Self-reliance or social accountability? The raison d'être of community health committees in Nigeria

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Abstract
Social justice requires that communities demand social accountability. We conducted this study to inform ongoing efforts to facilitate social accountability through community health committees in Nigeria. We theorised that committees may see themselves in two ways – as outwardly-facing (‘social accountability’) and/or as inwardly-facing (‘self-reliance’). We analysed the minutes of their meetings, alongside interviews and group discussions with committee members, community members, health workers, and health managers in four states across Nigeria. The committees’ raison d’être reflects a bias for self-reliance in three ways. First, seen as a platform for the community to co-finance health services, members tend to be the local elite who can make financial contributions. Second, in a one-sided relationship, they function more to achieve the goals of governments (e.g. to improve the uptake of services), than of the community (e.g. rights-based demands for government support). Third, their activities in the community reflect greater concern to ensure that their community makes the most of what the government has already provided (e.g. helping to drive the uptake of existing services) than asking for more. Optimising the committees for social accountability may require support by actors who do not have conflicts of interests in ensuring...
that they have the necessary information and strategies to demand social accountability.

**KEYWORDS**
accountability, community, decentralisation, governance, Nigeria, primary health care

**Highlights**
- Community engagement in health system governance can promote social justice
- Promoting social justice requires that communities demand social accountability
- Without being primed for social accountability, communities default to self-reliance
- Priming for social accountability requires non-government support for communities

1 | INTRODUCTION

In health systems around the world, there are institutionalised strategies to promote community engagement in governance. In many instances, such strategies involve a governing board or committee which may include community members and representatives. Each of these boards or committees is typically linked to a health facility or a unit of health system governance – such as a district. They therefore function within an implicitly decentralised governance of health systems. On the one hand, they help to connect communities to their health services and systems. On the other hand, they help to connect communities to governments who are responsible for creating and financing and governing the structures and systems within which health services are delivered. These roles have important implications for social justice. However, community boards and committees vary in the extent to which they are effective in performing these roles.

Existing analyses point to the important context in the varying effectiveness of such community boards and committees. For example, the information context (e.g., awareness of the minimum standard to expect from governments or service providers, and of their roles in decision-making); cultural context (e.g., attitudes on respect for authority or the use of individual patron-client relations rather than collective action to resolve problems); geographical context (e.g. access to alternative source of health services nearby, and impact of the size of land areas and travel distance on the cost of attending meetings or visiting government offices); socio-economic context (e.g., existence of other community entities that provide fora for expressing health-related needs; ability of members to bear the costs of attending meetings and participation); institutional context (responsiveness of government officials and health service providers, support of individuals with high level of legitimacy such as traditional or religious leaders, autonomy to make their own rules and rules that govern their health, and accountability for finances among themselves and to the community).

The contextual factors which influence the performance of community boards and committees have been extensively identified, and their roles (including their potential to advance social justice by demanding social accountability) have been extensively described. But not only is it necessary to understand how these and myriad other contextual influences manifest (or do not) within a community or jurisdiction, supporting and facilitating the performance of these community governance entities also requires an understanding of their endogenous raison d’être – that is, how do their members see the primary role of such community boards and committees, especially in settings
in which governments under-govern and service providers under-perform. Identifying such mechanisms receives much less attention in the literature.\textsuperscript{5–7} This study explores how community health committees see themselves (and its implications for social justice) in Nigeria.

Around the world, community health committees are the most common way in which governments and non-governmental organisations (NGOs) have promoted community engagement in primary health care (PHC) governance.\textsuperscript{2,3} These community structures are named differently in various settings. They are known as health committees, development committees, or health facility management committees. They are also labelled geographically – as village, ward, or community committees.\textsuperscript{2,3} They have been implemented across Africa, Central and South America and Central, South and South East Asia.\textsuperscript{2,3} In Nigeria, national guidelines specify that members may include ‘respectable’ people in the community, the health worker in charge of the health facility to which the committee is linked, representatives of traditional, voluntary, religious, women’s, youth, and occupational groups (including informal health care providers, school head teachers, and workers in the electricity, agriculture and water sectors).\textsuperscript{10,15,16}

The performance of community health committees (including whether they are successful as a strategy for promoting social justice) depends, among other things, on how they understand their role.\textsuperscript{7,10–17} Efforts to support and facilitate their performance (e.g., by NGOs and primary health care managers in Nigeria) require that those involved have a clear understanding of how the committees see themselves.\textsuperscript{7,10,16–18} This study was conducted to inform such efforts by seeking to answer the question – under what circumstances do the community health committees in Nigeria see themselves in a way that may facilitate social justice.

2 METHODS

We applied a realist-informed approach to analysis by first theorising ‘context’ and ‘mechanisms’ from the literature and then using empirical data to operationalise the theory.\textsuperscript{1,10,19} The premise of realist-informed analyses is that ‘outcomes’ of social interventions or phenomena are generated through human agency within certain structures. These structures (e.g. informational, cultural, geographical, socio-economic or institutional factors) are referred to as ‘context’; while the manifestations of human agency (e.g. the reasonings of health committee members in relation to social accountability or self-reliance) are referred to as ‘mechanisms’. The interactions between context and mechanisms generate outcomes – which in this study refers to committee performance in relation to promoting social justice. What we sought to do in this study was understand how the circumstances in which community health committees function (i.e. context) influences the ways in which their members see themselves (i.e. mechanisms) – and the potential effects of such influence on social justice. By social justice, we mean equitable distribution of wealth, opportunities, and privileges within a society.\textsuperscript{20} By social accountability, we mean people-led demands for social justice – that is demands for the respect of their rights and improved public service delivery.\textsuperscript{13} By self-reliance, we mean the use of local initiative, capabilities and resources within a community (as opposed to social accountability) to provide public services.\textsuperscript{21}

2.1 Theoretical framing

First, this study frames the diverse roles of the committees as governance – i.e. making, changing, monitoring, and enforcing both the formal and informal rules that govern the supply and demand of primary health care services in their community.\textsuperscript{22} Second, the study frames governance itself as occurring at three levels or worlds of action – the operational level, where individuals make economic and social choices in in their practical day-to-day activities and decisions; the constitutional level, where the rules governing collective and operational choices are made (e.g. by governments or similarly large or distant influential organisations), and the collective level, where the rules governing operational choices are also made (e.g. by community health committees, women’s groups, and other ‘close-to-ground’
governing entities). Governance takes place at and between these three levels – i.e. within and between them, rules are made, changed, monitored and enforced.

The relations among the three levels of governance are bi-directional. Each level influences and is influenced by the other two levels. The initial 'programme theory' for this analysis – based on our experience of working with community health committees and on our familiarity with the literature on primary health care governance was that the influences are mediated through two mechanisms – one which potentially advances social justice (i.e. 'social accountability' – or outwardly-facing) and another which does not (i.e. 'self-reliance' – or inwardly-facing). The collective level (i.e. community health committees) can influence the constitutional level (i.e. governments) in relations characterised social accountability. The relations between community health committees and the operational level (i.e. users or providers of health services) can also be characterised by social accountability. When the social accountability mechanism is not triggered, these relations can also be characterised by self-reliance, in which rather than demanding social accountability, committees simply compensate for weakness at the constitutional or operational level, even if sub-optimally.

The aims of our analysis, informed by this theoretical framing were to 1. Identify if and how these and any other potential mechanisms inform the actions, decisions, and relations of community health committees in Nigeria; and 2. Identify the contextual circumstances under which different mechanisms are triggered.

2.2 | Data collection

There were two waves of qualitative data collection. In the first wave, we collected 581 meeting minutes from 129 committees across four (of 36) states in Nigeria. The four states were selected to provide a mix of contexts with contrasting and complementary insights across Nigeria: one from northern Nigeria (Kaduna), one from southern Nigeria (Lagos), and two from central Nigeria (Nasarawa and Benue). In the second wave, in the same four states, we conducted 16 group discussions (4 in each state) with community health committees, and 130 interviews with health workers, health managers, committee members, and other community members. The details for each wave are described in detail elsewhere – first wave (research question: how and under what circumstances do community health committees in Nigeria influence the demand and supply of primary health care services?) and second wave (research question: how and under what circumstances do community health committees in Nigeria seek to limit informal providers operating in their local health care market?).

In the first wave, we sought the minutes of community health committee meetings from 150 communities across four states: 32 in Lagos, 34 in each of Benue and Nasarawa and 50 in Kaduna – from communities participating federal government initiative which provides rural communities with ad hoc health workers to improve their maternal and child health indices with more communities in Kaduna (northern Nigeria) where these indices are much worse compared with the south. The minutes were obtained over 4 months (November 2013 to February 2014) by federal PHC managers, who, during facilitation visits to the committees, requested the minutes of the last 10 meetings for which minutes were available in the previous 5 years.

In the second wave, conducted between November 2014 and January 2015, two local government areas were randomly selected in each state, and from each local government area, two communities were purposively selected, for having a health committee. In all, 16 communities were included in the study. For the interviews, four sets of participants were purposively selected based on their availability, on granting informed consent to participate, and on their potential to provide rich, relevant and diverse information: (1) the health worker in charge of the health facility and/or the longest-serving health worker at the facility; (2) the officials of the community health committees, such as the chairman, secretary or treasurer; (3) community members, that is individuals in the community who are not members of the health committee, such as religious, women's and traditional leaders; and (4) primary health care managers employed by the federal, state and local governments, who provide support for primary health care in the selected communities. For the focus group discussions, we included all committee members who were
available, had not participated in the interviews, and gave consent to participate. We excluded potential participants who were less than 18 years old. The interviews and group discussions were conducted using semi-structured questions and prompts.

2.3 | Data analysis

This paper reports the secondary analysis of existing data, in which community health committee is the unit and focus of analysis. In this realist-informed analysis, passages of the minutes and transcripts of interviews and discussions which document events (i.e. outcomes) that occurred due to committee actions, decisions or relations were coded for subtexts. These subtexts indicate implicit meanings and underlying motivations of those events (i.e. whether 'social accountability', 'self-reliance', or any other). These subtexts represent the understanding of committee members on the nature of their role or how change happens (i.e. mechanisms). Informed by repeated references to previous and subsequent passages on the same committee, subtexts were accompanied with notes about factors (which are related to the committee or the community) that enabled or constrained an event or outcome (i.e. context). As coding proceeded, the identified categories were debated, refined and adjusted between two authors (S.A. and D.D.) until there was a coherent scheme which broadly accounted for the range of committee actions, decisions and relations in the minutes and the transcripts.

2.4 | Ethics

Ethics approval for both waves of data collection included in this study was provided by the National Health Research Ethics Committee of Nigeria. In Nigeria, the minutes of community health committee meetings are publicly available documents, but those used for this study were obtained directly from each committee and participation in the study was entirely voluntary. Participation in the interviews and group discussions was likewise voluntary, based on the participant signing a written informed consent form. In line with the terms of consent, data from participants in interviews and group discussions are not publicly available and have been de-identified in this study report, by removing potentially identifying information such as name, gender, cadre, community and local government area of participants. The de-identified data are available on request.

3 | FINDINGS

In the first wave of data collection, from a total of 129 committees (86% of the 150 committees approached) across the four states, 581 individual minutes were submitted—121 from 27 (out of 32) committees in Lagos, 141 from 29 (out of 34) committees in Benue, 122 minutes from 27 (out of 34) committees in Nasarawa and 191 minutes from 46 (out of 50) committees in Kaduna. This makes an average of 4.5 minutes from each committee, ranging from 5.1 in Benue to 4.2 in Kaduna. Most of the minutes – 95.2% (553) were of meetings held within the year before the minutes were requested as part of data collection. In all the states, minutes were recorded by the community member serving as the committee secretary in prose, with in-depth documentation of discussions; each minute was ~4–5 handwritten pages. The minutes were typically written in English. However, minutes which were entirely written in or contained passages of Nigerian languages—for 3 committees in Lagos (Yoruba), 1 in Benue (Tiv), 1 in Nasarawa (Hausa) and 22 in Kaduna (Hausa)—were translated by native speakers among whom were authors (S.A.—Yoruba and S.K.M.—Hausa).

In the second wave, we obtained information from 223 community health committee members; 64 of whom participated in the interviews and 159 in the discussions. Of the participants who were community health committee
members, there were 40 in Lagos, 43 in Benue, 77 in Nasarawa and 63 in Kaduna. Their average age ranged from 43 years in Kaduna to 49 years in Lagos, with overall average age of 46 years. The male to female distribution in Lagos was 1:1, but it was 2:1 in Benue, Nasarawa and Kaduna. Lagos had the highest proportion of committee members with tertiary education, with 50% having attained some form of tertiary education. Further, 80% of committee members in Lagos had a dependable income either as business owners or civil servants, compared to between 38% (Benue) and 57% (Nasarawa and Kaduna). In Benue, 62% of committee members were either unemployed or subsistence farmers with no ready cash income, while 43% of committee members in Nasarawa and Kaduna were in this category, but only 18% in Lagos.

The two mechanisms – social accountability and self-reliance – were apparent within three domains or spaces (i.e., arena of activities) that define the committees: first, in the rationale behind the formation of committees (i.e., the spaces in which they were formed), second, in the justification of how they relate with governments (i.e., the spaces in which they relate with governments), and third, in the reasoning that informs their actions towards service providers (i.e., the spaces in which they function in their community). In each of these spaces, different contextual factors influence the manifestation of self-reliance relative to social accountability.

### 3.1 Origin stories

Committees were formed by governments and non-governmental organisations (NGOs), or emerged endogenously. The committees formed by governments were typically formed by federal PHC managers as part of routine efforts to strengthen PHC governance across the country. There was a sense in which ‘groups’ formed by NGOs or by communities only ‘become’ community health committees when they were visited by a federal PHC manager, and formally constituted as such, often with tweaks in their membership and operations to align with federal guidelines. NGOs also made recommendations to optimise membership and operations for effectiveness. But even when committee were formed by governments or NGOs, members were often nominated by traditional leaders, thus modifying rules for constituting committees – e.g. in two Benue communities, instead of through elections as proposed by a founding NGO, traditional leaders decided that each settlement in the community will be represented proportionally, with settlement heads nominating people to the committee.

Two sets of rationale characterised why communities endogenously formed committees. The first was to do what governments failed to do. In one community in Lagos, the health facility was founded during military rule, and the government took no responsibility for running the health facility, and so traditional leaders and community elders came together to form a committee for self-help. In a community in Kaduna, the committee was formed by four high-income community members, because the health facility was in a bad shape and they wanted to help their community: ‘we wanted to help ourselves and our community and reduce the number of deaths, especially of women who deliver at home’. The second rationale was to improve the uptake of services at the health facility within the community. In a community in Nasarawa, the founding mission was to address the ‘lack of patronage by people and patients who should come to the health facility’, so traditional leaders in the community met and decided that ‘the community needs a committee that would help see to the activities and running of the health facility’. In a community in Kaduna, it was ‘to increase skilled attendance at birth and to stop pregnant women from going to traditional birth attendants’. In a community in Benue, ‘the health committee was formed to bridge the gap between the community members and health facility’, and in another, to ‘go into the community to mobilise the people for clinic utilisation.’

Triggering such endogenous committee formation was context in which there were no alternatives for seeking health services, such that the community depended highly or exclusively on the health facility. In a community in Nasarawa in which the committee was not active and hardly held meetings, the reason was that the state of the health facility was not so bad and there was no serious competition from informal providers like traditional birth attendants. Endogenous origin meant that, committees set off for a specific purpose (e.g. to improve use of services) did not persist at the same high level of activity after they had attained the goal that led to their founding. In another
Community in Nasarawa, the committee in its heyday had clear concerns about improving access to health care. This drive waned when things improved. Committees also became less active when there were no financial incentives to continue to meet and function as members. In a community in Nasarawa, committee members complained that there was no stipend for their work, and a health worker said, ‘it seems they want to be paid before having a meeting because of the distance of their homes to the health facility’. In a community in Benue, a committee member complained about the ‘too much sacrifice’ involved in attending meetings and participating in community advocacy. These challenges were pronounced in large communities, that require long travel and time commitment to attend meetings and participate in activities, and, as was the case in a Benue community, where an NGOs had set up the committee beginning with stipends for members, thus raising the expectation of committee members. They were demotivated when the stipends stopped.

Committee members typically included people well positioned to offer needed financial support for the health facility or who could use their network within the community to spread information or build trust in the health facility’s services. At the start or subsequently, members were strategically recruited for their ability to or track record of making financial contributions to support the health facility or people who were educated and skilled and had leadership experience and influence in the community. These categories of people are in line with the federal government guideline. But the guideline prescribes a maximum of 20 members. In one community in Benue, a committee member wanted this limit removed, ‘so that the work can go faster’. In Lagos, committees approached government PHC managers for permission to expand their numbers: ‘some of them come to complain about the size of the people and we agree with them to increase it.’ While selecting for the local community elite may bias committees towards self-reliance (given a potential interest in preserving the status quo due to elite solidarity), proximity of the local elite to governments may put committees in a position to facilitate social accountability given greater access and information. But when such proximity was used, it seemed more like patron-client relations than social accountability relations. In Kaduna, a committee chairman said, ‘We used to meet with them (government officials) because I am special assistant to the governor presently, so we forward issues to the secretary to the governor and they have been helping.’

3.2 Government relations

The origin story of committees, even of those formed by governments, persisted in how they rationalised their existence. Justifying the reason for their efforts to fellow committee members, a committee member in Lagos said, ‘the government cannot do it all alone’, and in another Lagos committee, a member quoted John F Kennedy, saying ‘ask not what your country can do for you, ask what you can do for your country’. There was a mix between a dogged determination to be self-reliant, and the sense in which this determination itself stemmed from previous experience of government non-responsiveness, low expectation from governments, or limited awareness of what to expect from governments. Influencing their relations with governments was then the extent to which committee members felt it was their right to make demands of governments, and the nature of facilitation by NGO and federal government PHC managers – i.e., whether it was rights-based.

Another contextual influence on the functioning and nature of committee-government relations was how governments themselves saw the committees. The dominant narrative among local and state government PHC managers was one of using the committees to further governments’ goals – not the other way around; not that committees were there to ensure that governments serve communities’ needs. In the words of a local government PHC manager in Lagos, ‘we use them for awareness creation... whenever we have programmes, we communicate directly with them because we do not just go into the community; they are our eye in the community, our mouthpiece.’ A local government PHC manager in Nasarawa said ‘the (committees) here are committed and they are always available when we need their services’ and another in Kaduna said ‘without them we cannot succeed in our activities’ adding that ‘we won’t have women come in for ante-natal care, delivery, immunisation amongst other things if not...
for the committees.' In yet another example of unidirectional relations, committees helped to address vaccine refusal.

In the words of a local government PHC manager in Nasarawa: 'we use them for immunisations if there is a case of rejection. At times I don’t go there. I ask them to handle it. Except if it is above them then we the local government team go there ourselves.'

In line with community goals, local government PHC managers acknowledged the committee members’ indispensability in driving service uptake, sometimes through community-wide information campaigns. But relations with governments did not seem to work the other way around – i.e., committees making demands and holding governments accountable. This may be a reflection of federal guidelines which prescribe that committees should supervise activities at the health facility and raise funds within the community for health activities – but are silent on the committees making any demands of governments. Even when governments failed to fulfil their commitments, local and state government PHC managers saw the committees as a tool to quell potential disquiet. In the words of a state government PHC manager in Lagos, ‘in some places we have a drug revolving fund and people have pay a token, but the politicians in the course of election campaign must have told them that health is free, so they protest sometimes and reject our services out rightly sometimes, but with the (committees), we get them back.’ In one such example in Kaduna, the committee helped the local government and health facility to resolve a situation in which people were unwilling to pay for medicines at the health facility because the health facility had occasionally been supplied with free drugs, expecting that drugs will continue to be free. The committee had to call a meeting that allowed the health workers to explain the situation to the community, thereby restoring their willingness to continue to pay for medicines.

Over-reliance on local government PHC managers for guidance seemed to constrain the ability of committees to hold governments to account. In the words of one such PHC manager in Nasarawa: ‘I tell them to notify me if they have a meeting. I attend their meetings. I serve as their technical man. I give them the technical advice, tell them what to do, where to go.’ This relationship involves potential conflicts of interest – government PHC managers are not likely to encourage and support committees to challenge the policy of the government for which they work. However, as a potential corrective, NGOs and federal government PHC managers, which are not responsible for direct oversight and provision of PHC services, also sometimes had hands on involvement in the committees. They organised training workshops and provided occasional financial support. According to a federal PHC manager, ‘I monitor and supervise the activities of the committees by going to see how often they meet, seeing monthly minutes and other reports as well as seeing how they manage the facility.’ But across all the states, the engagement of NGOs and federal government PHC managers was ad hoc, compared to the more regular presence of local and state government PHC managers. When committees received training, it focussed on technical aspects of their role, reinforcing a bias for self-reliance, such that a committee member in Nasarawa said, ‘this is the only way to mobilise and take care of the government property that is meant for us’. It also reinforced committees seeing themselves as the first stop for solutions, as described by a local government PHC manager in Nasarawa: ‘the committee take health workers’ concerns to the committee meetings, and if they can’t solve it during their meetings, they take the issue to the local government’.

### 3.3 Community activities

There was a sense in which, because committee membership was optimised for information sharing and the potential to convince people within communities to use the health facility, such activities were dominant as an area of focus. In many instances, the rationale for such a focus was framed in terms of making the most of what the government had provided. The committees organised and participated in outreach activities and spoke actively to individuals in the community because, as said by committee members in a Lagos community, ‘we want our community to be aware of their rights in the community’ and ‘we want them to know their right about the health facility’. The rights being evoked here were not in relation to what the government owed them, but about what the government had already
provided. The dominant rationale for committee activities in the community was neither explicitly self-reliance nor social accountability, but something in-between, with characteristics of both mechanisms – i.e. making the most of what the government had already provided.

In the spirit of making the most of what the government had provided, committees brought information about health in the community to health workers and vice versa. One committee chairman in Benue said ‘we meet with the community members and identify their health needs and notify them at the facility.’ Another in Kaduna said, ‘it is my duty’ to pass health information to the community.’ Elsewhere in Kaduna, a committee member said ‘we come to the health facility to supervise them and advise them on what is right… so that they can be accepted by the community’. In a community in Lagos, committee members asked questions about health care needs and challenged of the people during outreaches ‘because it is our responsibility’ although more often ‘community members come to tell us their challenges; we do not have to go and meet them’. In a community in Nasarawa, it was the traditional leader who called community meetings, with committee members present, so that people can voice their challenges with accessing services in the health facility. Elsewhere in Nasarawa, a committee member said, ‘when we (the committee) go for visitation, we come back with reports – those that need to be extended to the health facility are communicated to the health workers and they handle the situation’. In this community, because of such feedback, health workers changed the immunisation and clinic days to the same day as market day, so that everyone would remember it and people could visit the town centre where the health facility was located, and shop in the market afterward.

There were limits to what a committee could do without directly lobbying or making demands of governments. The origin story and raison d’être of many committees was to improve uptake of health facility services, which required reducing the use of informal services provided by traditional healers, traditional birth attendants, and drug shops. But informal providers were typically more affordable or offered flexible payment options. People also sometimes chose to not use the health facility because the health workers were abusive or disrespectful, late to or absent from work, sometimes because the health workers did not have accommodation within the community and so must travel long distance to get to the health facility. Committees often did little else than persuade community members to use the health facility and persuade the health workers to change their behaviour. However they also paid rent to provide temporary accommodation, and as was in one community in Benue where the committee chairman said, ‘we actually used our own personal resources to build them so that the staffs can see where to lay their heads.’ Committees also sometimes actively intervened in transfers of health workers; seeking to transfer away those who were often late or absent, or abusive or disrespectful – or lobbying hard to keep those who were high performing, often with success across all four study states. They influenced health workers to provide home services for people who did not show up, and actively sought out sick people and referred them. When transportation was a barrier, committee members sometimes took routine medication to pregnant women at home. Or, as in the words of a committee member in Benue, ‘I give out my motorcycle… so that they can use it to carry a sick patient to the clinic.’ Or as a committee chairman said in Kaduna, ‘I also sometimes contribute my car to transport patients because the facility lacks vehicles.’

Social accountability requires a level of independence from the health facility. There is potential for conflicts of interest when the committee is very close to health workers; so close, for example, that when transportation cost is a challenge for committee members to participate in community outreach activities, as was the case in a community in Benue, where the health worker in charge of the health facility (i.e. officer in charge) gave them money from his/her pocket to cover the costs. Or so close that a community member in Nasarawa could say ‘the committee members and the health workers have become one’. In some instances, committee reached the government through the officer in charge: ‘they (the people) told us what they want, and there and then we notified the OIC (officer in charge) who alerted the local government’. As they often did to influence the transfer of health workers, committee members also resorted to seeking the help of local government PHC managers to regulate the practice of informal providers. In the words of one such PHC manager in Kaduna ‘we attend to their issues with traditional birth attendants who are also part of the committee.’ Addressing such concerns and intervening in transfers of health workers required that committee members have a high sense of legitimacy. When such a sense of legitimacy was lacking, committee members would go through traditional or religious leaders, to give pep talks to erring health workers, and later, to
seek transfer by speaking directly to local government PHC managers, not so much in the spirit of demanding rights, but of appealing for help.

4 | DISCUSSION

In this study, we identified three spaces in which the raison d’être of community health committees in Nigeria manifest, which help to answer the question – why do they engage in primary health care governance? First are the spaces in which they were formed, their origin stories, which suggest that at their beginning, given the driving motivation for forming such committees and the choice of local elite as members, the committees tend to be optimised for self-reliance rather than for social accountability. Second are the spaces in which they relate with governments, which suggest a one-sided relationship of use by government officials to achieve the goal of governments for communities, and not that of the community, thus indicating a bias for self-reliance over social accountability. Third are the spaces in which they function within communities, where the activities of the committees suggest a greater concern for ensuring that their community makes the most of what the government provides rather than outright self-reliance or social accountability. In all the three spaces, self-interest may play a role in why community health committees display a bias for self-reliance.

In ‘origin stories’ spaces, there is a possibility of self-interest inherent in selecting for the local elite – that is, given their status, elites may see the path to solving problems (or the problems worth solving) differently compared to others in the community. Their decision to set up such a committee (when it emerges endogenously) or their choice as ideal members (when formed by governments or NGOs) may lead to a preference for looking inward and using resources available in the community (such as their own personal income) to solve problems. They may share the same or similar social status with government PHC managers, officials, and politicians in a way that may grant them privileged access but may also limit their appetite to challenge power; instead, using friendship and patron-client relations to address problems, rather than making demands that signal social accountability. This tension between representation and influence is increasingly recognised in the literature, alongside its implications for who ought to be members of such committees.\(^7,10,14,27\) Nonetheless, it is often the local elite who have the resources to bear the costs of participation. A decision for members to be more representative of the community may have consequences for committees’ ability to negotiate short-term challenges through the use of personal networks and resources of ‘elite’ committee members.

In ‘government relations’ spaces however, the choice of self-reliance over social accountability seems to be hinged on how government PHC managers see the role of the committees, perhaps influenced by expectations implicit in federal guidelines for community health committees in Nigeria\(^28,29\) which emphasise self-reliance and de-emphasise social accountability. This concern has also been raised in South Africa.\(^30,31\) How committees are seen and how they see themselves is linked to their origin story, and how they are trained and mentored as to what their roles ought to be – that is, whether self-reliance and social accountability. Essential in this regard may be the self-interest of those who train or mentor the committees. In decentralised health systems such as in Nigeria, it may be important to ensure that officials representing or working for the levels of government which are responsible for primary health care (in Nigeria, these are state and local governments)\(^32\) should not be those who train and mentor community health committees. Perhaps those who train and mentor them should not work for any government – but instead should be NGOs and civil society organisations whose bias for social accountability, may enable them to support the social accountability roles of the committees.

In ‘community activities’ spaces, the dominant rationale for what the committees do in their community was making the most of what the government provides. This framing aligns with how the committees are seen by local government officials – as entities there to do the government’s bidding. But making the most of what the government provides could also require that the committees demand additional government spending, for example, to provide accommodation for health workers to reduce absenteeism. But it appears, as elsewhere across sub-Saharan
Africa,\textsuperscript{14,33} that committees take the option that does not require additional government spending – for example, they raise funds to solve the problem, or appeal to the local government to transfer a health worker to them who is less likely to be absent because they live close to the community;\textsuperscript{2} as health workers could be deployed at little or no additional cost to governments. This may be due to previous failure, their training, their guidelines, the narrative of their roles imposed on them, or their limited sense of legitimacy to challenge governments and service providers – for example, rather than confronting abusive and disrespectful health workers directly, committees often go through the local elite, as they do when seeking a transfer.\textsuperscript{8}

These findings extend the existing literature by focussing on why communities engage in primary health care governance. But it is a literature that reflects a ‘positive a priori bias’ – a bias that limits the clarity of analyses and assessment of the evidence. This concern is increasingly echoed in the literature, as a reason to embrace complexity in theorising community engagement in primary health governance.\textsuperscript{17,34–36} The positive a priori bias has been described by Rifkin\textsuperscript{6} in terms of the widespread expectation among researchers and practitioners that people and communities necessarily want to participate in decisions about their own health care; that providing information to people and communities will result in health improvements; and that empowering people and communities will make people act the way policy makers want them to. We sought to avoid such assumptions, by adopting an agnostic premise about the varied origins, motivations, relations, and activities of community health committees in Nigeria, which allowed a more in-depth analysis of what they do, and why they do what they do, that is, the nature of community engagement in primary health governance. Another strength of this study was the breadth of data that we were able to draw upon and triangulate in the analyses.

There are however limitations, given that it is a secondary analysis of existing and previously analysed data. The research question posed in this study is different from the one for which the first and second wave of data collection was conducted. This may have limited the extent to which we could answer the current research question conclusively. But the data we obtained focussed on committee activities in sufficient breath and detail to gain substantial understanding of their motivations and the perspectives of stakeholders with whom they interface – particularly government PHC managers, health workers in the health facilities, and other community members. The first wave of data collection – minutes of committee meetings – was not as constrained, because the minutes were not written with any research question in mind. However, future studies should seek to explore the potential trade-offs between committees seeing their primary role or rationale as self-reliance versus social accountability and the extent to which both are mutually exclusive or reinforcing. Studies may also evaluate how and under what circumstances training and mentoring focussed on social accountability can optimise committees for social accountability rather than self-reliance.

Long before European colonisation, many communities in Africa organised into kinship, women’s, men’s and other social groups to solve problems requiring collective action – for example, groups that took turns in farming activities such as land clearing, planting, weeding, and harvesting; or groups that provided traditional medical care, material and psychosocial support to the sick and their families or to bereaved families.\textsuperscript{37} During the colonial period, community self-help activities were organised by local groups that planned development programmes in their communities, funded by taxing themselves and the rest of their community.\textsuperscript{38} Colonial governments stimulated such efforts by co-financing community-initiated projects – such as pipe-borne water supplies, schools, and health facilities.\textsuperscript{38} But what also happened during the colonial period was the severance of existing pre-colonial relations of social accountability between community groups and their local traditional leaders who had coordinated their collective action and were accountable to their communities.\textsuperscript{40,41} Colonial governments removed the accountable responsibility of such local traditional leaders, centralising power in new and much larger ‘districts’, whose governments were created to extract resources from the communities.\textsuperscript{40–42} Post-colonial governments have retained this arrangement, which, while preserving self-reliance (for example via community health committees), did destroy long-standing local dynamics of social accountability.\textsuperscript{40–42}

Efforts to support community engagement in heath governance around the world should recognise that both ‘social accountability’ and ‘self-reliance’ are viable mechanisms, even if potentially in tension. Knowing which
mechanism to trigger, when and where, is important, and should be informed by a deep understanding of how context influences the ways in which a committee sees itself, and by extension, whether they are orientated towards social accountability and/or self-reliance. For example, institutional context \(^1\) (e.g., their knowledge of what to expect from governments or service providers, or the results of their previous efforts to demand social accountability or organise for self-reliance); geographical context \(^1\) (e.g., how community land size and ease of transport affects the cost of participation in meeting and committee activities, or how community remoteness affects access to service providers elsewhere); and socio-economic context \(^1\) (e.g., having individuals within the community with high enough status to lend their voice or funds to committee activities). In addition, such efforts to support them need to recognise that a committee’s origins and formation can optimise it for either social accountability or self-reliance, but so can the nature and content of their training and mentoring.

5 | CONCLUSION

In summary, there appears to be a paradox as to what to do with the knowledge of why communities engage in primary health care governance in Nigeria. When they emerge endogenously, community health committee seem optimised for self-reliance. External actors can do little to influence such an origin. But when committees are set up by external actors, and (as is the case in Nigeria) the guidelines focus on self-reliance or prescribe a membership structure that is dominated by the local elite, committees may also be optimised for self-reliance. Optimising the committees for social accountability may require that members are more representative of the community. But in such a scenario, the majority of committee members may not be able to bear the costs of participation, without deliberate efforts by external actors to provide funds to cover such costs. Optimising the committees for social accountability may also require training and mentoring, especially by actors without potential conflicts of interests (such as working for the government or health facility from which they will make demands) to ensure they have the necessary information and strategies to demand social accountability.

ACKNOWLEDGEMENTS

We thank the organizers and co-panelists of the panel session on social accountability and social justice (EADI ISS conference 2021) for their reflections on this paper. During the completion of this work, Seye Abimbola was supported by the Rotary Foundation Global Grant Scholarship (#GG1412096) and the National Health and Medical Research Council (NHMRC) Overseas Early Career Fellowship (#1139631). Data collection was supported by the National Primary Health care Development Agency, Abuja, Nigeria. No additional funding was received. The funders had no role in the study design, data analysis, or preparation of this manuscript.

Open access publishing facilitated by The University of Sydney, as part of the Wiley - The University of Sydney agreement via the Council of Australian University Librarians.

ETHICS STATEMENT

Ethics approval for both waves of data collection included in this study was provided by the National Health Research Ethics Committee of Nigeria. In Nigeria, the minutes of community health committee meetings are publicly available documents, but those used for this study were obtained directly from each committee and participation in the study was entirely voluntary. Participation in the interviews and group discussions was likewise voluntary, based on the participant signing a written informed consent form. In line with the terms of consent, data from participants in interviews and group discussions are not publicly available and have been de-identified in this study report, by removing potentially identifying information such as name, gender, cadre, community and local government area of participants. The de-identified data are available on request.
DATA AVAILABILITY STATEMENT

The de-identified data are available on request.

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REFERENCES

1. Abimbola S, Baatiema L, Bigdeli M. The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. *Health Policy Plan*. 2019;34(8):605-617.
2. McCoy DC, Hall JA, Ridge M. A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Policy Plan*. 2011;27(6):449-466.
3. Molyneux S, Atela M, Angwenyi V, Goodman C. Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. *Health Policy Plan*. 2012;27(7):541-554.
4. Hickey S, King S. Understanding social accountability: politics, power and building new social contracts. *J Dev Stud*. 2016;52(8):1225-1240.
5. Rifkin SB. Alma Ata after 40 years: primary health care and health for all—from consensus to complexity. *BMJ Glob Heal*. 2018;3(Suppl 3):e001188.
6. Rifkin SB. *Translating Rhetoric to Reality: A Review of Community Participation in Health Policy over the Last 60 Years* [Internet]; 2012. http://www.wzb.eu/sites/default/files/u35/rifkin_2012_rhetoric_to_reality_a_review_of_cp_and_health_policy.pdf
7. Abimbola S. Beyond positive a priori bias: reframing community engagement in LMICs. *Health Promot Int*. 2020;35(3):598-609.
8. Abimbola S, Olanipekun T, Schaaf M, Negin J, Jan S, Martiniuk ALC. Where there is no policy: governing the posting and transfer of primary health care workers in Nigeria. *Int J Health Plann Manage*. 2017;32(4).
9. Nelson S, Drabarek D, Jenkins A, Negin J, Abimbola S. How community participation in water and sanitation interventions impacts human health, WASH infrastructure and service longevity in low-income and middle-income countries: a realist review. *BMJ Open*. 2021;11(12):e053320.
10. Abimbola S, Molemodile SK, Okonkwo OA, et al. "The government cannot do it all alone": realist analysis of the minutes of community health committee meetings in Nigeria. *Health Policy Plan*. 2016;31(3):332-345.
11. Scott K, George AS, Harvey SA, et al. Beyond form and functioning: understanding how contextual factors influence village health committees in northern India. *PLoS One*. 2017;12(8):e0182982.
12. George AS, Mehra V, Scott K, Sriram V. Community participation in health systems research: a systematic review assessing the state of research, the nature of interventions involved and the features of engagement with communities. *PLoS One*. 2015;10(10):e0141091.
13. Lodenstein E, Dieleman M, Gerretsen B, Broere JEW. Health provider responsiveness to social accountability initiatives in low- and middle-income countries: a realist review. *Health Policy Plan*. 2016;32(1):125-140.
14. Lodenstein E, Mafuta E, Kpatchavi AC, et al. Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees. *BMC Health Serv Res*. 2017;17(1):403.
15. Uzochukwu BSC, Akpala CO, Onwujekwe OE. How do health workers and community members perceive and practice community participation in the Bamako Initiative programme in Nigeria? A case study of Oji River local government area. *Soc Sci Med*. 2004;59(1):157-162.
16. Abimbola S, Ogunsina K, Charles-Otoli AN, Negin J, Martiniuk AL, Jan S. Information, regulation and coordination: realist analysis of the efforts of community health committees to limit informal health care providers in Nigeria. *Health Econ Rev*. 2016;6:51.
17. Gram L, Daruwalla N, Osrin D. Understanding participation dilemmas in community mobilisation: can collective action theory help? *J Epidemiol Community Health*. 2019;73(1):90-96.
18. Schaaf M, Warthin C, Freedman L, Topp SM. The community health worker as service extender, cultural broker and social change agent: a critical interpretive synthesis of roles, intent and accountability. *BMJ Glob Heal*. 2020;5(6):e002296.
19. Shaw J, Gray CS, Baker GR, et al. Mechanisms, contexts and points of contention: operationalizing realist-informed research for complex health interventions. *BMC Med Res Methodol*. 2018;18(1):178.
20. Molony E, Duncan C, Duncan C. Income, wealth and health inequalities - a Scottish social justice perspective. *AIMS public Heal*. 2016;3(2):255-264.
21. Fonchongong CC, Fonjong LN. The concept of self-reliance in community development initiatives in the Cameroon grassfields. *GeoJournal*. 2002;57(1/2):3-13.
22. Abimbola S, Negin J, Martiniuk AL, Jan S. Institutional analysis of health system governance. *Health Policy Plan.* 2017;32(9):1337-1344.

23. Kiser LL, Ostrom E. The three worlds of action: a metatheoretical synthesis of institutional approaches. In: Ostrom E, ed. *Strategies of Political Inquiry.* Sage; 1982:179-222.

24. Abimbola S, Negin J, Jan S, Martiniuk A. Towards people-centred health systems: a multi-level framework for analysing primary health care governance in low- and middle-income countries. *Health Policy Plan.* 2014;29(Suppl 2):ii29-39.

25. Danermark B, Ekström M, Karlsson JC. *Explaining Society: Critical Realism in the Social Sciences.* 2nd ed. Routledge; 2019:242.

26. Pawson R, Tilley N. *Realistic Evaluation.* SAGE Publications; 1997.

27. Loewenson R, Machingura F, Kaim B, Rusike I. *Health Centre Committees as a Vehicle for Social Participation in Health Systems in East and Southern Africa* [Internet]; 2014. https://www.equinetafrica.org/sites/default/files/uploads/documents/EQUINET_HCC_Diss_paper_101_FINAL.pdf

28. National Primary Health Care Development Agency Nigeria. *Handbook on Participatory Learning and Action for the Formation and Reactivation of Ward Development Committees.* National Primary Health Care Development Agency; 2012.

29. National Primary Health Care Development Agency Nigeria. *Minimum Standards for Primary Health Care in Nigeria.* National Primary Health Care Development Agency; 2013.

30. Haricharan HJ, Stuttaford M, London L. Effective and meaningful participation or limited participation? A study of South African health committee legislation. *Prim Health Care Res Dev.* 2021;22:e28.

31. Haricharan HJ, Stuttaford M, London L. The role of community participation in primary health care: practices of South African health committees. *Prim Health Care Res Dev.* 2021;22:e31.

32. Eboereime EA, Abimbola S, Obi FA, et al. Evaluating the sub-national fidelity of national initiatives in decentralized health systems: integrated primary health care governance in Nigeria. *BMC Health Serv Res.* 2017;17(1):227.

33. Martin Hilber A, Blake C, Bohle LF, Bandali S, Agbon E, Hulton L. Strengthening accountability for improved maternal and newborn health: a mapping of studies in Sub-Saharan Africa. *Int J Gynaecol Obstet.* 2016;135(3):345-357.

34. Falisse J-B, Ntakarutimana L. When information is not power: community-elected health facility committees and health facility performance indicators. *Soc Sci Med.* 2020;265:113331.

35. Gram L, Fitchett A, Ashraf A, Daruwalla N, Osrin D. Promoting women's and children's health through community groups in low-income and middle-income countries: a mixed-methods systematic review of mechanisms, enablers and barriers. *BMJ Glob Heal.* 2019;4(6):e001972.

36. Rifkin SB. Examining the links between community participation and health outcomes: a review of the literature. *Health Policy Plan.* 2014;29(Suppl 2):ii98-ii106.

37. Mulumba M, Ruano AL, Perehudoff K, Ooms G. Decolonizing health governance: a Uganda case study on the influence of political history on community participation. *Health Hum Rights.* 2021;23(1):259-271.

38. Olouw D. Local institutes and development: the African experience. *Can J African Stud/Rev Can des Études Africaines.* 1989;23(2):201-231.

39. Akinola SR. Coping with infrastructural deprivation through collective action among rural people in Nigeria. *Nord J African Stud.* 2007;16:30-46.

40. Palagashvili L. African chiefs: comparative governance under colonial rule. *Public Choice.* 2018;174:277-300.

41. Asimeng-Boahene L. Issues and prospects of African indigenous systems of governance: relevance and implications for global understanding. In: McKinley EA, Smith LT, eds. *Handbook of Indigenous Education.* Springer Singapore; 2017:1-20.

42. Tumusiime P, Kwamie A, Akogun OB, Elongo T, Naboyonga-Orem J. Towards universal health coverage: reforming the neglected district health system in Africa. *BMJ Glob Heal.* 2019;4(Suppl 9):e001498.

**How to cite this article:** Abimbola S, Drabarek D, Molemodile SK. Self-reliance or social accountability? The raison d’être of community health committees in Nigeria. *Int J Health Plann Mgmt.* 2022;37(3):1722-1735. https://doi.org/10.1002/hpm.3438