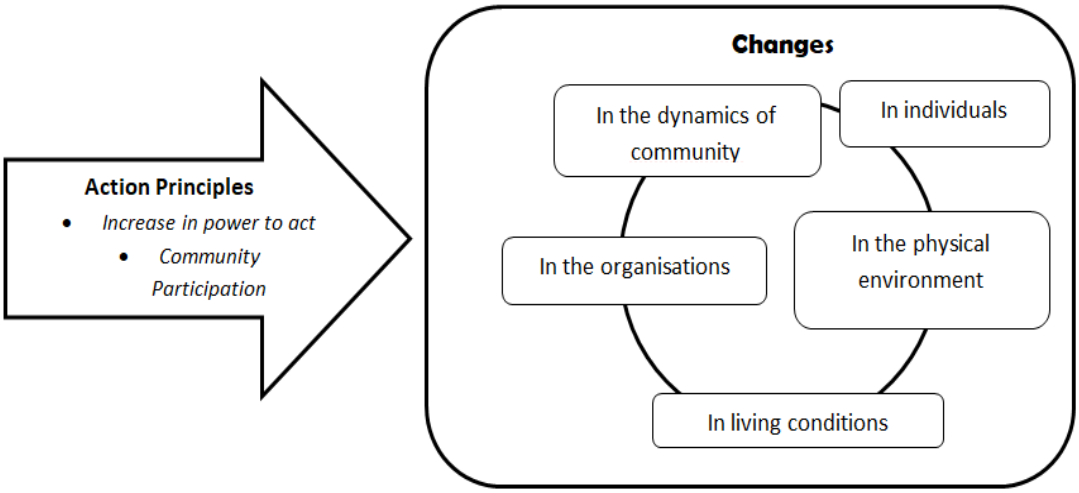
2.4 Concept of health development in a community:

Local or community development refers to two fundamental notions: community activities and development. It is important to define these concepts and place them in the Malian context. First, we can say that they are two closely related concepts in that one cannot exist without the other in the sense of development. Development can be understood as a defined physical space organized by a community that lives in it and depends on it. As for the community activity itself, it is made up of interdependent individuals (men and women) who have organized themselves, sharing the same history, identical values and having the territory in common.

Beyond its economic, social, cultural, spatial and sustainable dimensions, development "is the opportunity offered to men and women populations to express themselves on their current situation, to participate and to make decisions on their future, namely their development priorities" (FAO, 2002). As for Xavier GREFFE, quoted by GUILAVOGUI (2009), development is a process of diversification and enrichment of economic and social activities based on the mobilization and coordination of its resources and energies. It will involve the existence of a development project integrating its economic, social and cultural components; it will make a space of contiguity, a space of active solidarity.

As we can see in the different definitions, the word "development" is a term used nowadays in several fields to designate facts that can sometimes be opposed or contradictory. As for us, we favor the meaning according to which development designates socio-economic progress.

Figure 1: The Principles of Action for Community Development



Source: www.rechercheparticipative.org

Following the 1978 Primary Health Care Conference in Alma-Ata, much CPHD research has focused on practices rather than procedures that lead to positive results. Researchers have reported on community health workers being trained or community health committees being constituted, such as the village health committees, gatherings being held, and community contributions in cash or kind, for example. But, data about processes that drive change is necessary for planners in many countries (La Greca, 2005).

From as early as 1988 in Australia, several research have sought to create a measurement of community engagement (Manafò *et al.*, 2018). Since then, studies have been published that use various areas of effect on community engagement, such as competence, empowerment, and capacity (Goodman *et al.*, 2020). To match the plan in review, each researcher had to adopt a

specific method of measuring. The major application for community involvement measurement is to track the development of a program over time (Abdelhafiz *et al.*, 2020).

2.5 The concept of social and health development.

Socio-health development refers to a process that constantly mobilizes the resources of all the actors in a given locality with a view to promoting the economic, social and health aspects of a territory. In other words, it is a process that aims to involve communities with a view to improving living conditions in their localities. It can refer either to the process of improving the living conditions of a community or to the result of this process, or both. Some local elected officials, citizens and even donors see local development in terms of setting up community health infrastructures and policies (construction of health centers, management of community health associations, taking charge of certain community health agents, etc.); this is the material and quantitative vision of local development.

However, for the actors of social and health development, it must be a process that leads not only to the improvement of the living conditions of all the inhabitants of the community but also to their empowerment in the management of the health problems they face. A qualitative vision of the community's social and health development, which is measured by criteria such as: the reduction of disease, the community's ability to manage its health problems without being dependent on external aid, to meet the needs of children in terms of maternal and child health, and to have the maximum number of health workers in the community. Thus, quantitative and qualitative developments are the two sides of local development.

In this work, the analyses focuses on social and health development, both qualitatively and quantitatively, in order to better identifies and understand the impact of the participation of rural

populations for the collective well-being. This is why we will talk about community health associations that play a very important role in community development.

2.6 Community organization

Small groups, such as committees, religious and youth groups are examples of organizational systems in a community. The existence of these structures, as well as the level at which they work, is critical since it allows people to socialize and solve their issues and problems (WHO, 2021). Organizational structures, on the other hand, are insufficient to provide community organization and mobilization. There must also be feelings of belonging manifested through customs, place, rituals, and traditions, as well as a sense of cohesion among its members, concern for community issues, a sense of connection to the people, and feelings of belonging manifested through customs, place, rituals, and traditions (Ho, Chee and Ho, 2020).

Members of communities in Pakistan, India, and Cambodia who had a sense of belonging and were able to relate to others in their own conditions had a better probability of forming organizational structures (Ho, Chee and Ho, 2020). The social dimension of belonging, connectivity, and personal relationships is intertwined with the organizational dimension of committees and community groups in the interpretation of organizational structures for community empowerment (Glenn Laverack, 2001).

2.7 Community Health Center (CSCOM)

According to Article 3 of Ministerial Order No. 94/MSSPA-MATS-MP of August 21, 1994, the ComHC (community health center) is a first-level health facility created on the basis of the commitment of a defined population and organized within a community health association (ComHA) to respond effectively and efficiently to its health problems.

In addition, community health centers are key components of national health policy. Their results should augur well for the effects of the new institutional decentralization policy. In this respect, the community health centers are considered to be front-line structures in the process of organizing local development by decentralized communities, with the concerted participation of the State, NGOs and other partners.

2.9 Overview of communities participation in health activities

Since the early years of independence (1960), Mali has opted for a policy of health care accessible to a large number of the population. Since then, the State has made many attempts to involve civil society in the management of its own health problems.

The will to ensure the integrated development of the whole community life, including the integration or coordination of technical specialties; planning based on the "felt needs" of those concerned; emphasis on self-help; systematic search for local leaders who are then encouraged and trained; granting of technical assistance in the form of personnel, equipment, material or financial support. (Mezhow, 1963)

Civil society, either alone or supported by young health workers, mainly doctors, and with the political will of the State, has taken the initiative to form community organizations for each defined health zone in order to contribute to the efforts of the State to take charge of the health problems of the populations. These community health organizations were named: Community Health Association.

The intervention of civil society to take charge of its health problems really began in 1988, following the meeting of the ministers of health of the sub-region in Bamako in 1987. It was at this meeting that the Bamako Initiative (BI) was born.

In this work, the analysis focuses on both qualitative and quantitative socio-health development in order to better identify and understand the impact of the participation of rural populations in their socio-health well-being through community health associations. This is why we will talk about community health associations, which play a very important role in the socio-health development of the community.

A. Leadership

Community leaders must be chosen carefully to ensure that community participation continues (Bugnicourt, 1982). When people elect their rulers, they are respected, obeyed, and listened to, and they are successful in organizing behavior change in their communities, making CPHD a success (Kaseje et al., 1987). Community-chosen leaders usually deliver what the community plans, and if they don't, they can simply be changed by more effective ones, according to programs in the water and sanitation sector (Ryra, 1990). Members of the health management committee must be carefully chosen to ensure that they reflect the entire community. There is a risk that the activity of the health management committee will be controlled by health care providers, powerful community leaders, and/or community elite (Jinadu et al., 1997). (Moses et al, 1992). The other risk of such committees is their ability to handle other jobs once non-health community development issues are resolved (Rifkin, 1990).

When communities are involved from the start, health programs are more widely accepted, resources are more easily mobilized, and health outcomes increase (Aubel & Kinday, 1996). In programs aimed at improving health care, forming a community health committee, such as the village health committee (VHC) or the Health Center Development Committee (HCDC), from the ground up is typical (WHO, 1996).

In rural places, encouraging community control and ownership of health facilities and financial processes has helped to raise funds. But, caution must be exercised to see that CPHD does not obviate the state's interest in community-based PHC. This occurred in Ethiopia during the civil war from 1974 to 1991, resulting in a collapse of CPHD in health care after the war, with the community expecting the transitional government to take over (Barnabas, 1993).

Good leadership in community activities is crucial (Rifkin, 1990). Leadership and participation are inextricably linked (Goodman et al., 1998). Leadership necessitates a strong participant base, just as participation necessitates strong leadership's direction and structure.

Leaders play a crucial role in the formation of local groups and community organizations that are part of a larger process of community empowerment. Disorganization is common when people participate without a formal leader. Leaders are frequently presented as external organizers in a program environment because they are perceived to have the appropriate skills and competence (Gruber & Trickeett, 1987). In most societies, leaders are historically and culturally determined; initiatives that ignore this have a slim likelihood of being approved or used by the major stakeholders (Rifkin, 1990).

In the Philippines, non-governmental organizations (NGOs) established competent local leaders among the poor who had a better understanding of the community's problems and culture. Nevertheless, it was discovered that their positions as leaders were limited due to a lack of skills, training, and previous management experience. As a result, leadership style and talents can have an impact on how organizations and communities evolve, and therefore on empowerment (Constantine-David, 1995).

The difficulty of selecting competent leadership can be solved by taking a pluralistic approach in the community. This is where the positional leaders, those who have been appointed, and the

reputational leaders, those who help the public socially, interact. This interaction has a better possibility of resulting in community capacity and empowerment (Goodman et al., 1998).

B. Assessment of requirements

Needs assessment is a community-based process of identifying problems, viable answers, and action plans to address them, with the ultimate goal of empowering people (Cantor and Thorpe, 2018).

To accomplish this, the community may need to develop new skills and abilities. A number of health initiatives have recognized the need of needs assessment for community empowerment (Stolow *et al.*, 2020).

Despite the fact that many initiatives encourage broad participation, community involvement is restricted. These initiatives miss out on the chance to include the community in the decision-making process for establishing larger requirements that affect stakeholders, and they have been found to fail to fulfill their goals (Health *et al.*, 2021).

The goal of a Hong Kong hospital project aimed at improving health and health care among the urban refugee community was for the community to be able to manage its own health care. The hospital's management concluded that the best way to accomplish this was to improve service d: livery. In the refugee area, the hospital management established three community clinics and a health insurance system without consulting or involving the community in the decision-making process.

2.10 Community Health Center (ComHC)

Community health centers in Mali are health centers that are managed by a private, non-profit association of users and that are linked to the State by an agreement requiring them to participate

in the provision of public services. They thus ensure a minimum package of activity and operate with resources derived from cost recovery mechanisms.

According to Article 3 of Ministerial Order No. 94/MSSPA-MATS-MP of 21 August 1994, the ComHC is a first-level health facility created on the basis of the commitment of a defined population, and organized within an Association of Community Health to respond effectively and efficiently to its health problems.

2.11 Community participation in health development is influenced by culture.

Paying for health care is culturally acceptable in Africa, but mobilizing the community to join in a health-prevention program with indirect benefits is tough (Kohrt *et al.*, 2018).

In many parts of Africa, initiatives to provide free health care have resulted in insufficient or non-existent services, particularly for the poorest and most vulnerable. In the ancient African system, the community acknowledged the need of compensating health practitioners, as well as other services (Barnett *et al.*, 2018).

The impoverished were frequently better cared for under such system than under modern procedures.

The introduction of free health care in many newly independent countries ran counter to this tradition and weakened it (Troup *et al.*, 2021).

2.10.1 Missions

The mission of the Community Health Associations is to provide the minimum package of activities, namely:

- To manage the implementation of social and health actions within the population ;
- Provide curative services such as : routine care for the sick, screening and treatment of local endemic diseases, routine para-clinical exploration

- To ensure the availability of essential drugs ;
- Develop preventive care activities (maternal and child health/family planning/vaccination, health education, etc.);
- Initiate and develop promotional activities (Hygiene-Sanitation, Community Development, Information Education Communication…) ; and
- Promote community participation in the management of community health centers and the management of individual and community health problems (FENASCOM).

The community health centers are key components of the national health policy. Their results should augur well for the effects of the new policy of institutional decentralization. In this regard, ComHCs are considered to be front-line structures in the process of organizing local development by decentralized communities, with the concerted participation of the State, NGOs and other partners (technical and/or financial).

CHAPTER THREE: MATERIALS AND METHODS

3.1 Introduction

We are very interested in this subject and we are amazed by the community activities carried out and by the good anchoring of the associative culture. The current context has led us to question the impact of community activities on social and health development in rural areas. Also, being in an underdeveloped country, and given the scarcity of resources for the management of health problems, the state alone cannot provide all the resources necessary for the management of health problems. To do so, it is naturally assisted by other development actors, including non-governmental organizations, community health associations and even the target population. This support, far from being a universal solution, requires us to really think about the role and place of associations and health management committees in the country's health policies.

At the professional level, as researchers, we thought it would be useful to start thinking about community participation in the health effort. Our ambition is to make community action more effective and visible while proposing strategies that can facilitate community development. This requires the development of a strategy adapted to the context. We remain convinced that the participation of the beneficiary populations in the management of their health problems is essential.

Finally, at the scientific level, this work should contribute to enrich the literature on associative life. Indeed, almost all the literature in this field generally deals with the case of community centers in a generalized way. By deciding to focus on the role played by the community health association and the management committees as well as all the personnel involved in the smooth running of the community health center's activities, we believe that we will be able to identify as

much as possible the real contribution of the association to the country's social and health development.

3.2 General Background

Over the past few years, Mali has lived in a very difficult social and health context marked by inadequate or non-existent health coverage over part of the country, particularly in terms of health care and care for the population. In addition to these problems, the majority of the population has financial difficulties in accessing health care and medication in their place of residence (Rogers *et al.,* 2018).

In conditions where the government has difficulty in obtaining sufficient human, financial and material resources to meet the growing health needs, community participation has been offered as one of the alternatives that can support the government in its fight to make health accessible to all. The financing of the health system is ensured by the State, the local communities, the beneficiary populations, other private individuals and legal entities and development partners (Law 02-049 AN RM on the health orientation law, article 42) (Rogers *et al.*, 2018).

Thus, the main thrust of our study is to reveal the importance of community participation in the health effort through community health associations by setting up community health centers. As a member of this population, we are equally concerned by the health problems facing our country (Zombre *et al.*, no date).

The analysis of the participation of the population in the health effort is of interest to the communities, the State and to us as researchers, since it allows us to gauge the level of involvement, understanding, responsibility and knowledge of the population about their health situation and to assess their contribution, and consequently to see if they are capable of taking part in the social and health development of their community.

3.3 Country profile

3.3.1 Geographic, demographic and administrative characteristics

Figure 02: Map of the study area

Source:

Located in the heart of West Africa, Mali is a continental country with an area of 1,241,238 km². It extends from North to South over 1,500 km and from East to West over 1,800 km. It shares 7,200 km of borders with Algeria and Mauritania to the north, Niger to the east, Burkina Faso and Côte d'Ivoire to the south, Guinea Conakry to the southwest and Senegal to the west.

The climate is tropical, alternating between a dry season and a rainy season lasting an average of 5 months in the south and less than 3 months in the north, with very high temperature variations. The water system, consisting of two major rivers, the Niger and the Senegal, mainly serves the south of the country and part of the north (Luis *et al.*, 2018). According to the final results of the

4th General Census of Population and Housing (RGPH) 4, the resident population was 14,528,662 in 2009, with a slight predominance of women: 50.4% of the population, or a ratio of 98 men to 100 women. Life expectancy at birth is estimated at 55 years.

"This population reached 15,840,000 in 2011 according to the results of projections from the 2010 revision of the World Population Prospects by the United Nations Population Division.

The vast majority of Mali's population is sedentary. Nomads represent 0.92% of the population. They live mainly in rural areas. There are 3,274,727 urban residents (22.5%) compared to 11,253,935 (77.5%) in rural areas (Luis *et al.*, 2018). The density of the country is approximately 12 inhabitants per square kilometer. This national average conceals very strong regional disparities.

Mali experienced a rapid increase in population between 1976 and 2009. The population growth rate, estimated at 1.7% on average between 1976 and 1987, reached 3.6% between 1998 and 2009. At this rate, Mali's population will double almost every 20 years, with possible consequences for the improvement of individual well-being. Mali's population is characterized by its extreme youth. Those under 15 years of age represent 46.6% of the population, the 15-64 age group represents 48.4% and the population aged 65 and over is 5% (Samake *et al.*, 2022)

Mali has eight administrative regions, 49 cercles, the district of Bamako (the capital) and 703 communes. The latter are administered by the local authorities. The stability that the country has enjoyed for two decades has allowed the implementation of major development programs and the attraction of a significant volume of external financing.

3.3.2 Economic and social situation

Mali's economy is based on agriculture, fishing and livestock, all of which are highly dependent on rainfall, which remains very uncertain and insufficient (Luis *et al.*, 2018). The average annual growth rate of GDP was 4.4% between 2007 and 2011, far from the 7% expected by the GPRSP in 2011 (2011 GPRSP Implementation Report 2007-2011). During this period, the structure of the economic fabric was as follows: primary sector 36.5%, secondary 18.4% and tertiary 38%. Although lower than the 6.5% forecast in the GPRSP, according to the same report, the GDP growth rate of 4.5% observed in 2009 was still higher than that of the WAEMU zone. In its ranking based on the HDI (Human Development Index), the UNDP ranked Mali 175th out of 187 countries in 2011 (Samake *et al.*, 2022).

The proportion of the Malian population considered poor fell from 55.6% in 2001 to 47.4% in 2006 and 43.6% in 2010 based on a real poverty line of 165,431 CFA francs per year. According to the same source, the decline in the incidence of monetary poverty over the past decade has been more favorable to the rural sector (from 65% to 51%). Despite this decline, extreme poverty (inability to meet basic nutritional needs) still affects 22% of the population.

3.4 National health and social development policies and organization of the social and health system

3.4.1 National Policies (Mali's Health and Social Development Plan 2014-2023)

3.4.1.1 National Health Policy:

The sectoral health and population policy adopted by the government in 1990 defines the main orientations of Mali's health development. It is based on the principles of primary health care and the Bamako Initiative adopted in 1987 (Res *et al.*, 2021).

It was implemented through: the PSPHR, which experimented with and accompanied the development of the sectoral approach until 1998, and the ten-year programe of social and health

development of Mali (1998-2007), which definitively established the sectoral approach through the materialization of its main pillars, including the establishment of a single planning, implementation and monitoring-evaluation framework, the coordination of all actors through steering bodies and a common preferential financial procedure in place of a multitude of procedures

The Sectoral Health Policy was reconfirmed and enshrined in Law No. 02 R 049 of July 22, 2002 on the Health Orientation Law, which specifies the major orientations of the national health policy. Its main objectives are:

(i) to improve the health of the population;

(ii) the extension of health coverage and;

(iii) the search for greater sustainability and performance of the health system.

To achieve these objectives, the following strategies have been outlined:

- The differentiation of the roles and missions of the different levels of the health system. This consists of changing the concept of the health pyramid from a hierarchical and administrative concept to a more functional concept;
- Guaranteeing the availability and accessibility of essential medicines, rationalizing their distribution and prescription through the implementation of the pharmaceutical sector reform;
- Community participation in the management of the system and the mobilization of health system financing, including cost recovery and optimization of their use;
- The promotion of a dynamic private sector and a community sector complementary to the public system.

As part of the implementation of the decentralization policy, the Government of the Republic of Mali has transferred certain competencies and resources to the local authorities at the commune and circle levels in accordance with Decree 02-314/P-RM of 4 June 2002 (Johnson *et al.*, 2018).

3.5 Organization of the health system:

The health system is made up of all the public (State and local authorities), private, community (associations and mutual societies, foundations) and religious structures and bodies, as well as the professional health orders, whose activities contribute to the implementation of the national health policy.

At the institutional level, the health system is structured in three levels:

- the operational level : the district is the operational unit responsible for planning health development, budgeting and management ;
- the regional level is the technical support level for the first level ;
- The national level is the strategic level that defines strategic orientations and determines investments and operations. It also defines the criteria for efficiency, equity and sustainability.

It ensures that norms and standards are applied. It endeavors to mobilize private, state and donor resources to finance quality care accessible to all.

The local authorities participate in the administration of health care under the conditions defined by Law No. 95-034 of June 4, 2002 on the local authorities' code. Thus, the communal council, the cercle council and the regional assembly deliberate on the policy for the creation and management of dispensaries, maternity hospitals, community health centers and regional

hospitals. They also deliberate on public hygiene, sanitation and solidarity measures for rural populations (Johnson *et al.*, 2018).

The professional orders of the health sector participate in the execution of the National Health Policy under the conditions set by law.

Beneficiary populations organized in associations or mutual societies, foundations and religious congregations also participate in the design and/or implementation of the National Health Policy through the establishments they are allowed to create and operate.

At the level of health care structures, the health pyramid is divided into three levels :

The central level includes : 5 Public Hospitals, 3 of which have a general vocation (Point G, Gabriel Touré and the Hospital of Mali) and 2 with a specialized vocation (National Center of Odontology and Stomatology, Institute of Tropical Ophthalmology of Africa);

5 Public Scientific and Technological Establishments: the National Institute of Public Health Research (NIPHR), the National Center for Blood Transfusion, the National Health Laboratory (NHL), the National Center for Support in the Fight against Disease, the Center for Research, Studies and Documentation for Child Survival , the Center for Research and Fight against Sickle Cell Disease (Gottert *et al.*, 2021). These establishments and institutes at the top of the pyramid constitute the 3rd reference. It is at this level that all serious cases requiring specialized intervention or advanced para-clinical investigations are referred.

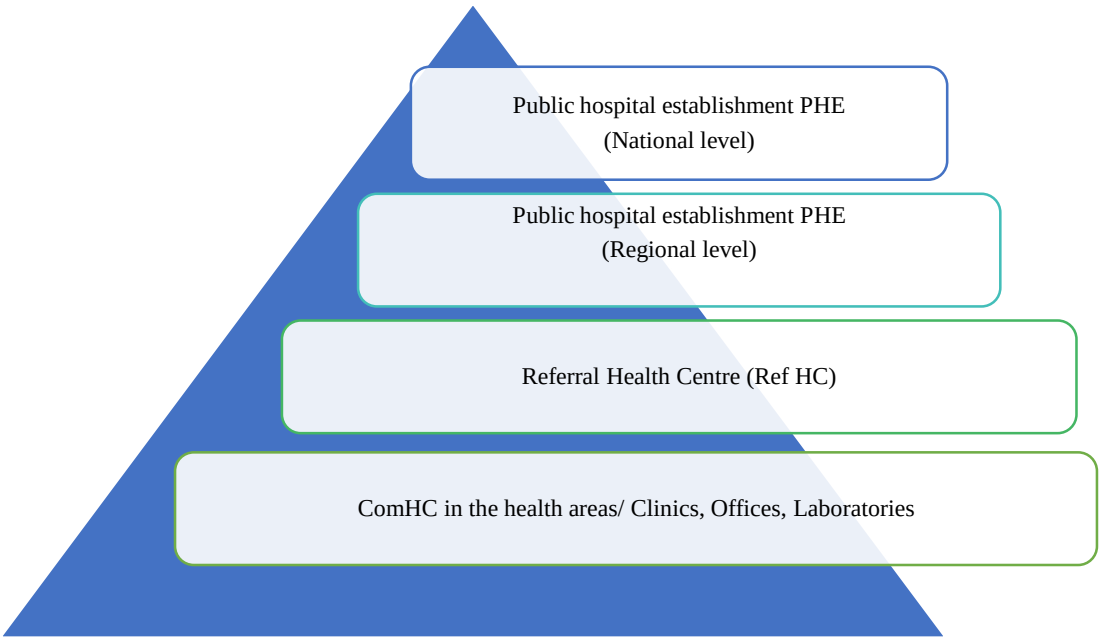
The intermediate level includes seven Public Hospitals (PH) providing the 2nd general referral and located respectively in the regions of Kayes, Sikasso, Ségou, Mopti, Timbuktu, Gao and Koulikoro (Kati Hospital). In addition, there is the "Mother and Child" Hospital in Luxembourg, a private non-profit health establishment (Gottert *et al.*, 2021).

The health district level with two levels:

(i) The first level (the base of the pyramid) or first level of recourse to care, offers the Minimum Package of Activities (MPA) in the Community Health Centres (1086 in 2011). There are other health structures: parapublic, religious, dispensaries, rural maternity hospitals and private health establishments (around 1,308 in 2011) which complete the first level. Certain aspects of the health care offer are provided by NGOs, especially reproductive health, child survival and the fight against STIs and HIV/AIDS. In addition, it is important to note the existence of traditional medicine consultation centres, whose collaboration with modern medicine needs to be improved (Gottert *et al.*, 2021).

(ii) The second level of care (first referral) is made up of the 60 Health Centres of Reference (RefHC) in the health districts, corresponding to the circles, communes or health zones. They provide care for cases referred by the first level.

Figure 3: Mali's health pyramid



Source: National strategic Plan of essentialcare in the community of Mali

3.6 Theoretical framework

This section refers to the different theories we have used in this study. This is the decree 94-5092 of 21 April 1994, which in its article6 states: The Community Health Centre's mission is to provide the Minimum Package of Activities and in particular, to promote community participation in the management of Community Health Centres and the management of health problems of the individual, the family and the community (Purnamasari *et al.*, 2020).

3.6.1Socio-health development theory

The concept of local development emerged in a context where the state's centralised management strategy was criticised by a number of local actors. The latter considered that community development policy should take into account the needs and aspirations of the community.

"Some governments have succeeded in linking population programmes with health, education and rural development projects and, moreover, have implemented them within the framework of large-scale socio-economic programmes in villages or regions (United Nations 1987 "Brundtland Report") (Purnamasari *et al.*, 2020).

A second is the need for local planning, monitoring, ownership and participation. The essential element of community ownership of local development is the participation of all its members regardless of gender, age and religion in their own development both locally and globally. Community development, according to one participant, is based on the strengths of the people. (J. Barnsley and D. Ellis).

3.6.2 History of community health

Around the 1960s, Mali opted for a health policy that allowed most of the population to access health care. From then on, many attempts were made to involve the beneficiary communities in the management of their own health problems.

The strategy of promoting health through the involvement of beneficiary communities only began to bear fruit in 1988, following the meeting of the ministers of health of the sub-region in

Bamako in 1987 (Barnett *et al.*, 2018). It was at this meeting that the Bamako Initiative (BI) was born.

The will to ensure the integrated development of the whole of community life, including the integration or coordination of technical specialities ; planning based on the "felt needs" of those concerned; emphasis on self-help; systematic search for local facilitators who are then encouraged and trained; granting of technical assistance in the form of personnel, equipment, material or financial support. (Mezhow, 1963)

Civil society, either on its own or with the support of young health workers, mainly doctors, and with the political will of the state, has taken the initiative to form community organisations for each defined health zone in order to contribute to the efforts of the state to deal with the health problems of the population. These community health organisations are called : Community Health Association (Troup *et al.*, 2021).

In this work, the analysis focuses on both qualitative and quantitative socio-health development in order to better identify and understand the impact of the participation of rural populations in their socio-health welfare through community health associations. This is why we will talk about community health associations, which play a very important role in the socio-health development of the community.

3.6.3 The concept of community participation

The community as a whole is led to reflect on its own situation and to be ready to solve its common problems, which will allow it to develop instead of remaining in the role of passive beneficiaries of development aid.

This means that:

- Community members do not feel obliged to implement solutions when they are not appropriate,
- They realise that they can be innovative in finding appropriate solutions.
- They need to develop the capacity to appreciate a situation, analyse the different options available and identify what their own contribution might be
- The community must be willing to learn, and the health system must explain, advise and provide clear information on the positive and negative consequences of proposed interventions and their costs.

Thus, "community participation" is an important factor for the management of care, with a view to changing the quality of practices by involving the population (men and women) in the management of health in Mali (Settipani *et al.*, 2019).

3.7Community Health Centre (CSCOM)

The community health centres in Mali are health centres that are managed by a private non-profit association of users and are linked to the State by an agreement that requires them to participate in the provision of public services (Agarwal *et al.*, 2019). They thus ensure a minimum package of activity and operate with resources from cost recovery mechanisms.

According to Article 3 of Ministerial Order No. 94/MSSPA-MATS-MP of 21 August 1994, the ComHC (community health centre) is a first-level health facility created on the basis of the commitment of a defined population, and organised within a community health association (ASACO) to respond effectively and efficiently to its health problems (Castillo *et al.*, 2019).

3.7.1 Missions

The mission of the Community Health Associations is to provide the Minimum Package of activities, namely:

- to manage the implementation of social and health actions within the population
- provide curative services such as: routine care for the sick, screening and treatment of local endemic diseases, routine para-clinical exploration
- ensuring the availability of essential medicines;
- developing preventive care activities (maternal and child health/family planning/vaccination, health education, etc.);
- initiate and develop promotional activities (Hygiene-Sanitation, Community Development, Information Education Communication...); and
- promoting community participation in the management of ComHCs and the management of individual and community health problems.

Community health centres are key components of the national health policy (Barnett *et al.*, 2019).

Their results should augur well for the effects of the new policy of institutional decentralisation. In this regard, ComHCs are considered to be frontline structures in the process of organising local development by decentralised communities, with the concerted participation of the State, NGOs and other partners (technical and/or financial).

3.8 Methodology

In this section, we will look at the preparatory phase on the one hand and the field research phase on the other.

For the collection of information, we focused on the qualitative method through three survey techniques: documentary review, semi-directive interview and observation.

To verify these different hypotheses, two types of data were collected from each target group. These data are qualitative and quantitative. They highlight organisational aspects, performance and perspectives according to the health centre staff, the members of the ASACO and the beneficiary communities. Also, the information allows us to understand the expectations of the populations and to appreciate the degree of involvement of the beneficiary populations in the resolution of the health problems facing the community. The technique used was the semi-structured interview. This form was preferred given the sample size of 663 people out of the 14766 in the Tousséguela health area.

A.The preparatory phase:

We divided this phase into two parts, including documentary and Internet research following the administration of an interview guide and a questionnaire on the research topic.

1.1. Documentary and Internet research:

a) Documentary research:

In libraries and documentation centres in the city, we read general and specific works in order to better understand the contours of community participation in health. Similarly, the archives in the health information system department of the Kolondièba health district were very useful.

b) Research on the Internet:

The contribution of sites related to social and health development as well as search engines such as Yahoo and Google was significant in enriching this work. These sites enabled us to compare the information collected.

B. Excution phasis

- **The interview:**

The interview was conducted with various health actors in the Tousséguela health area (village authorities, associations, etc.).

It enabled us to collect information from the population as well as from community leaders and health actors. It was carried out by focus group with discussion with a gender distinction, thus allowing us to have the point of view of both genders having participated in this activity.

The local authorities (technical director of the health centre, health management committee, communal and village council, community leaders) for all questions relating to the history of the health centre and the advantages and difficulties linked to the management strategies of the health centre.

- **Focus group discussions:**

The use of this data collection tool was very helpful in the research process. However, we decided to use the focus group technique where the use of questions, sometimes in the form of a case study requiring a judgement referring to their theories of participation in the health effort and the barriers they face, allows for a better understanding of the concept. The operationalisation of community participation in these group interviews was done using open-ended questions focusing on community participation in social and health development.

- **The Questionnaires**

Knowing that the critical eye of third parties is essential to better appreciate the contribution of communities to the socio-health development of the study area, we submitted a questionnaire to the commuties. Between October and December 2021, six hundred and sixty-three (663) people were able to express their opinions on the whole range of issues of the variables that were the subject of this research. Closed questions with a limited response margin were used; respondents

were asked to answer yes or no. When we wanted to obtain more information, we used open-ended questions to give the respondent the freedom to express themselves and to have a precise answer. When we wanted to obtain more information, we used open-ended questions to give the respondent the freedom to express themselves and to have a precision of response.

A questionnaire was used to collect data on the participation of the population in health activities and the care of community health workers in their community. It was addressed to the beneficiary populations and the technical director of the centre (TDC) as well as the health workers and community relays.

The questions aimed to obtain the following information:

- The socio-demographic characteristics of the respondents, populations,
- Their perception of the health management association,
- The importance of the health management association for the communities,
- The importance of the health management association for the communities,
- The gaps observed by the communities in the management process of the community health centre.

The aim of our questionnaire was ultimately to find out the extent and role of the quality of the structure and the level of understanding of the target community on their contribution to the health effort. This data collection allowed us to measure the numerical variables, i.e. human, material and financial inputs. This also facilitated correlation between indicators to highlight the different causalities between variables and thus made data analysis easier.

However, it also had disadvantages because of the somewhat superficial answers (not sufficiently detailed). It implied a reduction of the analysed phenomena to those aspects of them

that are most directly perceptible. It may have impoverished the content of the observation. In order to overcome these drawbacks, we used these two techniques in a complementary way, namely the qualitative and quantitative methods. They led us to understand the context, the importance and the scope of the participation of the beneficiary populations through the community health associations while giving us an angle on the strengths and weaknesses of this intervention.

These methods guided us to answer our research question and validate our hypotheses. Closed questions with a limited response margin were used; respondents were asked to answer yes or no. When we wanted to obtain more information, we used open-ended questions to give the respondent the freedom to express themselves and to have a precise answer. When we wanted to obtain more information, we used open-ended questions to give the respondent the freedom to express themselves and to have a precision of response.

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However, it also had disadvantages because of the somewhat superficial answers (not sufficiently detailed). It implied a reduction of the analysed phenomena to those aspects of them that are most directly perceptible. It may have impoverished the content of the observation (Angers and Bernatchez, 1996). In order to overcome these drawbacks, we used these two techniques in a complementary way, namely the qualitative and quantitative methods. They led us to understand the context, the importance and the scope of the participation of the beneficiary populations through the community health associations while giving us an angle on the strengths and weaknesses of this intervention.

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Typical sampling is the sampling of the research population by selecting exemplary items from the research population. In typical sampling, all items selected for the sample are models of the population under study; one or more items considered to be typical portraits of the population under study are sought. Incidental sampling is a sampling of the research population at the convenience of the researcher imposing as few constraints as possible on the selection of items (Angers and Bernatchez, 1996).

During the collection within the beneficiary communities, 7 villages were randomly selected from the thirteen (13) villages of the Tousséguela health area.

The sample size per village was calculated according to the population size of the area (14,700) and that of the village. During this collection, a questionnaire was sent to the beneficiary populations, service providers and members of the health association, and community leaders. In addition, focus group discussions were conducted in the seven villages, with the focus groups divided by gender (men and women). Each group was developed and administered in the 7 data collection sites.

C. Tools and data processing:

For the processing of the collected information, we had to:

Analyze the information collected, transcribe it in full and group all the data collected that seems to represent the views of all the interviewees.

Analysing the content and highlighting the main areas of interest in the results obtained.

As processing tools we used Word and Excel for text processing, tables, charts and data processing.

3.9 Community Health Association

A community health association is a private, non-profit association of inhabitants of the same geographical area (urban district or group of villages), called a "health area", which manages a community health centre and carries out health protection and promotion activities in this area. The Community Health Association is created in accordance with law N° 04-038 of 5 August 2004 relating to associations in general assembly and its legal recognition is done by obtaining a receipt issued by the territorial administration. At the regional level by the governor and at the circle level by the prefect (Mendenhall *et al.*, 2014).

3.9.1 Missions

The ComHCs are responsible for providing the minimum package of activities, namely

- managing the implementation of social and health actions within the population

- providing curative services such as: routine care for the sick, screening and treatment of local endemic diseases, routine para-clinical exploration

- ensuring the availability of essential medicines;

- and promote community participation in the management of ComHCs and the management of individual and community health problems (Mendenhall *et al.*, 2014).

3.9.2 Membership of the ComHA:

Membership of the ComHA is voluntary and is subject to: obtaining a membership card, the amount of which is fixed by the General Assembly, or paying a membership fee.

Every member has the duty to:

- pay their periodic membership fees,
- participate in the General Assemblies,
- respect the statutes and internal regulations of the ComHA,
- inform the Board of the ComHA about any health problem in their geographical area,
- defend the interests of the ComHA at all times and in all places

3.10 Management bodies of the ComHA.

The General Assembly:

This is the supreme decision-making body of the ComHA. It is made up of all the representatives of the villages, districts or fractions that make up the health area. It is the assembly that sets up the board of directors.

The board of directors:

Its mission is to ensure the proper functioning of the ComHC; as such it is responsible for

- Examining and adopting the centre's budgets and annual activity programmes.
- Ensuring the follow-up and control of the execution of programmes.
- Recruiting on the basis of contracts, the staff necessary for the operation of the centre.

- Reporting to the General Assembly on the functioning of the ComHC.

The Board of Directors meets in ordinary session once every six months and in extraordinary session whenever necessary. It is elected for a renewable term of three (3) years and comprises A president, a vice-president, an administrative secretary, a general treasurer, a deputy treasurer, two(2) organisational secretaries, two (2) auditors and two(2) conflict auditors (Kolbe, 2019).

The Management Committee:
It ensures that the decisions of the Board of Directors are properly implemented:

- Monitoring the management of the ComHC.

- Approving the monthly operating budget of the centre proposed by the head of the ComHC.

- Making compulsory expenditure for the proper running of the centre,

- Justifying the expenses incurred to the Board of Directors.

- To decide on first degree disciplinary sanctions for the staff.

It meets once a month in ordinary session, and in extraordinary session when the need arises. Elected by the Board of Directors from among the members with voting rights, the Management Committee comprises a president, a treasurer, an auditor, the manager of the pharmaceutical warehouse and the head of the CSCOM.

The supervisory committee: responsible for controlling the inputs and outputs of the ComHC and checking that the other management bodies are functioning in accordance with the internal regulations. It is made up of the auditor and 4 (four) members of the board of directors (Kolbe, 2019).

3.11 Dimensions of community participation.

Collective community participation in primary health care (PHC) takes different forms and some of the main building blocks are

- The organisation of services on a community basis: access to services is facilitated and open to all; this can range from basic services and the simple intention to eventually cover the whole community to the appropriate provision of basic health needs and the actual extension of all services to all community members.
- Community contribution to the operation and maintenance of services: this can range from voluntary contributions in cash and in kind, to supplement resources provided by government, local authorities or agencies outside the community, to direct payments (Chemouni, 2018).
- Community participation in the planning and management of services available within the community: either in the simplest of cases, health technicians seek the advice of community members informally, or at the other extreme, a representative community body assumes the full responsibility for collaboration (health committees).
- Community input into overall strategies, policies and programme implementation plans.
- The elimination of fragmentation and conflicts of interest in the community to establish participation on the broadest possible basis, especially including disadvantaged groups. The situation may vary from case to case, depending on whether we try to make services available to groups as equitably as possible while recognising the conflicts of interest that exist, or whether we try to build cohesive communities capable of undertaking community efforts that benefit all. The latter requires us technicians to be highly skilled negotiators and human resource managers. During the field data collection we found that some communities are well organised with regard to health finance dans leurs villages dans le souci de financer les problèmes de santé tout en en participant au financement des activités génératrices de revenu (Chemouni, 2018).

3.11 The benefits of community participation in the health effort:

The intangible benefits of community action:

- The weight of participation for the poorest. Participation, while intended to be egalitarian, cannot escape the fact that it requires the poor to make the necessary efforts to obtain what the privileged part of the population benefits from through public funding.
- Participation is sometimes seen as a diversion offered by governments that lack the political will to generate new domestic resources and redistribute existing ones.
- Insufficient inter-sectoral coordination creates difficulties in motivating people to organise for self-reliant development. There is a risk that sectors will compete with each other to introduce particular services.
- The community does not perceive the sectoral aspect of the problems and considers its needs as a whole.

Sectoral programmes produce a vertical transfer of limited information in such a way that the community cannot really integrate this information into its daily life (Purnamasari *et al.*, 2020). Collective community participation in primary health care takes different forms and some of the main building blocks are

- The organisation of services on a community basis: access to services is facilitated and open to all; this can range from basic services and the simple intention to eventually cover the whole community to the appropriate provision of basic health needs and the actual extension of all services to all community members.

- Community contribution to the operation and maintenance of services: this can range from voluntary contributions in cash and in kind, to supplement resources provided by government, local authorities or agencies outside the community, to direct payments.

- Community participation in the planning and management of services available within the community: either in the simplest of cases, health technicians seek the advice of community

members informally, or at the other extreme, a representative community body assumes the full responsibility for collaboration (health committees).

- Community input into overall strategies, policies and programme implementation plans.
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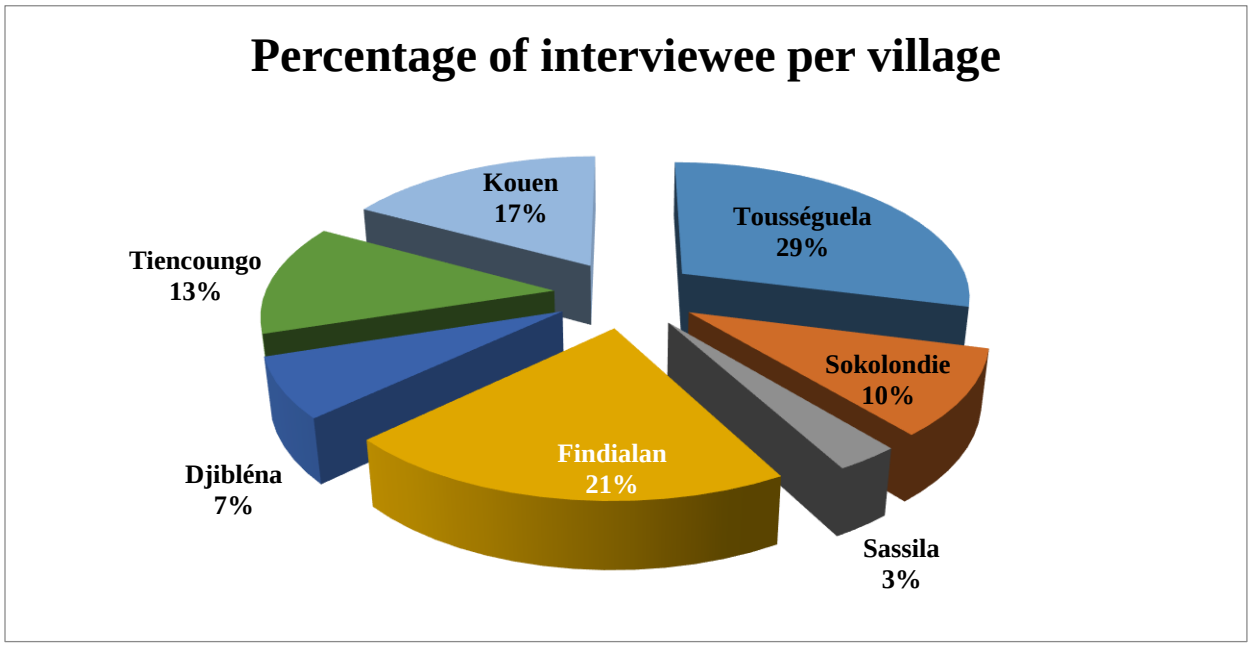
CHAPITER FOUR: RESULTS AND DISCUSSION

The results of this analysis are drawn from surveys conducted in 7 (seven) of the 13 (thirteen) villages in the Tousséguela health area. The interview with the beneficiary communities reached a sample of 663 people after eliminating inaccurate questionnaires, with wrong answers and voluntary omissions.

4.1 Respondents' socio-demographic characteristics

4.1.1 Geographical distribution of surveys Table 1 of the villages selected for data collection

Figure 4: the percentage of interviewee per village



Source: Field survey, 2021

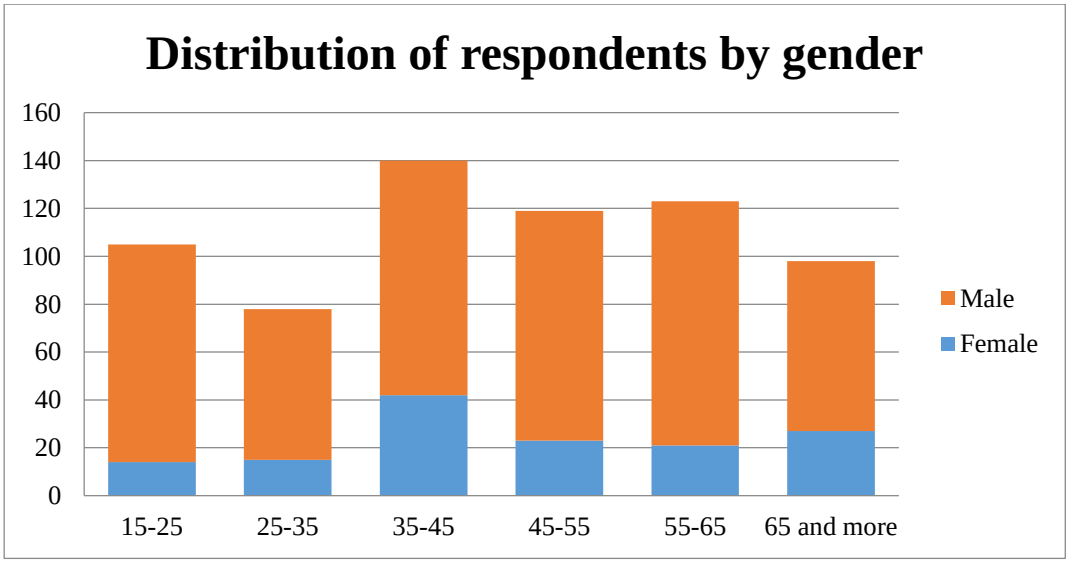
The graph of the geographical distribution of respondents shows the percentage of people who were subjected to the questionnaires. It should be noted that we selected 7 (seven) villages from the 13 villages in the Tousséguela health area. During planning, sampling was done according to

the total population of the Tousséguela health area, but also according to the population of the villages selected for data collection.

4.1.2. Structure by age and sex Sociological profile of the respondents:

A. Gender and age of respondents

Figure 5: Distribution of respondents by gender and age

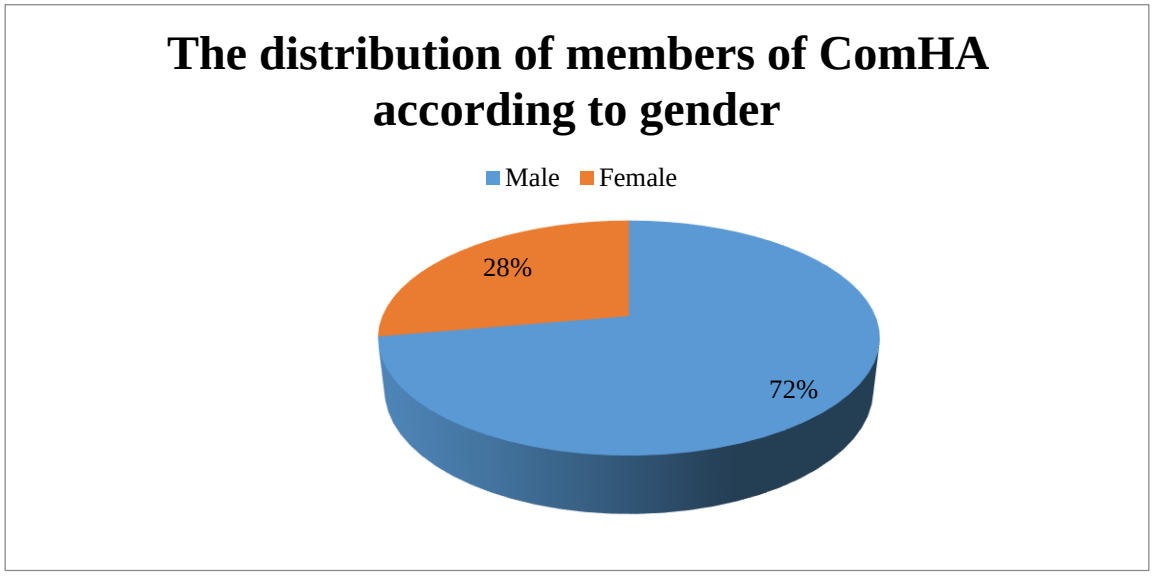


Source: Field survey, 2021

The data in the graph above relate to the sex and age of the respondents. These results revealed that 663 people were surveyed, 142 of whom were female and 521 male. The age of the respondents ranged from 15 to 65 years and over, divided into age groups of 10 (ten years). The largest age group was 35-45 years, accounting for 21% of respondents, followed by 55-65 years and 25-35 years. The low percentage of women interviewed during the data collection is due to the death or absence of male heads of households in the households that were selected for data collection.

B. Education level of respondents:

Figure 6: Distribution of ASACO members by gender

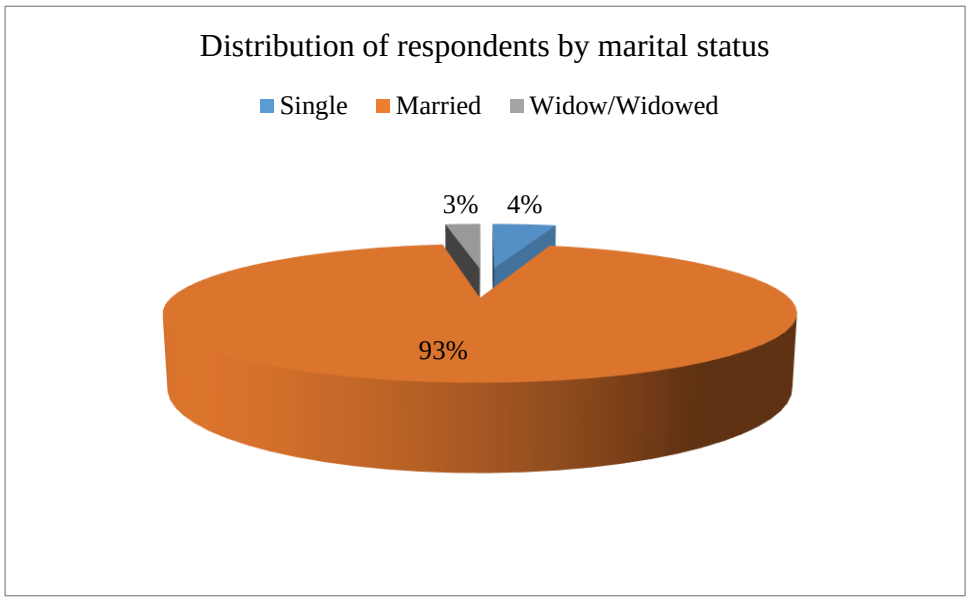


Source: Field survey, 2021

The graph above allows us to highlight a lack of female representation, the number of women on the committee is very low (28%) relative to the number of men (72%) who are members of the ComHA management committee. This may affect ComHA's performance in implementation and the quality of results obtained.

C. Marital status of respondents

Figure 7: Distribution of respondents by marital status

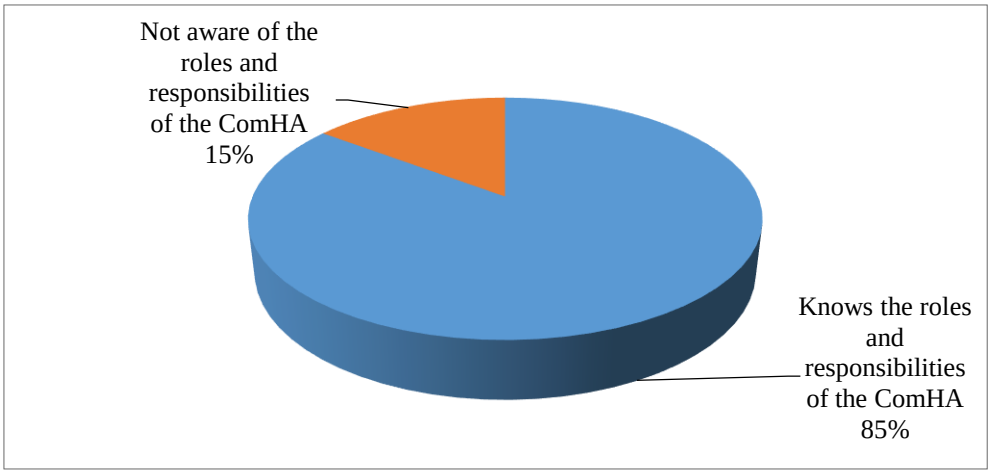


Source: Field survey, 2021

The results in figure 7 showed that the highest proportion of the respondents represented the married with 93% of the respondents; followed by the single with 4%; and the lowest proportion was the widowed with 3% of the respondents.

D. Respondents' acquaintance with the roles and responsibilities of the ComHA

Figure 8: Respondants' knowledge of the roles and responsibilities of the ComHA



Source: Field survey, 2021

To the question: "Are you aware of the roles and responsibilities of the ComHA"?

85% of the people said they knew, the remaining 15% had no idea about the roles and responsibilities of ComHA.

In the focus group sessions, the groups in 3 villages claimed to have been involved only in the planning and evaluation (those more than 15 km from the community health facility) of health activities in the community and the focus groups in the remaining 4 villages claimed to have been involved in the planning. They claim to be involved in the collection of co-payments through the collectors who are responsible for collecting the money for the referral evacuation. And the evaluation of health activities carried out in the community (those within 15 km of the community health facility).

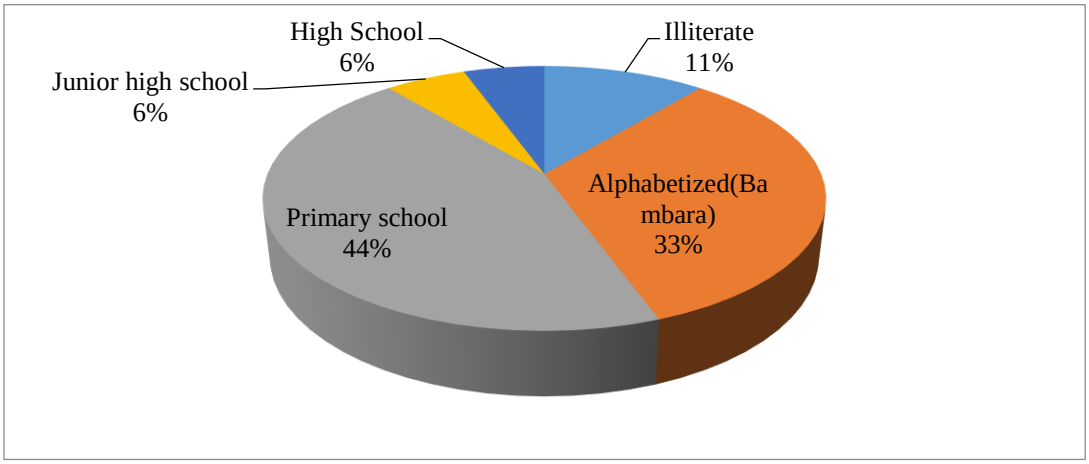
- To the question: "Do you have representatives in the ComHA management committee"?

All the representatives of the 12 villages in the Tousséguela area affirm that they all have 2 representatives on the management committee of the community health association.

They say that they have participated in the election of its members and all know about the existence of the health committee in their community.

4.2 Impact of education on community health association performance:

Figure 9: Distribution of ComHA members by education level



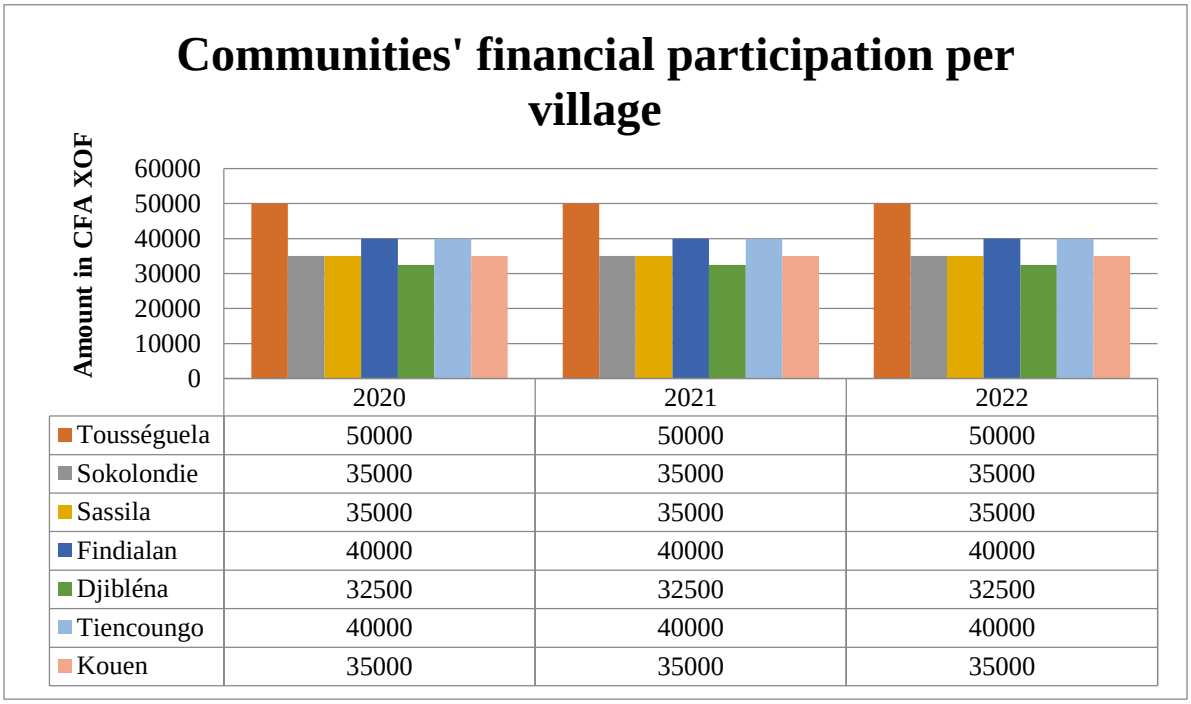
Source: Field survey, 2021

The data from the graph reveals that the vast majority of ComHA members are limited to primary school, representing 44% of members; followed by those who are literate, 33%; then illiterate, 11%; and finally those who are limited to lower secondary school and high school, 5% each. The absent levels of education are and higher education, representing 0%.

Given the situation, we can conclude that the general academic level of all the members of the health management committee makes it difficult to understand and apply the knowledge acquired during the continuous training sessions that the members of the management committee benefit from. This can not only have impacts on the health development process, but also problems with the management and qualitative monitoring of health activities in the beneficiary communities.

4.3 Contribution of beneficiary communities to the payment of referral/evacuation co-payments for children and pregnant women

Figure 10: Contribution of beneficiary communities to the payment of co-payments for referral/evacuation

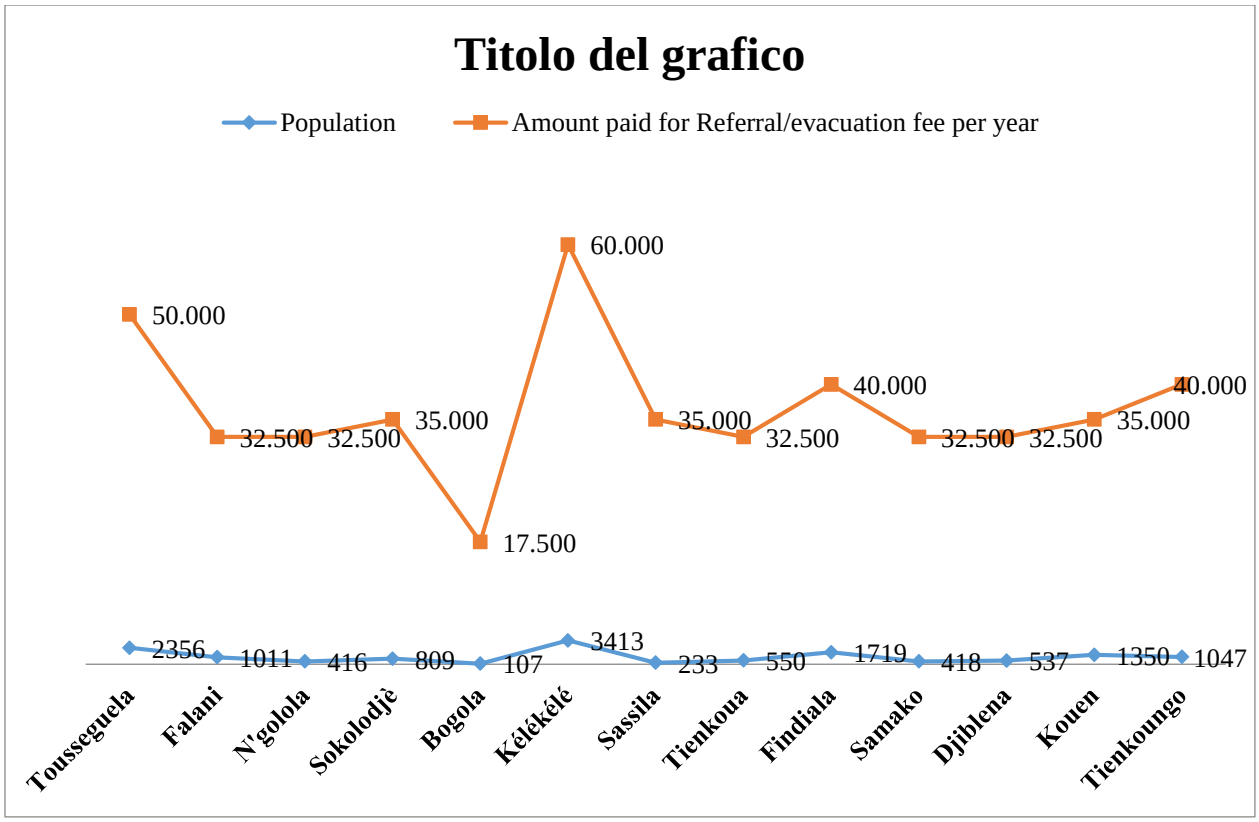


	2020	2021	2022
Tousséguela	50000	50000	50000
Sokolondie	35000	35000	35000
Sassila	35000	35000	35000
Findialan	40000	40000	40000
Djibléna	32500	32500	32500
Tiencoungo	40000	40000	40000
Kouen	35000	35000	35000

Source: Field survey, 2021

After multiple meetings with local authorities and members of the community health association concerning referral/evacuation from the community health centre to the referral health centre, it turned out that the villages that are more than 15 km from the community health centre pay their contributions punctually while those close to the community health center pay their contributions late. This can sometimes penalise all the villages in the health area.

Figure 11: Amount of contributions according to population size



Source: Field survey, 2021

4.5 Community participation

- For curative care

In order to make curative care accessible to all the communities living in the Tousséguela health area, they have joined forces to set up a fund to take charge of the curative care of those who do not have the means to pay for their care. R.K., a housewife in Djiblena, explains: "Before the

health solidarity fund was set up, we had difficulty in taking care of our health problems, and some pregnant women had difficulty keeping prenatal appointments due to a lack of financial resources. Thanks to the fund, we have easy access to the money needed for health care, and today this problem is no longer a problem in our village.

The beneficiary communities are reviewing their contribution strategies with regard to health financing. Added the technical director of the O.K. facility

As most of the focus groups testified, community initiatives for health promotion are evolving in positive ways.

- For preventive care

The beneficiary communities are the primary stakeholders in managing the health problems they face. They have an enormous responsibility for achieving the social and health development objectives of their communities. For this reason, the partners, technical and financial partners of the community health associations have thought of setting up a village health committee that works with a number of volunteers working in the community for community health activities such as monitoring children and pregnant women through malnutrition screening sessions, talks and health awareness.

4.5 The advantages of community participation in the health effort:

Community participation is an indispensable process that all populations should be able to enjoy. It allows communities to:

- to view their health status objectively rather than fatalistically and encourages them to take preventive measures;
- invest labour, time, money and materials in health promotion activities

- use and maintain the facilities they have built;

- extend health care delivery activities to the periphery;

- to make health education effective and integrate learning into their activities and to promote equity through shared responsibility, solidarity, provision of services to those most in need while promoting community self-reliance in managing the health problems they face.

Community participation in the management of health centers is one of the essential aspects of the Bamako initiative. Apart from the fact that this participation is poorly defined and often confused with financial participation, many problems persist. This notion is a key obstacle to the implementation of Bamako initiative (Deschamps 2000).

Studies seem to show that people are still rarely involved in decision-making. Community participation is minimal. For example, in Benin and Guinea, UNICEF found that very few people were aware of the existence or role of their representatives on management committees (UNICEF 1997).

The vast majority of respondents (78%) in a survey in Mali said they had not been involved in decisions made by the community health association (Nzapayeke 1997).

Community mobilization, especially for maternal health care, remains relatively sclerotic in Nigeria, and the establishment of the Bamako Initiative has not changed this (Ogunbekun, Adeyi et al. 1996).

Community participation is cross-cutting and must be allowed at all stages of the local development project cycle. The effectiveness of this participation allows the population to have the power of initiative and decision in the definition and implementation of actions and programs that concern their own future.

In the framework of the implementation of social and health development projects, participation essentially means:

- Physical participation in social and health activities.
- Financial participation: financial contribution to the cost of health activities.
- Participation in project development, decision-making and evaluation through the community health association.

This effective and sustainable empowerment of communities in the planning, implementation and evaluation of development actions facilitates the task of local authorities in the process of implementing decentralization and community development policies. This will enable external stakeholders to recognize beneficiary communities as key players and not just beneficiaries, which will allow them to take part in the decision-making process regarding projects that concern them.

We can therefore only speak of community participation in social and health development activities if a partnership relationship is established between the community (population) concerned by a health program and the health actors. This assumes that the program is based on an adapted and concerted solution, and that its orientations take into account the aspirations, objectives and constraints of the different parties. An intervention is therefore only participatory if it is the result of compromises between the communities and the various external stakeholders in local development.

4.6 Barriers to communities' participation

The limits of community participation in social and health development :

Community participation in a participatory approach is an enormous asset for the health development of beneficiary communities.

However, local leaders and target communities deplore a number of difficulties in the process of managing health activities. As O.K., advisor to the chief of the village of Tiencoungo, points out: «As far as communication between ComHA and the target communities is concerned, there is a huge gap in the awareness and involvement of these communities in the health activities».

As mentioned by the community relay of Kouen, the population finds it difficult to accept the fact that some decisions concerning them are taken without their agreement, thus making the process of community participation in health activities difficult.

The problem of marginalisation of women in terms of election to positions of responsibility in the community health association was highlighted by most of the women's groups we spoke to.

Furthermore, the existence of a weakened village power does not always guarantee the application of decisions taken, especially the financing of health activities of the beneficiary population.

The case of the rural commune of Tousséguela is quite particular, where some villages are very far from the main town of the commune Tousséguela, which is why some villages or hamlets are not involved in decision-making concerning health development activities.

The management committee is performing well on the meter, while it should be noted that their academic level is insufficient for the proper management of a community health structure and also making their capacity continuous with regard to the methodologies of effective management of health problems facing the communities.

4.7 Availability of emergency transport vehicle at the community health facility

Table 1: Availability of emergency transport vehicle at the community health facility

Respondents	**Favorable arguments**	**Unfavorable arguments**
The staff of community health centre	-Cost for referral is affordable -Medical vehicle is available at the referral health centre	-Medical vehicle leaves the referral health centre for emergency transport of our patients, which takes too long. -The tricycle used for transport is abandoned by the community for lack of comfort during transport
Municipal authorities (The Town Hall)	- Cost for referral is affordable -Medical vehicle is available at the referral health centre	The tricycle used for the reference is not comfortable for the transport of our patients
-Management Councils of the 13 villages of the Tousseguela health area	-Medical vehicle from the referral health centre for emergency transport is very expensive	-Medical vehicle leaves the referral health centre for emergency transport of our patients, which takes too long. -The referral weighs heavily on the families' budget -The tricycle used for transport is abandoned by the community for lack of comfort during transport

Source: Field survey, 2021

The group interviews showed that the transport vehicle is out of order and those accompanying them preferred to transport their patients by motorbike instead of the tricycle made available to the community for referral of patients. As the DTC of the CSCOM of Tousséguela testifies, I quote: "Our ambulance is currently broken down and the beneficiary communities do not want to

use the tricycle. They put forward the problem of the road and the lack of comfort for the patients when they are referred to the referral centre.

However, divergent opinions have been expressed regarding the use of the ambulance from the referral health centre for the transport of patients, some communities claim to have been confronted with payment problems having paid the co-payment which is not normal as testified by the majority of the beneficiary communities.

To better understand the origin of the problem, we approached the president of the ASACO as well as some members of the management committee. It turned out that the beneficiary communities are very late in paying their contributions for the evacuation of patients, thus penalising those who paid their contributions on time.

4.8 Levels of organization of the referral

Table 2: Respondents' views on referral of patients

Respondents	**Favorables arguments**	**Unfavorables arguments**
Management boards	Referral is well organised in 7 of the 13 villages in the health area: the solidarity committees pay the share that the target communities must pay to the town hall	Complains of some delay in transporting patients to the referral health centre
Village Councils	Same as management board	Same as management board
Heads of households and women of childbearing age	Same as Village Councils	Same as Village Councils

Source: Field survey, 2021

The community thinks that referral is not well organised at the community level and deplores some insufficiency in the process of transporting patients to the referral health centre, which is located thirty (30) kilometres from the community health centre.
In the other 6 villages, people say they frequently use their own means to transport their patients to the health centre (ComHC/RefHC).

4.9 Knowledge of the roles and responsibilities of the community health association (ASACO)

- To the question: "Do you know the roles and responsibilities of the ComHA?

93.34% of the staff said they were aware of the roles and responsibilities of the ComHA, the remaining 6.66% were not aware of the roles and responsibilities of the ComHA.

- To the question: "What are the barriers that prevent you from fully participating in community health activities?

After a multitude of discussion and brainstorming sessions with the different communities, it turned out that some representatives of certain communities do not convey information within their community and that the information, instead of being conveyed, remains in their possession, which somewhat hampers community mobilisation activities in favour of health activities. The 45% from villages located more than 10 km away and the 5% are villages surrounding the community health centre.

They say that they participate in health financing through the payment of a quota distributed among the villages, which is paid on an annual basis.

Table 3: Proportion of respondents aware of the need for financial and/or material support from the beneficiary communities for health development

Status of interviewees	**12 villages in the Tousséguela health area**	
	NUMBERS INTERVIEWEE	**PERCENTAGE**
Participates in financial support for health activities in the community	523	79%
Does not participate in the financial support of health activities in the community	140	21%

Source: Field survey, 2021

Community participation in the management of health centres is one of the essential aspects of the Bamako Initiative. Apart from the fact that this participation is poorly defined and often confused with financial participation, many problems persist. This notion is a key obstacle to the implementation of the Bamako Initiative (Deschamps 2000).

Community mobilisation, particularly in relation to maternal health care, remains relatively sclerotic in Nigeria and the implementation of the Bamako Initiative has not changed this (Ogunbekun, Adeyi et al. 1996).

In Mali, the lack of financial management skills is a recurrent problem for operators wishing to support management committees in the organisation of community health centres (Royal Netherlands Embassy 1999).

Community participation is cross-cutting and must be allowed at all stages of the local development project cycle. The effectiveness of this participation allows the population to have the power of initiative and decision in the definition and implementation of actions and programmes that concern their own future.

In the context of the implementation of social and health development projects, participation essentially means:

- Participation in the planning, decision-making and monitoring of community health activities;
- Participation as a volunteer in awareness-raising activities and screening for malnutrition in the community;

- Material participation in the construction of health centres and accommodation for community health workers: provision of construction materials available in the village (sand, gravel, water, etc.);
- Financial participation: financial investment (payment of quotas for the evacuation of children and pregnant women);
- Financial participation: financial contribution to the cost of the project.

Community participation in social and health development activities can only be said to exist if a partnership relationship is established between the community (population) concerned by an action programme and the other actors. This presupposes that the programme is based on an adapted and concerted solution, and that its orientations take into account the aspirations, objectives and constraints of the different parties. An intervention is therefore only participatory if it is the result of compromises between the communities and the various external stakeholders in local development.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATION

5.1 CONCLUSION

The purpose of this research was to assess the level of participation of beneficiary communities in the community health effort. To achieve this objective, we immersed ourselves in the rural world during five months of intense activity and we adopted a theoretical approach borrowing concepts and a methodological approach from the fields of public health policy and development anthropology.

We postulated that only the combination of these two fields of knowledge could make explicit the nature of the relationships between the actors and provide some explanations for this problem, which has been decried many times by researchers, and even more recently. (Gwatkin, Bhuiya et al. 2004)

As we have explained throughout this work, it appears that community participation in the health effort occupies an essential place in the process of sustaining the activities of the community health center and plays an important role in the social and health development of the populations.

The first hypothesis, formulated above, is indisputably verified because the populations participate in the health effort in the Tousséguela health area through the activities of the health association.

The second hypothesis is also true because most of the target populations are not only aware of the ASACO but also receive feedback from their representatives within the ASACO, which allows the beneficiary communities to measure their performance.

Development is therefore not the burden of a single actor in the field. All the actors must invest a lot so that the actions of the associations are wanted and supported by all. The factors blocking or facilitating participation are the technical level, the communication level, the decision-making

level, the level and the financial level.

The community does not perceive the sectoral aspect of the problems and considers its needs as a whole. The sectoral programs produce a vertical transfer of limited information in such a way that the community cannot really integrate this information into its daily life. (ASSUKULU MAKYAMBE Noé et al).

Given the documents verified during the data collection, we were able to see that the ASACO has tools for managing its activities, which helped us a great deal in collecting data during the field survey. In addition, a periodic evaluation of the association's activities allows to identify the strong points as well as the points to be improved. It encourages constant questioning and better decision-making. It demonstrates the ability to learn from the association's experience and to maintain the confidence of other technical and financial partners. If the real needs of the populations are well identified at the outset, thanks to well-adapted operational and strategic planning, there can only be an optimization of the health association's performance in the end.

In view of the quantitative and qualitative changes observed in the health and social sectors and at the level of governance, we can affirm with certainty that the beneficiary communities participate in the social and health development of the Tousséguela area. Their usefulness is recognized, proven and even requested by all partners.

From all the above, despite the difficulties encountered, the community health associations would need to provide.

5.2 RECOMMENDATIONS

Health associations, while providing solutions to the health problems facing the community, have themselves evolved enormously. Today, they fulfill functions that are as complex as they

are diverse and are at the center of multiple issues. They contribute to the reinforcement of this policy of decentralization of health and to the strengthening of strong social links and quality services at the community health center level.

The success of community health center management strategies is only possible through mobilization, continuous consultation and unfailing collaboration among all the actors. The village chief said it so well when he declared that: "It is by joining forces that we manage to overcome the problems facing our communities, let's keep this for a better and fulfilled future.

To ensure sustainable health services to the beneficiary communities, the health associations with the help of the beneficiary communities must:

- Put the beneficiary communities at the center of the process of electing the members of the management committee while taking into account the role of women in the smooth running of the association's activities;
- Avoid conflicts of interest in the communities to establish participation on the broadest possible basis, especially including women and disadvantaged groups.
- Develop strategies to provide the necessary financial and human resources for community activities;
- Coordinate and communicate with the beneficiary communities to motivate them to organize themselves for the development of comprehensive strategies and policies as well as the implementation plan of the health programs.

Therefore, the associations must first rely on the target communities and work to collaborate more in order to be stronger on health development activities in the beneficiary communities.

As for the state, it must revise its health policy in order to help community health associations in

their efforts to make primary health care more accessible. It must rid the legal and institutional environment of any ambiguity in order to avoid contradictions between the actors in the field. Better still, the State can draw up a charter for associations in order to involve and make community leaders more responsible in the processes of initiating, planning, managing and evaluating health activities.

As far as the beneficiary communities are concerned, far from being passive, they must make all health activities their own. The cornerstone of all sustainable community activities lies in the full empowerment of these populations to improve their own living conditions, their own development and that of the entire country.

As for the beneficiary communities, they must actively participate in the improvement of their living conditions and entrust women with positions of responsibility.

Similarly, through the elaboration and effective implementation of local development plans within the framework of community participation, the participation effort will be better oriented towards the priorities of the beneficiary communities. Being the first ones concerned, the populations must stop being eternally assisted and be the real actors of the improvement. This effective and sustainable empowerment of communities in the planning, implementation and evaluation of development actions facilitates the task of local authorities in the process of applying decentralization and community development policies. This will enable external stakeholders to recognize beneficiary communities as actors in development and not merely as beneficiaries.

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