

An overview of community participation in health promotion in contexts of conflict and fragility: Contextual challenges faced by community actors in the Logo Health Zone, Ituri, Democratic Republic of the Congo

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ABSTRACT

Introduction

Addressing the social determinants of health is a key priority for health promotion, as emphasized in the Ottawa Charter for Health Promotion (World Health Organization [WHO], 1986). However, there is limited evidence on the challenges faced by community participation bodies in fragile and conflict-affected settings such as the Logo Health Zone.

Purpose

This study describes local challenges and conflict-related factors that influence community dynamics in the Logo Health Zone, an area characterized by a fragile health system affected by armed conflict.

Methods

A cross-sectional study was conducted in 12 conflict-affected health catchment areas within the Logo Health Zone. The study targeted active community participation bodies, including Health and Development Committees (HDCs), Community Outreach Units (COUs), and Community Health Workers (CHWs) operating for at least one year, as well as head nurses (HNs). Convenience sampling was used to recruit 395 participants. Data were collected using a structured questionnaire administered through the KoboCollect application. Descriptive statistics (frequency analysis) were performed using SPSS and Microsoft Excel.

Results

CHWs reported poor community engagement (53.0%), requests for financial incentives (30.5%), and lack of transparency regarding bonuses for paid activities (26.6%). COUs reported poor community participation (27.3%) and poor CHW involvement (21.2%) as major barriers. Meanwhile, HDCs reported poor community ownership (33.3%) and poor collaboration with health centers (25.0%). Head nurses reported poor ownership of health initiatives (41.7%), requests for financial incentives (33.3%), and mistrust between HDCs/CHWs and health centers as major barriers. Finally, the main contextual factors contributing to conflict were population and participation body instability (75.0%) and disruption of activities (41.7%).

Conclusion

Strengthening supervision of community actors, improving financial transparency, and enhancing collaboration between health facilities and community bodies appear necessary to support community participation and strengthen health system resilience in fragile settings.

INTRODUCTION

Efforts to promote health through effective community involvement remain a global priority, as emphasized in the Ottawa Charter for Health Promotion (World Health Organization [WHO], 1986). Addressing the social determinants of health likewise remains a key concern of the international community, as highlighted by the Committee on Economic, Social and Cultural Rights in General Comment No. 14 (United Nations, 2000). However, in many resource-constrained countries—particularly in fragile or conflict-affected settings—the effective implementation of community participation within health systems continues to face substantial challenges.

Recent studies indicate that fragile health systems rely heavily on community engagement and the involvement of community health workers (CHWs) to maintain access to essential health services in crisis-prone areas (Adsul et al., 2024; Werner et al., 2023). These findings are consistent with observations from other fragile contexts, although some studies place greater emphasis on institutional constraints, including limited involvement of community actors and governance-related limitations (Collins et al., 2014; LeBan et al., 2021), rather than on community engagement itself.

Within this broader context, the WHO has warned of risks affecting community participation, a major driver of global health equity, particularly in developing and politically unstable countries. These settings are often characterized by inefficient management of national health systems, insufficient financial resources, and top-down decision-making processes that exclude local communities. In this regard, Fassin (2000) noted that insecurity is among the key factors undermining community engagement in health initiatives.

Similarly, Rococo et al. (2021) identified a lack of conceptual clarity, along with organizational and sociopolitical barriers, as obstacles to developing effective strategies for implementing community participation frameworks in Europe. This issue appears even more pronounced in Africa, where several studies highlight the influence of economic conditions, local perceptions, social inequalities, and local conflicts on community

participation (Perry, 2020; Sombié et al., 2015). These findings are broadly similar to those observed in other regions, but they show a particularly strong influence of socioeconomic and security-related factors. This aligns with analyses suggesting that such constraints directly affect the performance and integration of community actors into health systems (LeBan et al., 2021).

These constraints hinder the operationalization of community dynamics, particularly through weak interpersonal relationships between health professionals and communities, as well as shortages in the supply of health facilities. According to LeBan et al. (2021), these challenges are further compounded by the limited integration of CHWs into national health systems, which undermines both their effectiveness and institutional sustainability. Similarly, Atkinson et al. (2011) and Zulu et al. (2013) emphasize that the credibility of CHWs depends on the quality of services provided by the health facilities to which they are affiliated, which in turn determines their acceptance and legitimacy within the community.

The situation becomes even more complex in contexts of instability, where the destruction of infrastructure and looting severely weaken community dynamics (Erismann et al., 2019; Miller et al., 2020). These conditions are particularly concerning for women, as emphasized by Idriss-Wheeler et al. (2024). Insecurity also reduces the operational capacity of community participatory bodies. Lin et al. (2023) further observe that the challenges faced by CHWs in fragile or conflict-affected settings share notable similarities with those observed in other environments. Among these common constraints, Collins et al. (2014) identify limited financial resources, difficulties related to the selection and retention of volunteers, and divergent stakeholder approaches that may strain relationships with communities. Collins et al. (2014) also argue that political and security instability undermines the long-term commitment of volunteers and disrupts the continuity of community initiatives. In addition, Raven et al. (2022) stress the importance of institutional support and incentives to strengthen the motivation and effectiveness of community actors.

Regardless of mitigation strategies, the resilience of health systems in developing countries remains closely linked to

the empowerment and effective integration of community health actors (Schleiff et al., 2021). Recent analyses also confirm that community engagement is a major determinant of the continuity of health services in fragile and conflict-affected settings (Adsul et al., 2024; Werner et al., 2023), corroborating earlier findings, although variations exist depending on local contexts (Collins et al., 2014; Raven et al., 2022).

In the Democratic Republic of the Congo (DRC), particularly in the eastern provinces affected by persistent armed conflict, these challenges are even more acute. Armed violence, destruction of infrastructure, and population displacement undermine the functioning of health services and compromise community dynamics. In the Logo Health Zone, located in Ituri Province, security and institutional constraints affect the functioning of community participation bodies as well as the engagement of local actors in health initiatives (Kenanewabo et al., 2020). Despite the importance of community participation in strengthening health systems, few studies have specifically examined the factors influencing community dynamics in conflict-affected health zones in eastern DRC.

Research conducted in other post-conflict health zones in eastern DRC highlights the importance of community engagement for strengthening local health system resilience (Masumbuko et al., 2024). However, the extent of engagement varies depending on security and organizational contexts, consistent with analyses indicating that resilience in fragile settings depends heavily on both community involvement and institutional conditions (Raven et al., 2022; Schleiff et al., 2021). Nevertheless, despite extensive international research on community participation, studies specifically addressing security-fragile contexts in eastern DRC remain limited. Recent work further emphasizes that community participation remains a key lever for improving access to health services and strengthening health system resilience (Houssein Ali et al., 2025).

In this context, this study seeks to answer the following research question: *What structural and contextual factors hinder effective community participation in fragile health systems in the Logo Health Zone?* Accordingly, this study

aims to analyze local challenges and conflict-related factors influencing community dynamics in the fragile and conflict-affected Logo Health Zone.

METHODS

Study Site

This study was conducted in the Logo Health Zone, one of the 36 health zones within the Ituri Provincial Health Division. The Logo Health Zone is bordered by the Mahagi Health Zone to the north, the Nyarambe Health Zone to the east, the Rethy Health Zone to the south, and the Rimba Health Zone to the west. The southern part of the zone is particularly unstable due to insecurity in the region.

Study Design

This descriptive study used a cross-sectional design. This approach enabled the identification and description of barriers faced by community engagement actors, as well as contextual conflict-related factors, within a specific setting at a particular point in time.

Study Period and Population

The study was conducted over a three-month period, from June 18 to September 14, 2025, in an unstable environment affected by ongoing violence. The study covered 12 conflict-affected health catchment areas in the Logo Health Zone and focused on the following actors: Health and Development Committees (HDCs; $n = 12$), Community Outreach Units (COUs; $n = 38$), Community Health Workers (CHWs; $n = 394$), and head nurses (HNs; $n = 12$).

Sample and Sampling Strategy

Convenience sampling was used to recruit a sample of 395 participants, distributed as follows: 338 CHWs, 33 COU chairpersons, 12 HDC chairpersons, and 12 head nurses from the 12 health centers. Although 38 COUs were identified in the health zone, only 33 chairpersons were available and consented to participate during the data collection period. Participants were included based on availability and consent during the study period.

Inclusion criteria were active and available community actors who had worked in the relevant health catchment areas for at least one year.

Data Collection, Validity, and Reliability

Data were collected using a structured questionnaire administered by trained research assistants through the KoboCollect application. The questionnaire captured information on barriers encountered by different community participation actors, as well as contextual factors contributing to conflict.

Prior to data collection, the questionnaire was pretested with 45 CHWs from a nearby health center that was not included in the study. The pretest helped identify ambiguities and supported the reformulation of several questions to improve clarity.

Data reliability was strengthened through prior training of research assistants and the use of standardized questionnaire administration procedures.

Data Analysis

Data were analyzed using SPSS and Microsoft Excel. Descriptive statistics, including frequency analysis, were used to describe the distribution of responses and identify key trends regarding barriers and contextual factors affecting community participation in the Logo Health Zone. Analyses were conducted primarily at the individual level for CHWs and at the organizational level for community participation bodies (HDCs and COUs), as well as for head nurses. Inferential statistical analyses were not performed because the sampling strategy was non-probabilistic.

Ethical Considerations

The study protocol was approved by the Ethics Committee of the Higher Institute of Medical Techniques of Kinshasa (ISTM-Kinshasa), under clearance letter number 139/CBE/ISTM/KIN/RDC/PMBBL/2025, dated May 7, 2025. All participants provided written, free, and informed consent prior to participation. Participant anonymity was maintained throughout the study and during dissemination of the findings.

RESULTS

Challenges Reported by Local Community Engagement Stakeholders in the Logo Health Zone

The barriers identified by local community engagement stakeholders are presented in **Tables 1-4**.

Table 1: Challenges Identified by Community Health Workers (CHWs), by Level of Intervention (n = 338)

Level of intervention	Reported barrier	n	%
Health Zone Office	Lack of transparency regarding bonuses for paid activities	90	26.6
	Lack of financial and material support	76	22.5
	Insufficient supervision of CHWs	21	6.2
	Poor communication	4	1.2
	No answer	149	44.1
Health Centers	Poor incentives	73	21.6
	Poor organization and insufficient staffing	53	15.7
	Poor collaboration and communication	43	12.7
	Insufficient work materials	40	11.8
	Insufficient supervision of CHWs	32	9.5
	Other obstacles (security-related)	29	8.6
	Irregularity of healthcare staff	6	1.8
	Irregularity of meetings	6	1.8
	Lack of transparency (including bonus management)	5	1.5
	Lack of consideration	2	0.6
	Low number of CHWs	2	0.6
No answer	97	28.7	
Community	Poor community engagement	179	53.0
	Requests for financial incentives	103	30.5
	Poor understanding of CHWs' roles	33	9.8
	Poor community participation	21	6.2
	Other barriers	5	1.5
	No answer	4	1.2

Note: CHW = Community Health Worker.

At the Health Zone Office level, the lack of transparency regarding bonuses for paid activities (26.6%) and the lack of financial and material support (22.5%) were the most frequently reported obstacles. At the health center level, the main barriers included poor incentives (21.6%), poor organization and insufficient staffing (15.7%), poor collaboration and communication (12.7%), and insufficient work materials (11.8%). At the community level, poor community engagement (53.0%) and requests for financial incentives (30.5%) were the main barriers reported by CHWs.

Table 2: Barriers Reported by Community Outreach Units (COUs) and Health and Development Committees (HDCs), by Level of Intervention

Body	Level	Type of constraint	Reported barrier	n	%
COU (n = 33)	Health Zone Office	Governance/supervision	Lack of supervision	3	9.1
			Lack of financial transparency	3	9.1
		No answer	27	81.8	
	Health	Institutional	Poor collaboration	6	18.2

Body	Level	Type of constraint	Reported barrier	n	%	
	Centers	collaboration	with health centers			
		Institutional supervision	Poor supervision from health centers	5	15.2	
			No answer	22	66.7	
	Community	Community participation	Poor community participation	9	27.3	
		Community ownership	Lack of ownership of activities	6	18.2	
			No answer	18	54.5	
	CHWs	Engagement of community actors	Poor CHW involvement	7	21.2	
				No answer	26	78.8
	HDC (n = 12)	Health Zone Office	Governance/supervision	Lack of supervision	2	16.7
				No answer	10	83.3
Health Centers		Institutional collaboration	Poor collaboration with health centers	3	25.0	
				No answer	9	75.0
Community		Community ownership	Poor community ownership	4	33.3	
				No answer	8	66.7
CHWs		Governance of community work	Non-compliance with work rules	2	16.7	
				No answer	10	83.3

Note: COU = Community Outreach Unit; HDC = Health and Development Committee; CHW = Community Health Worker.

Most COU and HDC respondents did not report barriers at several levels. However, among COUs, barriers at the health center level were mainly related to institutional collaboration and supervision (33.4% combined). At the community level, poor community participation (27.3%) and lack of ownership of activities (18.2%) were frequently reported. Among HDCs, lack of supervision (16.7%), poor collaboration with health centers (25.0%), poor community ownership (33.3%), and non-compliance with work rules (16.7%) were reported at the Health Zone Office, health center, community, and CHW levels, respectively.

Table 3: Barriers Reported by Head Nurses, by Level of Intervention (n = 12)

Level	Reported barrier	n	%
Health Zone Office	Lack of financial transparency in paid activities involving community bodies	3	25.0
	Excessive workload imposed on head nurses by the Health Zone Office	1	8.3
	Poor supervision of participation bodies	2	16.7
	No answer	8	66.7
COUs and HDCs	Requests for financial incentives	4	33.3
	Lack of financial support	1	8.3
	Demotivation of COUs due to lack of financial support	1	8.3
	Weak commitment of some HDC members and other	2	16.7

Level	Reported barrier	n	%
	actors		
	Instability of participation bodies	1	8.3
	Mistrust between HDCs and COUs	1	8.3
	Failure to renew terms	2	16.7
Community	Poor ownership of health initiatives	5	41.7
	Mistrust or misunderstanding between HDCs/CHWs and health centers	4	33.3
	Patients' inability to pay for care	2	16.7
	Conflicts within or between communities	1	8.3
	Overload due to multiple local development initiatives	1	8.3
	No answer	2	16.7

Note: COU = Community Outreach Unit; HDC = Health and Development Committee; CHW = Community Health Worker.

Although most head nurses did not report barriers at the Health Zone Office level (66.7%), lack of financial transparency in paid activities involving community bodies (25.0%) and poor supervision of participation bodies (16.7%) were reported. At the COU and HDC level, the most frequently reported barriers were requests for financial incentives (33.3%), weak commitment among some HDC members (16.7%), and failure to renew terms (16.7%). At the community level, poor ownership of health initiatives (41.7%) and mistrust or misunderstanding between HDCs/CHWs and health centers (33.3%) were most frequently reported.

Contextual Factors Contributing to Conflict in the Logo Health Zone

Conflict-related contextual factors reported by stakeholders involved in community participation are presented in Table 4.

Table 4: Conflict-Related Contextual Factors Reported by Community Participation Actors

Actors/bodies	Reported factor	n	%
CHWs (n = 338)	Burning and destruction of homes and health center buildings, and looting of property	94	27.8
	Population and CHW instability	88	26.0
	Food insecurity	77	22.8
	Disruption of community activities	58	17.2
	Forced displacement of CHWs	21	6.2
	Movement restrictions	16	4.7
	No answer	6	1.8
COUs (n = 33)	Population and participation body instability	8	24.2
	Disruption of activities	5	15.2
	Conflict-related displacement/overcrowding	3	9.1
	Movement restrictions	3	9.1
	Pressure from armed groups	2	6.1
	No answer	12	36.4
HDCs (n = 12)	Population and participation body instability	5	41.7

Actors/bodies	Reported factor	n	%
	Overcrowding in villages due to conflict-related displacement	3	25.0
	Disruption of activities	1	8.3
	Mistrust between communities and participatory bodies	1	8.3
	No answer	2	16.7
Head nurses (n = 12)	Population and participation body instability	9	75.0
	Disruption of activities	5	41.7
	Killings and destruction/looting of property in certain villages	4	33.3
	Overcrowding in villages due to conflict-related displacement	3	25.0
	Staff turnover and suspension of activities	2	16.7
	Weakening of participatory bodies	1	8.3

Note: CHW = Community Health Worker; COU = Community Outreach Unit; HDC = Health and Development Committee.

CHWs most frequently cited destruction and looting of homes and health centers (27.8%), population and CHW instability (26.0%), and food insecurity (22.8%). Among COUs, population and participation body instability (24.2%) and disruption of activities (15.2%) were most frequently reported. Among HDCs, population and participation body instability (41.7%) and overcrowding due to displaced populations (25.0%) were the main factors cited. Head nurses most frequently cited population and participation body instability (75.0%) and disruption of activities (41.7%).

DISCUSSION

Challenges Faced by Local Actors in Community Participation in the Logo Health Zone

Challenges Identified by Community Health Workers (CHWs)

At the Health Zone Office level, the lack of transparency regarding bonuses for paid activities and the lack of financial and material support highlight major governance and institutional weaknesses within the local health system (Table 1). Transparency in resource management, particularly regarding incentives linked to paid activities, may strongly influence trust between community actors and health authorities. Institutional trust is a key determinant of community engagement and sustained participation in health promotion initiatives.

This finding aligns with Rococo et al. (2021), who report that community participation mechanisms are often undermined by organizational challenges and unclear governance structures. Similarly, LeBan et al. (2021)

emphasize that limited institutional recognition and inadequate organizational support for CHWs reduce their effectiveness and contribution to health interventions.

In fragile or conflict-affected settings, these constraints may be exacerbated by structural weaknesses and limited resources. Several studies suggest that CHW performance depends largely on institutional support, supervision systems, and appropriate incentives to sustain engagement in community activities (Adsul et al., 2024; Raven et al., 2022). Therefore, barriers reported at the Health Zone Office level may reflect broader weaknesses in coordination, supervision, and financial governance, which may ultimately undermine motivation and reduce the effectiveness of community health initiatives.

At the health center level, low incentives, poor organization and staffing shortages, limited collaboration and communication, and insufficient working materials underscore the importance of organizational capacity for effective community participation (Table 1). Supervision quality, communication, and incentive structures appear to strongly shape relationships between health facilities and CHWs.

Evidence from fragile contexts suggests that the effectiveness of community participation depends heavily on relationships between health workers and community actors, role clarity, and institutional coordination mechanisms (Lin et al., 2023). Collins et al. (2014) also emphasize that demotivation of community actors and limited resources are frequent barriers to participation in resource-constrained systems. Moreover, CHWs require sustained support to contribute effectively to health programs, particularly in fragile and crisis-affected settings (Raven et al., 2020). More broadly, the institutional integration of community actors and clarity regarding responsibilities remain essential for strengthening health system performance in fragile environments (Werner et al., 2023).

At the community level, poor community engagement and requests for financial incentives suggest major challenges related to community ownership of health initiatives (Table 1). Community participation relies strongly on social trust, understanding of stakeholders' roles, and perceived legitimacy of interventions.

Studies conducted in African settings indicate that community participation can be constrained by mistrust in health facilities, financial expectations, and limited understanding of CHW roles (Sombié et al., 2015). In fragile contexts, these dynamics may be amplified by poverty and insecurity, which limit community capacity to engage in voluntary initiatives. Other research highlights that volunteer fatigue and dependence on external financial support can undermine mobilization and sustainability (Erismann et al., 2019; Idriss-Wheeler et al., 2024). Furthermore, Houssein Ali et al. (2025) emphasize that social trust, transparency, and local ownership are essential determinants of participation in fragile health systems.

Overall, the barriers reported at the community level appear to reflect broader governance challenges and socioeconomic constraints. Strengthening community participation in unstable contexts requires improved transparency, better communication between health facilities and communities, and locally adapted engagement strategies.

Challenges Reported by COUs and HDCs

Although most COU and HDC respondents did not report barriers at several levels (Table 2), the lack of supervision at the Health Zone Office level indicates limitations in institutional oversight and monitoring of community participation bodies. In decentralized health systems, technical guidance and organizational support are essential for ensuring effective functioning and integration of community bodies into health governance.

Several studies suggest that community participation depends heavily on institutional support, supervision, and clear coordination mechanisms between health services and community structures (LeBan et al., 2021; Rococo et al., 2021). In fragile settings, these issues may be intensified by limited resources and weak administrative capacity, which reduce the ability of health authorities to support and supervise community actors effectively.

At the health center level, poor collaboration and weak supervision highlight the importance of institutional relationships between health facilities and community structures. Collaboration is essential for coordinating health interventions and sustaining community

mobilization. Studies in fragile contexts show that unclear roles, communication gaps, and coordination difficulties may significantly weaken community participation mechanisms (Collins et al., 2014; Lin et al., 2023). These findings suggest that improving coordination between health facilities and community bodies is a critical lever for strengthening community participation.

At the community level, poor community participation and limited ownership of activities reflect persistent challenges related to engagement and legitimacy of interventions. Evidence from sub-Saharan Africa indicates that participation may be limited by socioeconomic constraints, limited understanding of program objectives, and past experiences that have undermined trust (Sombié et al., 2015). In fragile contexts, instability further reduces the capacity of communities to sustain engagement. Similarly, Houssein Ali et al. (2025) stress that social trust and ownership are key determinants of participation in fragile health systems.

At the CHW level, non-compliance with work rules suggests governance challenges within community-based systems. Coordination among community structures and clear delineation of responsibilities are essential for effective functioning. Research indicates that community participation mechanisms may be undermined by divergent expectations among stakeholders and inadequate monitoring (LeBan et al., 2021; Rococo et al., 2021). Strengthening governance, clarifying roles, and ensuring consistent support therefore appear essential.

The high proportion of missing responses among COUs and HDCs may reflect reluctance to report sensitive issues that could affect future collaboration with health authorities. This non-response may introduce reporting bias and should be considered when interpreting these findings.

Challenges Reported by Head Nurses

At the Health Zone Office level, although most head nurses reported no barriers, lack of financial transparency and weak supervision suggest challenges related to governance and oversight of community participation structures (Table 3). Transparency in the management of incentives and paid activities is essential for maintaining trust between health facilities and community actors.

Similar findings have been reported elsewhere, where shortcomings in governance and limited institutional support undermined participation mechanisms (LeBan et al., 2021; Rococo et al., 2021). In fragile settings, high workloads may further reduce the capacity of health staff to supervise community bodies regularly.

At the COU and HDC level, requests for incentives, limited engagement among some members, and failure to renew terms reflect motivational and organizational weaknesses. Stability and motivation are key conditions for continuity of activities. Collins et al. (2014) similarly report that demotivation and instability of community structures can undermine participation. Adsul et al. (2024) further emphasize that sustainability depends on recognition mechanisms, institutional support, and capacity-building interventions.

At the community level, low ownership and mistrust between community bodies and health centers reflect barriers related to trust and perceived legitimacy of health interventions. In fragile contexts, mistrust, socioeconomic hardship, and difficulties accessing services can reduce participation (Sombié et al., 2015). Houssein Ali et al. (2025) again highlight that transparency and local ownership are key drivers of participation in fragile systems.

Conflict-Related Contextual Factors Affecting Community Participation

CHWs reported destruction of infrastructure and looting, population instability, and food insecurity as major contextual constraints (Table 4). These factors illustrate the direct effects of insecurity on living conditions and health service delivery. Armed conflict frequently disrupts health systems through destruction of infrastructure, displacement, and service interruption (Miller et al., 2020). In such environments, food insecurity and movement restrictions further limit the ability of CHWs to operate effectively.

At the COU level, population instability and disruption of activities indicate that community structures are directly affected by displacement and insecurity. Lin et al. (2023) note that security instability weakens local governance and reduces participation in health initiatives. Armed group pressure and movement restrictions may further

compromise communication between community actors and populations.

Among HDCs, population instability and overcrowding due to displaced populations reflect disruption of social structures and local governance. Displacement can reduce trust and weaken relationships between communities and participation bodies (Erismann et al., 2019), thereby limiting the effectiveness of participatory mechanisms.

For head nurses, population instability and disruption of activities highlight the broader impact of conflict on health facilities and community participation structures. Kruk et al. (2015) note that armed conflict weakens health systems through displacement, destruction, and service disruption. Strengthening health system resilience in such settings requires supporting community structures, reinforcing governance mechanisms, and adapting interventions to security and social realities.

Given the descriptive nature of this study, causal relationships cannot be established. Longitudinal studies could provide deeper understanding of changes over time in barriers, perceptions, and community participation dynamics, particularly in fragile and conflict-affected contexts.

CONCLUSION

This study analyzed operational constraints affecting community participation in the conflict-affected Logo Health Zone, within the framework of the National Strategic Plan for Community Health in the Democratic Republic of the Congo.

The findings highlight several major barriers to community participation at different levels of the local health system. *First*, institutional weaknesses—including limited supervision of community actors, particularly CHWs, and inadequate coordination between health facilities and community participation bodies—appear to undermine community dynamics. *Second*, concerns regarding transparency in the management of paid activities and the lack of adequate support and incentive mechanisms may reduce the motivation of community actors. *Third*, low community engagement and limited understanding of the roles of community actors constitute important barriers to effective participation.

The study also demonstrates the influence of conflict-related contextual factors on the functioning of community participation bodies. Population instability, displacement, destruction of homes and infrastructure, and disruption of community activities significantly affect the continuity of community actors' work and the functioning of local participatory bodies.

In light of these findings, strengthening community participation in fragile and conflict-affected settings requires improved supervision and support mechanisms, enhanced transparency in resource management, and stronger collaboration between health facilities and community participation bodies to promote local ownership. Capacity building in community governance should also be considered.

In fragile settings such as the Logo Health Zone, strengthening community participation remains a key strategy for improving the resilience of local health systems and supporting the implementation of community health interventions.

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