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Negotiating Access to Health Care for All through Social and Political Accountability: A Qualitative Study in Rural Nigeria

Afeez Folorunsho Lawal ^{1,*} and Elsbet Lodenstein ²

¹ Department of Science and Technology, National Research Foundation South African Research, Chair Initiative in Social Policy, University of South Africa, Pretoria 0002, South Africa

² Sustainable Economic Development and Gender, Royal Tropical Institute (KIT), 1090 HA Amsterdam, The Netherlands; contact@lodenstein.com

* Correspondence: afeezzone0606@gmail.com

Abstract: Social accountability is an important strategy towards ensuring that political leaders and actors implement the right policies in the interest of the entire society. In 2007, a community-based health insurance programme was implemented in selected rural communities in Kwara State, Nigeria, through collaboration between the Dutch Health Insurance Fund, PharmAccess Foundation, the Kwara State Government, and Hygeia Nigeria Limited to provide access to basic healthcare for the people. After operating for 9 years, the programme stopped in 2016. This paper describes how social and political accountability shaped the introduction, functioning, and stoppage of the CBHI programme. The study adopted a qualitative approach for data collection, particularly in-depth ($n = 22$) and key informant interviews ($n = 32$). Findings indicate that the community-based health insurance programme was proposed by the foreign agency and that the state government was instrumental in the stoppage of the programme. Also, the change in government (via voting against a political bloc that had been in power since 2003) in Kwara State during the 2019 general elections was among the accountability measures employed by the citizenry in reaction to the stoppage of the Community-Based Health Insurance programme. The implication of this is that the current government, expectedly, will not only draw up a more robust healthcare policy for implementation but will also ensure that the people are carried along through adequate social and political accountability mechanisms.

Keywords: social accountability; political accountability; health insurance; access to care



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1. Introduction

The healthcare system is a critical sector in society. Its importance is closely linked to the development and survival of the economy. Most countries have committed a lot of resources for developing their healthcare system and have unfortunately recorded little relative difference in terms of healthcare outcomes. In Africa, healthcare systems are faced with a series of challenges that are partly linked to socio-economic problems, poor leadership, inadequate human resources, inadequate budgetary allocation, issues of mismanagement of resources, absence of technical know-how, and required facilities (Oleribe et al. 2019; Chimezie 2015). Further, Alegbeleye and Mohammed (2020) identified continuing decay of health infrastructure, diversion of healthcare resources, and lack of political will to invest in healthcare as problems of healthcare development in Africa. While the extent may vary, the problems are characteristic of most African nations.

The consequential effects are huge and militating against the development of each nation, especially in terms of meeting global standards. Nevertheless, the 'healthcare crisis' in Africa today cannot be delinked from the implementation of Structural Adjustment Programmes (SAPs) in the 1980s. This culminated in the stagnation of African economies in the late 1980s and early 1990s compared to Asia and Latin America as "the annual growth

rate in per capita income in Africa barely rose above 1 percent over this period, compared to growth rates of 2–3 percent in similar economies outside the continent” (Mwabu 1998). This threatened the plans of aligning with the Alma Ata Declaration, which argues that healthcare is a fundamental human right and, as such, everyone should have access to comprehensive healthcare.

The weakness of healthcare systems led to the promotion and adoption of Community-Based Health Insurance (CBHI) on the continent as an alternative model for healthcare delivery. CBHI was implemented in many African countries such as Mali, Benin, Guinea, Burkina Faso, Ethiopia, Cameroon, and Nigeria. It is seen as a means of providing access to healthcare for the people, especially those in rural areas, and could assist developing countries in developing mechanisms, institutions, and capacities for attaining universal health coverage [UHC] (Sekhri and Savedoff 2005; Odeyemi and Nixon 2013). In this context, UHC is understood as one ‘ultimate goal’ in the healthcare system towards which CBHI can contribute.

Based on the experience with CBHI over the years in developing countries, including African countries, scholars have also identified challenges to the implementation of the programme. “Stock-out of drugs, poor quality of care, non-responsiveness of healthcare providers, discrimination against the poor” (Jacobs et al. 2020), reduced benefit packages, and long waiting periods are some of the common challenges that stand against the achievement of the desired results in CBHI schemes. Kalisa et al. (2015) and Kodom et al. (2019) reported cases where enrollees were directed to purchase drugs primarily covered by the premium in Rwanda and Ghana, respectively. Also, a study in Uganda found that high blood pressure and diabetes were excluded from the benefits package of a CBHI programme (Ayebazibwe 2019). In other words, enrollees with these ailments would be denied access to care under the CBHI programme. All of this tends to adversely affect enrolment coverage and the overall success of CBHI. In view of these challenges, Collyer (2015) argued that “the replacement of publicly-provided or publicly-financed healthcare services by others owned or run by private, for-profit organisations presents a serious challenge to the governance of the state in its efforts to produce healthcare services based on equity of access, accountability, cost at the point of service, and quality of service”.

One of the reasons that social protection programmes such as CBHI are faced with challenges in Africa, specifically in Nigeria, is partly due to the autonomy given to the state government and the relative inability of the federal government to effectively monitor the governance at the state level (Holmes et al. 2012). This kind of governance structure tends to weaken the efficiency of social accountability mechanisms because the citizens do not have adequate knowledge of government activities through which the leaders could be held accountable.

CBHI and Accountability

Mladovsky and Mossialos (2008) stated that corruption in government has detrimental consequences for CBHI programmes. Poor management and a lack of accountability obstruct progress in CBHI programmes (Ranson 2003). Wiesmann and Jutting (2000) emphasized the critical role of accountability in the success of CBHI programmes. They added that mismanagement is detrimental to people’s confidence and the overall success of the programme. This is because the sense of ownership by community members would help improve health behaviour and reduce abuses, including moral hazards.

In view of this, accountability mechanisms are employed to ensure that public projects achieve appreciable results. Accountability is especially important because of the need to attain the Sustainable Development Goal (SDG) 3, which seeks to “ensure healthy lives and promote well-being for all at all ages” by 2030. Part of the rationales for deploying accountability measures is to ensure that transparency, integrity, ethics, and due process are upheld in the healthcare delivery system. This is more important because of the negative consequences of corruption and mismanagement on the healthcare system (Sanders et al. 2005).

Accountability can take several forms, depending on the institutions and actors involved. This paper focuses on social and political accountability.

Social accountability refers to the “wide range of citizen actions to hold the state to account, as well as actions on the part of government, media, and other actors that promote or facilitate these efforts” (McNeil and Malena 2010, p. xi). It is often used by the citizenry for improving government responsiveness and openness (Headley 2014), and it offers a set of approaches and tools to promote citizen engagement and monitoring to improve system performance, effectiveness, and responsiveness to public needs (Primary Health Care Performance Initiative n.d.). As a component in the accountability ecosystem, social accountability serves as one of the ‘devices’ for successful healthcare reform and development. In most cases, if the right policy is adopted but lacks effective monitoring or management, the policy tends to fail. Most social accountability initiatives address problems in primary healthcare and are largely found in Asia and Africa (Lodenstein et al. 2017a). Common social accountability mechanisms are health committees who “facilitate social accountability by engaging with health providers in person or through meetings to discuss service failures, leading to changes in the quality of services, such as improved health worker presence, the availability of night shifts, the display of drug prices and replacement of poorly functioning health workers” (Lodenstein et al. 2017b, p. 1).

In her study, Habiyonizeye (2013) found that effective social accountability mechanisms at the local level were instrumental to high enrolment and the entire success of CBHI in Rwanda. Also, Blake et al. (2016) found that social accountability can improve the culture of accountability in delivering maternal healthcare in Ghana. In a donor-sponsored healthcare project in Kenya, community health committee members were trained on social accountability and the budget process. It yielded results via providing quality healthcare services (Mutea 2021). Also, part of the social accountability mechanisms built into the Kwara CBHI scheme was regular monitoring and evaluation (M&E) exercise carried out by a joint committee of the partners funding the programme. In areas where the information about the benefits package was spread, beneficiaries could challenge the providers when they fell short.

For effective oversight and result attainment, answerability and enforceability are critical for social accountability. According to (Danhoundo et al. 2018, p. 2), “answerability is the obligation of politicians, policymakers, and providers to explain and justify their actions. This involves being responsible for meeting performance objectives and goals within the network of stakeholders having varied interests and levels of authority”. They defined enforceability as “the capacity to ensure that action is taken and can involve penalties, consequences, or remedies for failure to do so” (Danhoundo et al. 2018, p. 2). These two components can help sustain a standard for accountability among various stakeholders.

Political accountability refers to citizens calling politicians to account on electoral promises and performance through regular elections (Brinkerhoff 2004). It is another mechanism through which citizens can influence decision-making and policy reform. According to Bellamy and Palumbo (2017), political accountability ensures that public interest takes centre stage in the political system and the citizens are able to call their representatives to account. Also, political accountability seeks to ensure that political decisions are fairly and equitably taken in the people’s interest. It holds to the “principle that governmental decision-makers in a democracy ought to be answerable to the people for their actions” (Bassette 2001, p. 38). Just like the politicians, political accountability includes bureaucrats because they are largely in charge of implementing policies made by the politicians (Priyadarshi and Kumar 2020).

According to (Bratton and Logan 2006, p. 2), the two main purposes of political accountability are: checking the power of political leaders by preventing them from ruling arbitrarily and ensuring that governments operate effectively and efficiently. For instance, elections can be used to secure political accountability (Moncrieffe 1998; Bratton and Logan 2006). Lewis et al. (2020) found that voters are willing to return incumbents to office in Indonesia provided they perform satisfactorily. However, this is mostly achievable in

settings where the democratic system efficiently provides the opportunity (Dauda 2006). Notwithstanding, if political accountability is deployed reasonably, it can facilitate health-care reform (Nunes et al. 2009). Also, using the case of India, Priyadarshi and Kumar (2020) pointed out the link between political accountability and improved healthcare delivery. In other words, as it relates to access to healthcare, social accountability aims to improve access and service delivery performance at the programme/service delivery level, and political accountability aims to improve political decisions on health programmes and resources more broadly as well as to call politicians to account on their promises. They are complementary mechanisms and are expected to be in balance.

The Community-Based Health Insurance scheme in Kwara State was introduced in 2007 through collaboration among Dutch Health Insurance Fund (HIF), PharmAccess Foundation, Kwara State Government, and Hygeia Nigeria Limited (Gustafsson-Wright and Schellekens 2013). The programme was designed to improve access to quality healthcare services. It provided “coverage for medical consultations, diagnostic tests, and drugs for all conditions that can be managed at a primary care level and limited coverage for secondary care services” (Brals et al. 2017, p. 991). Interested community members were registered on the payment of enrolment premium (which was N500 [1.38 USD] as at the time the programme stopped) and provided with enrolment cards. The enrolment card granted its holder the opportunity to access healthcare for a year in a designated healthcare facility. The enrollees had the right to visit the healthcare facilities whenever they were ill.

As of 2015, the programme was operational in 43 healthcare facilities across 11 rural Local Government Areas (LGAs) and two tertiary referral centres within the state capital (Ilorin). The target was that the programme would cover up to 600,000 people by the end of 2017 (Amsterdam Institute for Global Health and Development 2015). Important information about the programme is summarized in Table 1 below. However, the programme stopped operations in less than ten years. This incidence seemingly left the enrollees in considerable despair regarding access to affordable healthcare services. This study examines the ways in which social and political accountability shaped the introduction, functioning, and stoppage of the CBHI programme.

Table 1. Important Information about the CBHI Programme.

Information	Figure
Estimated population of Kwara as at the end of the programme (2016)	3,166,513 (Nigeria National Bureau of Statistics 2018)
Enrolment target in 10 years (2007–2017)	600,000
Actual enrolment coverage as at the end of the programme (2016)	139,713
Enrolment premium	N500 (1.38 USD as of 2016)
Healthcare facilities	43 Health Care Providers (HCPs) located across 11 out of 16 Local Government Areas (LGAs)

Source: Authors.

Though there are some social and political accountability studies on healthcare service delivery in Africa (e.g., Kenya School of Government 2015; Hoope-Bender et al. 2016; Mutea 2021), few studies have been conducted on health insurance in Nigeria, particularly community-based health insurance programmes and its relations to accountability mechanisms.

2. Materials and Methods

2.1. Study Setting

Kwara state in southwest Nigeria is comprised of 16 Local Government Areas (LGAs) delineated across 3 Senatorial Districts. It has both urban and rural areas, but the CBHI programme existed only in rural areas. As of 2016, the population of Kwara State is

approximately 3.2 million ([Nigeria National Bureau of Statistics 2018](#), p. 7). The primary source of income in rural Kwara is agriculture. Some other economic activities drive the rural dwellers to migrate or regularly travel to urban areas. Inadequate access to healthcare is another factor that takes the rural dwellers to the urban areas for medical attention. The major languages spoken by the people of the State are Yoruba, Baruba, Nupe, and Fulani, while the majority of the people belong to Islam, Christianity, and the traditional religion. There is limited access to quality healthcare, especially for the rural dwellers. For instance, Kwara State has the second-highest maternal mortality rate [1404.4 per 100,000 deaths] in Nigeria as of 2019 ([AbdulRahman 2021](#)). This is partly because there are 900 doctors for a population of about 3.2 million ([Rotimi 2021](#)).

2.2. Study Design

The study adopted a qualitative approach using in-depth interview (IDI) and key informant interview (KII). A purposive sampling technique was used for data collection. It was used to select the communities with the highest enrolment rate from each of the 11 Local Government Areas (LGAs) hosting the programme to ensure that the views of the majority of the enrollees in the programme were captured in the study. The communities are Aboto-Oja, Gure, Bacita, Osi, Idofian, Oro, Edidi, Kaiama, Bode Saadu, Odo-Owa, and Erinle. A total of 22 IDIs were conducted among community members. In each community, a male and a female participant were purposively selected among the former enrollees to explore gender differences in health needs and experiences. Most of the community members were willing to participate in the study, perhaps because of the possible implications it could have on social policy decisions regarding their communities. They were randomly selected, and only those who could present their enrolment cards as evidence of participation in the programme were part of the study. Meanwhile, the community leaders in each community were formally informed about the study before recruiting participants.

Also, 32 KIIs were conducted among community leaders in all the communities (11), healthcare providers (12), policymakers (4), officials from the Health Maintenance Organization (2), officials of PharmAccess Foundation (2), and a research consultant on the programme. The same set of questions was asked to each category of participants for consistency. The difference in the various category questions was based on their roles and level of involvement in the programme. The questions were asked to elicit information regarding the accountability measures adopted in implementing the programme.

This study adhered strictly to the ethical requirements for conducting research. Each of the participants was assured of confidentiality and informed about their rights to refuse participation in the study. Also, their informed consent was obtained before they were finally recruited into the study. After securing the ethical clearance of the relevant Research Ethics Committee at the University of South Africa, South Africa, the researcher also obtained ethical clearance from the Kwara State Ministry of Health in Nigeria before embarking on the fieldwork. The study adopted thematic analysis, and ATLAS.ti was used to aid the analysis of the data collected. After translating part of the data obtained in the local language, all recorded discussions and interviews were transcribed and coded to yield major themes. ATLAS.ti was used to manage, extract, compare, and explore data within the texts that have meanings for the analysis.

3. Results

The study data indicate that certain social and political accountability measures were instrumental for the introduction, functioning, and stoppage of the CBHI programme in Kwara State, Nigeria.

3.1. Introduction of the Programme

The emergence of the CBHI programme resulted from the poor healthcare situation in Kwara State, the demands expressed by the people, the ambitions and political motivation of the State governor and a foreign agency supporting improved health outcomes

(PharmAccess Group 2017; Bonfrer et al. 2018). The political leadership of the state at that time believed that addressing the healthcare challenge would improve their followership. On the motive for introducing the programme, one of the HMO officials explained that: “The purpose of the programme was to improve the health indices in the State because before the commencement of the programme, the health indicators of the State were poor” (KII, HMO Official 1, 26/07/2019, Ilorin). Also, an official of the foreign agency stated: “Our stay in Kwara State has been since 2007 when the then Governor of Kwara State, Dr. Abubakar Bukola Saraki wanted to ensure that he improved the health status of the people in rural areas” (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

The programme was funded through two main sources: counterpart fund by the partners—Kwara State Government (KWSG) and the Dutch Health Insurance Fund (HIF), and enrolment premium by the enrollees (but the premium constituted a relatively small fraction of the funding requirement of the programme). The community members and potential beneficiaries were delighted with the introduction of the programme. However, they were not directly involved in its planning and implementation.

3.2. Social Accountability Measures in the Kwara CBHI Programme

During the active years of the programme, social accountability measures involved setting up of Health Committee and Enrollees Forum in each of the communities. The role of the health committees in each community was to oversee the implementation of the programme in the community. It also had the role of intimating the programme managers (i.e., Hygeia Community Health Care—implementing partner) with observed challenges and identifying a common solution. The HCHC thereby functioned as an interface structure between health providers and citizens or users of health services. The committee consisted of community/religious leaders, healthcare providers, and the CBHI programme managers.

The enrollees’ forum allowed beneficiaries to express their views regarding the quality of services provided by the healthcare facilities. It comprised of the enrollees, healthcare providers, and the implementing partner. The managers (i.e., the HMO) were expected to act and address the issues raised by the enrollees. The enrollees’ forum was periodically organized where the Programme Managers and the users met to air their views about the programme. It served as a platform for discussing and solving identified programme challenges (such as reducing health benefits and preference for non-enrollees). The information collected from the gatherings was meant to assist the Programme Managers in improving the efficiency of the programme across the communities.

A healthcare provider confirmed that:

“... There was a forum of enrollees and PharmAccess Foundation/Programme Managers where they interacted with enrollees and took up their complaints with the providers”. (KII, HCP, 20/06/19, Bode Saadu)

Some other participants added that:

“There was a complaint box in each hospital, and complaint forms were given to enrollees during community activities to identify and correct issues identified by enrollees”. (KII, HMO Official 1, 26/07/2019, Ilorin)

While the membership of each forum (i.e., health committee and enrollees forum) varies, the kinds of issues discussed are similar. Common issues raised at these fora include stock-out of drugs (IDI, Male, 15/06/2019, Edidi), reduction in health benefits (IDI, Female, 03/07/2019, Gure), a long waiting period (KII, Community Leader, 20/06/2019, Bode Saadu), preference for non-enrollees (IDI, Female, 17/06/2019, Odo-Owa). For example, a participant noted: “We waited several hours without being attended to” (IDI, Male, 03/07/2019, Gure). Another one explained: “Priority was given to those who paid out-of-pocket for care” (IDI, Female, 17/06/2019, Odo-Owa).

These indicate that certain formal platforms were put in place to monitor and evaluate the programme when it was operational. They provided an avenue for calling the partners—especially the healthcare providers—to account regarding the delivery of quality healthcare services. At the same time, they served as social accountability measures adopted to ensure that the citizens or community members were involved and informed about the implementation process of the programme. For instance, the enrollees' forum provided the opportunity for community members to contribute to the running of the programme by, for example, reporting long waiting periods that could enhance efficiency in terms of increasing the workforce in the healthcare facilities.

Apart from the formally established structures (health committee and enrollee forum), more informal accountability mechanisms emerged. Further, community leaders also had access to the Programme Managers to lodge complaints (such as a reduction in health benefits and non-availability of drugs) and share their opinions regarding the progress of the programme. A community leader explained: "Whenever we had a complaint, we called the Enrolment Officer, and he attended to us. At times, we involved him in the meeting of the Health Committee [in the community] and the health officials [in the facility]" (KII, Community Leader, 15/06/2019, Edidi). One HMO official confirmed: "... We also used the traditional rulers and agents within the communities to tell us how things were run in the hospitals" (KII, HMO Official 2, 29/07/2019, Ilorin).

Most of the participants claimed that the measures yielded positive results in improving service delivery. A female community member stated: "... The Programme Managers came to the community to interact with the enrollees to improve the service" (IDI, Female, 26/06/2019, Oro). Another participant confirmed: "... Some of us were contacted by phone for feedback on the quality of service. I was called twice" (Male FGD, 27/05/2019, Osi). Also, stressing the effectiveness of the accountability measures, a healthcare provider explained that the enrollees once reported to the Programme Managers about a reduction in the quality of care. According to her: "The Programme Managers usually conduct survey to assess our performance on the programme for improvement. For instance, when the capitation [i.e., paid to the healthcare providers to treat the enrollees] was reduced, the dosage [of drugs given to patients] was also reduced, the enrollees complained via the questionnaire, and we explained that it was due to low capitation" (KII, HCP, 13/06/2019, Erinle). This was one reason for increasing the capitation at the time, because the Programme Managers utilized and acted on the information obtained from the enrollees.

3.3. *The CBHI Stoppage and 2019 General Elections: Any Link?*

When the CBHI programme stopped in 2016, various community delegations (i.e., community leaders and concerned community members) called the state government to account; they demanded an explanation for the stoppage and were told it had to do with expanding the programme to cover the entire State. They were assured that a renewed programme would be introduced; this new programme was eventually launched in the second half of 2018. Several months after the launch, the programme did not commence. When it was time for the general elections, citizens decided and voted out the political party at the state and local levels.

Analytically, the political system in Kwara State could be identified with godfatherism. Late Dr. Olusola Saraki was a significant player on the political scene in the State. He was very influential in determining who emerged as governor or held political positions in the State, primarily, since Nigeria's return to democracy in 1999. For instance, Dr. Saraki was instrumental in the emergence of his first son, Dr. Bukola Saraki, as the governor in 2003, using the platform of the People's Democratic Party (PDP). Dr. Saraki ruled as governor between 2003 and 2011. Still, under the aegis of the Saraki dynasty, Governor Abdul Fatah Ahmed (also from PDP) was elected and ruled between 2011 and 2019. However, both Saraki and Ahmed and all other candidates from their political bloc lost massively in the general elections in the wave of 'Oto Ge' (i.e., Enough is Enough), the mantra demanding a change in the leadership and public affairs of the State by the people. In the governorship

elections, the All Progressives Congress (APC) had 73.12% (331,546) of the total votes while the People's Democratic Party (PDP) had 25.31% (114,754).

The trajectory highlighted above indicates that the Saraki family dominated the politics of Kwara State between 1999 and 2019. The CBHI programme was introduced during the tenure of Governor Saraki in 2007 and stopped during the tenure of Governor Ahmed in 2016. Asked if there was any link between the collapse of the CBHI programme and the loss of the election by the political bloc that was in government, 7 out of 13 participants (who responded to the question) did not rule out the possibility but opined that there were many other factors that influenced the outcome of the elections. This is because people all over the state were generally complaining about poor governance. Some Healthcare Providers noted that:

I don't know if there is a causal relationship between the collapse of the programme and change in government because many factors went into that change. (KII, HCP, 19/06/2019, Bacita)

The voting pattern in the last election was a conglomeration of many factors relating to poor governance. It may be one of the reasons but not the main reason. (KII, HCP, 27/07/2019, Oro)

An HMO official added that:

The collapse of the programme might play a role but not the sole reason for voting against the last government. Part of it was that the people were tired of the Saraki dynasty. (KII, HMO Official 2, 29/07/2019, Ilorin)

A government official submitted that:

I don't think the stoppage of the programme affected the decision to vote the last administration out of government. (KII, KWSG Official 1, 20/08/2019, Ilorin)

Also, an international agency official and a researcher noted that:

Some people believe that the CBHI programme was a political tool in 2015, which was not so, but we don't know if the stoppage eventually affected the voting decision in 2019. (KII, Foreign Agency Official 2, 02/09/2019, Ilorin)

I don't think the suspension of the programme has anything to do with general elections. In civilised countries, that should have been a major reason people voted against their leaders. Most people in the State are not even aware of the programme anyway. There are several other reasons for voting out the formal government. It could be part of the reasons for the former enrollees. (Researcher, 30/07/2019, Ilorin)

On the other hand, the remaining (6 out of 13) participants (who responded to the question) noted that the collapse of the programme influenced the members of the communities in voting against the ruling party in the State. A community leader stated that it was the community member's way of expressing their dissatisfaction with the programme. He stated that: "I can't say that the stoppage of the programme did not affect the outcome of the 2019 general elections in the community, but the extent is what I don't know. This is because directly or indirectly, the voters have been denied continuous access to healthcare, and they are expected to react" (KII, Community Leader, 11/07/2019, Idofian).

Another community leader opined that the government failed to prepare an alternative for accessing care. He noted that:

The stoppage of the programme affected the outcome of the 2019 general elections in the community because the government was not proactive enough to refurbish government hospitals in the community to make them functional. People voted for the opposition hoping that the CBHI programme might be revived. (KII, Community Leader, 01/07/2019, Aboto-Oja)

Also, some of the participants in the implementation of the programme argued that the stoppage was partly responsible for the loss of the election by the PDP. According to an HCP:

If the programme did not stop, the PDP would have won the 2019 general elections in the State. (KII, HCP, 13/06/2019, Erinle)

An HMO official added that:

Part of the reasons for the loss of the 2019 general elections by the PDP in the State was the stoppage of the programme because the communities were dissatisfied. The opposition used it to campaign against them on radio, while some people outrightly declared that they wouldn't vote for them. (KII, HMO Official 1, 26/07/2019, Ilorin)

Also, a government official gave a more precise insight that the programme had always given the political leadership some advantages during elections because it was one of the 'beautiful things' happenings in the State. He submitted that:

The programme had a link with the 2011 and 2015 general elections because it was an election-winning programme. The people never wanted the programme to be phased-out. Our advocacy then was that if you have something beautiful happening in a place, you have to keep it up. The people were very anxious and happy with the programme. In all the areas where the programme was operational, we had bloc votes. It was the same thing that happened during the 2019 general elections because we were unable to operate, and the people were not happy. In all the areas we had had bloc votes, we had zero votes. Because already, 2 to 3 years after the programme stoppage, people were unhappy. The people's reaction was that why did you give us the programme when you knew you couldn't sustain it, and we voted you for this. (KII, KWSG Official 2, 24/07/2019, Ilorin)

The submissions above indicate that the stoppage of the programme, to an extent, had a link and was part of the reasons for the loss of the election by the political bloc that had led the State for almost two decades. This is because the stoppage left the beneficiaries and those wanting to benefit in a state of despair and helplessness.

The voting pattern had a significant influence on the new government to finalize and implement state-wide health insurance (which the immediate past administration was 'planning') in 2020, and enrolment exercise has started in some communities in the State. The programme eventually failed due to a high poverty rate and possible lack of ability to pay. Notwithstanding, the gesture of the community members created a standard of operation for the government in that regard, culminating in the implementation of the new health programme. This reflects the strong effect of social accountability measures on governance. A similar experience in Ghana led to the implementation of health insurance because of the people's demand for an alternative to user fees. ([Owusu-Sekyere and Bagah 2014](#))

In reality, the stoppage of the programme was partly influenced by the non-payment of the counterpart fund by the Kwara State Government (KII, HCP, 15/06/2019, Edidi). However, the foreign partner continued with the funding until it could no longer cope (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). Unfortunately, the community members were not formally informed about the decision to stop the programme (IDI, Male, 20/06/2019, Bode Saadu). Most learned when there was no longer a structure in place to facilitate the renewal of enrolment in the programme. (IDI, Male, 19/06/2019, Bacita)

4. Discussion

Findings indicate that social and political accountability measures interacted and shaped the introduction, functioning, and stoppage of the CBHI programme in Kwara State, Nigeria. The health committees and enrollees forum assisted in strengthening the healthcare services under the programme. This supports the findings of other research. [Lodenstein et al. \(2017a\)](#), for example, found that health committees in West Africa played positive roles in improving health service delivery. In addition, the enrollees' forum in our study aimed to enable the beneficiaries to participate in improving the healthcare service delivery. This is in line with findings from [Anigbogu \(2019\)](#), who noted that the enrollee forum provided enrollees the opportunity to raise questions on grey areas in the implementation of the Anambra Health Insurance Scheme (ASHIA) in South-east Nigeria. However, on a wider note, the programme appears to have lacked equity and social justice because it benefitted only those who could afford the enrolment premium. Community members who did not pay enrolment premiums were excluded from accessing healthcare services. Those who benefitted were less than 5% of the state population, indicating a large-scale inequity and injustice in healthcare services provisioning.

It is noted that the programme was co-funded by an external donor, and financial power is one of the tools often used for influencing and dominating social policy in the global south ([Adésinà 2007, 2020](#); [Storeng et al. 2019](#)). In the case of Kwara, perhaps, the healthcare model (which was proposed by the foreign partner) was not suitable, but the political leadership accepted it due to its political gains ([Bohn 2011](#); [Sarwar 2018](#)). Nevertheless, the government was responsible for ensuring equity in access among the people, especially given the alarming rate of poverty ravaging many communities in the state. Social accountability through the Health Committee and the Enrollees forum did not provide the platform to advocate for more equal access to healthcare and the sharing of risks in communities either. Perhaps, as suggested elsewhere, social accountability at the health facility level, and thus in CBHI, is limited to addressing operational problems for a relatively small group of citizens, while issues of more structural inequality cannot be addressed.

Unfortunately, injustice and lack of equity culminate in vulnerability and social risk ([De Coninck et al. 2013](#)). Fundamentally, however, social justice requires that the burdens and privileges (including healthcare protection) in society are equitably shared among members ([Anaemene 2020](#)). This principle is enshrined in the Alma Ata Declaration of 1978. [Fischer \(2018\)](#) argued that targeting the poor for an intervention programme derived from social justice concerns but, for the most part, has been counter-productive to social justice. Thus, targeting particular needs for a category of people is unwarranted in a society where the social needs of the people can be comprehensively managed, especially when a majority of the people are in need or fall below the poverty line. This is also because the mechanisms for adequate targeting are largely non-existent ([Stierle et al. 1999](#)).

[Woolf \(2019\)](#) noted that the absence of social justice and equity breeds violence and unrest. For solidarity and peace, social justice is attained in a healthcare system when everyone (rich and poor) has equal access to the same health services regardless of their geographical, socio-cultural, and economic differences ([Pande et al. 2017](#)). Therefore, social policy programmes (including intervention programmes in the healthcare sector) must be equitably accessible and beneficial to all members of society. In other words, social justice in healthcare is largely synonymous with the attainment of universal health coverage such that the disadvantaged members of society are protected from out-of-pocket health expenditure.

In addition, this study exposes the accountability ecosystem (i.e., the interplay between political accountability and social accountability). Basically, political accountability is often seen as the core form of accountability for citizens: the way citizens hold government and politicians to account. Social accountability is thus a form of accountability used in between elections, i.e., to make sure electoral promises are monitored and implemented. The social accountability measures in the CBHI programme served this purpose. Findings from this study reveal that the change in voting patterns during the 2019 general elections may have been triggered by the stoppage of the programme, because the programme formed part of

the campaign promises during the 2011 general elections of the then ruling party, and was also targeted to cover 600,000 rural dwellers (mainly the poor) by the end of 2017. Hence, as (McConnell 2014, p. 2) notes, “policy failures can cause electoral and reputational damage to governments, and even lead to the downfall of public officials, politicians, governments, and regimes”.

While the target (i.e., 600,000 enrollees) largely raised concerns in terms of equity in access, the relative hope of the rural dwellers in the extension and expansion plans of the programme was thwarted by the sudden stoppage. More so, the social accountability measures mainly focused on the day-to-day functioning of the programme rather than issues of equity which were decided at the policy level by the partners (mainly Kwara State Government and Health Insurance Fund). In essence, there was interplay between social accountability and political accountability in the programme. While social accountability was used to ensure adequate implementation of the programme, the members of the communities deployed political accountability in reaction to the stoppage of the programme.

5. Conclusions

Social accountability is an effective strategy for improving health service delivery at the facility and district levels. Political accountability has the complementary potential to attain larger health policy goals and outcomes. Both forms of accountability help to ensure that the various actors play their roles effectively. However, individuals saddled with these responsibilities need to be altruistic and armed with the necessary training and skills to play their roles adequately. On a wider note, and more importantly, this study reveals how joint action can assist in getting political office holders and leaders to deliver dividends of democracy to the people. As such, government needs to recognize the importance of transparency and social accountability in governance and the need to create an enabling environment for these mechanisms to thrive across all levels of government. The relevant stakeholders should be able to access relevant information and engage the government progressively.

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