Community participation and leadership in initiating and implementing a health development programme in Saradidi, Kenya were examined. Organization of the area into villages had to be sensitive to existing community organizational structures such as geography, religion, kinship and administrative boundaries. The lowest level government leaders did not always have the support of the community. Some groups such as women and those who were not wealthy were not always included in leadership positions; these people, however, were often most aware of certain village problems. In Saradidi, women's groups were important for community development; they supported the volunteer community health workers and carried out many village health activities. Many village health committees did not function effectively. Village health workers were supported principally by the programme centre. Village income-generating activities were not very successful. Group involvement in income raising ventures proved to be inefficient; many ended up as income draining activities. Village group income projects must be well selected relative to the skills and resources available and the ability of the product to be marketed; only exceptional ones should be encouraged. Those based at the programme's centre were more successful perhaps because of a greater investment in skills, money and marketing. Age was an important factor in accepted leadership roles in Saradidi; most effective leaders were more than 45 years of age. Village health helpers volunteered a significant proportion of their time despite poor support by village health committees and no financial remuneration. The central project structure and the training they received compensated for the lack of guidance by village health committees.