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Crisis of Legitimacy and Community Mobilization in Health: A Case Study in Burkina Faso

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Abstract

The objective aim of this article is to understand the low level of community mobilization for health by questioning the legitimacy of the Community-Level Health Committees (CLHCs) and their leaders. In other words, it will focus on the process of judging the CLHCs and their leaders by the local population, identifying and analyzing all the elements that serve as references for the construction of their legitimacy. Data were collected from 9 CLHCs' members and 60 heads of households recruited in three villages, through individual interviews. All interviews were recorded, transcribed and entered into Word files. Data processing was done using NVIVO10 software. The results of the study indicate that the CLHCs, which are supposed to facilitate community mobilization, do not work like they are supposed to do. As an effect of this situation, the populations do not trust the CLHCs and its first officials. Through analysis, we note that the criteria used for their implementation did not take into account the real needs and expectations of the communities. This community structure does not have the expected support. Both their composition and their mode of operation did not meet the social norms and aspirations of the populations. The CLHCs were not perceived as community structures that help to improve the conditions of access to health care, but rather as a mechanism put in place by health agents with the complicity of certain members of the population so as to use the resources of the health facilities for their own interests. Hence the lack of trust in them.

Keywords

Legitimacy, Community Mobilization, Participation, Health, Burkina Faso

1. Introduction

1.1. Conceptualization and Research Problem

The concept of legitimacy is widely used both in speeches and in research articles, and lies at the crossroads of social sciences, political sciences, administrative and management sciences, and governance theories. The debate on the question of legitimacy is recurrent and persistent in an evolving context in terms of democracy and claims of citizens' rights to public actions. Taking into account the expectations and needs of the different actors is more than a requirement, it is a categorical imperative and is even one of the conditions necessary for the indispensable recognition and commitment of the populations and beneficiaries.

The dictionary of philosophical notions defines legitimacy as "conforming not only to the laws but also to morality, to reason". The psychologists French Jr. & Raven (1959) referred to legitimacy as a social influence induced by feelings of "should", "must" or "has the right to", i.e. by appeals to an "internalized norm or value". Suchmann defined legitimacy as follows: "is a generalized perception or assumption that an entity's actions are desirable, correct, or appropriate within a socially constructed system of norms, values, beliefs, and definitions (Suchman, 1995: 574)." Simply put, legitimacy is that perception that one person should obey another. It is a form of power that gives authorities the ability to shape the behavior of others (Ford & Johnson, 1998; Hurd, 1999).

Different conceptions of legitimacy have been developed progressively with the evolution of sociological thought. The validity and effectiveness of the legitimate order are always based on social mechanisms (Matheson, 1987). Many sociologists have worked on this concept and have developed several approaches. Max Weber places social norms at the heart of his approach to legitimacy (Weber, 1978). According to him, a social order is only legitimate if it is oriented towards norms and values that are recognized and shared by the members of the group. The Weberian approach offers the central idea that legitimation occurs through a social construction in which the elements of a social order are considered to conform to norms, values and beliefs that individuals assume are widely shared, even if they do not personally share them (Walker & Zelditch Jr, 1993). Legitimacy is expressed by the conformity of actors to a social order as a set of social obligations, or as a desirable pattern of action (Spencer, 1970; Zelditch Jr., 2001). Weber distinguishes three sources of legitimacy of a social action. The first source is the laws, the rules that a group has enacted in order to live together. The author speaks of legal domination. The second source remains the traditions, the beliefs, the culture of the group. Thus, those who are called to exercise functions see their domination accepted in the name of customs. The third source is the exemplary values, the charisma of an individual, what the author calls the charismatic domination. The American sociologist, in his article: Managing legitimacy: strategic and institutional approaches, identifies three types of organizational legitimacy (Suchman, 1995). The first type, called pragmatic legitimacy, is a form of evaluation of the value of an organization by its

main stakeholders. This type of legitimacy "rests on the self-interested calculations of an organization's most immediate audiences. Support for the organization is not necessarily due to the fact that it fosters exchange but simply because it meets the needs of others. Legitimacy is judged by the interests of the stakeholders. The organization's capacity to promote exchanges between individuals is given little consideration. The second is moral legitimacy. It is defined as a normative assessment of an organization. The judgement is less about what the organization brings to individuals but more about the legality of the activities implemented. Does what the organization develops as actions comply with the laws, the texts that govern its operation. Moral legitimacy often takes the form of an evaluation of tools and procedures, results and their consequences. The third, called cognitive legitimacy, evaluates the organization's activities according to pre-constructed beliefs about how to organize work and generate social value. The views of the actors, based on their experiences, remain at the heart of the assessment process. In the context of this study, legitimacy is seen as the acceptance and adherence of populations to health promotion initiatives implemented by CLHCs. Low adherence to CLHCs' actions is considered a crisis of legitimacy.

Like many African countries, Burkina Faso initiated a major reform of its health system in the early 2000s. Indeed, under the aegis of the WHO, following the adoption of the Bamako Initiative, measures were taken to involve communities in the management of health services. Community-level health committee (CLHCs) have been set up in all the country's health facilities. Composed of elected members of the community, the CLHCs should facilitate community mobilization around health actions. Designated as a "State-community participatory management body", the CLHCs' essential missions are to ensure the functioning of the health center, promote community participation and facilitate the mobilization of financial resources.

Empirical data collected in the health districts indicate that the community participation process is fraught with difficulties. The CLHCs encounter enormous difficulties in convincing local populations to participate in the various activities implemented within the framework of health promotion. Whether it is the general assemblies, the statutory meetings of the offices, the mobilization for the realization of community works for the benefit of the health center, the renewal of the CLHCs' authorities, the contributions to support the functioning, all these activities know more and more a very low involvement of the populations. The participation mechanisms put in place to promote and facilitate the involvement of communities in the animation of the health system are not functioning as expected. There is a certain distance between the populations and the CLHCs, an authority that can help organize them for better involvement. The low level of adherence of the population to the actions of the CLHCs raises questions about the legitimacy of this community body set up to boost community mobilization for health actions. Studies have identified a certain number of factors that could explain the difficulties related to community mobilization. In-

deed, the economic difficulties of households, intra-community conflicts, the behaviours of health workers, the management capacities of CLHCs' leaders, poor understanding of CLHCs' missions, previous experiences racketeering and illicit sale of medicines, political conflicts(competition for elective positions), crises of traditional chieftaincies, low involvement of village executives in the establishment and management of CLHCs, are all factors used to understand and explain the dynamics of community participation in health (Ilboudo et al., 2016; Kunjuraman, 2022; Sombié et al., 2017; Song et al., 2022; Stone, 1992). The aim of this article is to understand the low community mobilization for health by questioning the legitimacy of the CLHCs and their leaders. In other words, it will focus on the process of judging the CLHCs and their leaders by the local population, identifying and analyzing all the elements that serve as references for the construction of their legitimacy.

1.2. Health System and Community Participation

Since the implementation of the Bamako Initiative (BI) in the 1990s, the Burkina Faso health system has made community participation an essential dimension of its strategy for improving the quality of care. Indeed, as a follow-up to the recommendations of the Alma-Ata conference, the political and health authorities decided to adopt a district health system. This system favors a multi-actor management. In addition to doctors, paramedics and technicians, the health system is open to the population, who sit on the decision-making bodies through their representatives. To facilitate greater involvement of the population in the management of health issues at the local level, the villages making up a health area were asked to set up a body called the "CLHCs" which will represent them in the health system. It is also this community structure that organizes the mobilization and participation of the population in the activities of the health facility. It is this structure that acts as an interface between the health system and the populations. Its role is crucial and determining for the success of the adhesion and commitment of the population of the communities. The hopes and expectations raised when this community structure was set up have gradually faded. The long-awaited participation is not producing results. The community mobilization arm of the health system is slow to assume its full role. Its operational difficulties have not allowed it to achieve the expected results. It is clear from the speeches that the populations have difficulty trusting the CLHCs, which are in lethargy and in crisis.

2. Methodology

2.1. Setting of the Study

The study took place in the Tenkodogo health district, located in the central-eastern health region. It has about sixty health facilities with an estimated population of about 915977 inhabitants. In terms of religion, the population is divided between Muslims, Catholics, Evangelical Christians and Animists. The

ethnic groups are, in order of numerical importance, Mossi, Bissa, Yaana and Peulh. The gross enrollment rate in primary school in 2011 was 77.7% and 10.9% in secondary school. Data was collected in the areas of Loanga, Ouéguédo and Soumangou.

2.2. Study Population and Sample

Two categories of people were included in the study. These were the members of the CLHCs of the three localities forming the zone of the study. Three board members were selected: the president, the secretary general and the treasurer. These are the three most influential members who participate most in the various meetings. A total of 9 CLHCs' members were interviewed. Their ages ranged from 57 to 32. They are all married, some in monogamy and others in polygamy. The average number of children per person is 4. Of the 9, only 3 have a primary school education, 4 have participated in literacy courses in Mooré and Bissa. Among the 9, there are 2 women who all hold treasurer positions. In addition to the CLHCs' members, heads of households were also included in the study. In each of the study locations, 20 heads of household were selected from the village where the health facility is located. A total of 60 heads of households participated in the study. For their selection, with the help of the delegate, we divided the village into 4 zones and used a 10-step for the identification of the concession. With the help of certain community leaders, five female heads of household were identified in each locality and included in the study. In summary, 60 heads of household were interviewed, including 45 men and 15 women. The average age of the men was 29 years. Less than half had any level of schooling. Two heads of household indicated that they had obtained their first cycle of study certificate (BEPC). They are all married and have several children. The average number of children is 7. They are all farmers and have secondary jobs such as mechanics, trade, handicrafts, and many other small jobs that allow them to earn money. Related to women, their age varies between 41 and 22 years. None of them has attended modern school. They are all housewives and work in small commerce.

2.3. Data Collection, Processing and Analysis

Data were collected during the period from September to December 2022 in three phases. All interviews were recorded on digital tapes using dictaphones and telephones. At the end of the collection, all tapes were retrieved by the principal investigator and saved on a computer and server. All tapes were coded to make them anonymous and thus respect ethical rules of confidentiality. Care was also taken to erase all recordings on the devices used by the two assistants. Subsequently, all audiotapes were transcribed and entered into Word files. It is important to note that some interviews were conducted in the local language and transcribed into French. All files were imported into the NVIVO qualitative data processing and analysis software. It should be noted that codes were used instead

of the names of the interviewees when recording the files. This precaution aims to respect the ethical rules that govern qualitative research. A coding guide was developed and used to code all the transcribed speeches. The content analysis method was used. The first step of the analysis consisted in grouping the parts of the interviews according to the codes. The second stage was devoted to the search for elements of meaning. To support and substantiate the analysis, verbatims were extracted and used in parts of the report. In order to respect the rules of confidentiality, codes are used instead of the names and functions of the interviewees. This ensures that the real identity of the authors of the speeches used in the text is not disclosed. This contributes to the strict respect of ethical standards in research.

3. Results

The results of the study indicate that the legitimacy of the CLHCs is built on the following factors: the expectations of the population and the missions of the structure, the profiles of the members of the office, previous experience, and the behavior of health workers.

3.1. The Missions of the CLHCs and the Expectations of the Population

We note that the heads of household have little knowledge of the missions of the CLHCs. In fact, there is a lot of confusion among the people interviewed. There is total confusion between the missions of the CLHCs and those of the health facilities. Some believe that the CLHCs should accompany the health workers in the provision of care. They therefore consider the members of the CLHCs to be people who should be trained so that they can also assist the population at their level in difficult times. A head of household states:

> "When we created the CLHCs, I think we said that the people we will put there will be trained to help the health workers. It's like we understood and then we don't see anything." (Household head Male _2)

Others go further by confusing the CLHCs with development projects, which generally mobilize financial, material and human resources to help the population in specific areas. When we know that many villages have benefited from the actions of many projects, we can understand the difficulties for some people to establish the differences between these two different elements. A woman interviewed in the village of Loanga noted:

> "Me I think the CLHCs should do like the projects. They get the money and they come to help us with our health. Otherwise, what is the point of them? The members of the office are not health workers to help us, but they can ask the government for the means to help us pay for the medicines and the gas for the ambulance. If they can't do that, they don't have to. I don't see what they are really for." (Householder Woman_12)

Another group sees the CLHCs as structures that receive money from the state through the profits generated by the sale of medicines and various donations and grants. They should use this money to help people get health care. Instead of doing this, the members of the CLHCs with the complicity of the health agents share these resources. A head of household emphasizes:

> "Me I understood that the CLHCs earn money from the pharmacy. This money should be used to help people who do not have the means to treat themselves. But that's not what they do. People go into the offices to take advantage of that money and the people don't gain anything. That's how it is and that's what discourages people." (Householder Man_31)

On the missions of the CLHCs, the interministerial decree N˚2010-429/MS/MATS/MEF of December 29, 2010, the CLHCs are "a non-profit, participatory State-Community management body of public utility". Their missions are defined as follows: i) to ensure the efficient functioning of the health and social promotion center or the medical center; ii) to promote the full participation of the communities in health activities; iii) to participate in the development of the annual action plan of the health facility; iv) to ensure accessibility to health care for all; v) to manage the funds generated by the activities of the health and social promotion center or the medical center and by the activities initiated by the management committee.

We note that the missions of the CLHCs as defined by the official texts are far from what the populations expect. They should rather play an interface role between the health services and the populations. It is a body that represents the populations since it is composed of members elected from the population of its area of competence. The CLHCs work with health workers to ensure that the opinions of the population are taken into account in the management of the health center, and to mobilize resources within the community to use them to improve the performance of the health center. The ministry of health-community co-management system requires efforts on the part of the population to support the government in its efforts. For example, the construction of housing, the repair of the health center's boreholes, the maintenance of rolling stock, and the purchase of certain office furniture are the responsibility of the CLHCs, i.e., the community. It is a body that should enable the population to organize itself for greater participation in the efforts to be mobilized to guarantee better functioning of the health center and an improvement in the quality of care. This mission is misunderstood and misinterpreted by the population. They base their judgment on unfulfilled expectations that are not the responsibility of the CLHCs. The lack of knowledge of the missions of the CLHCs contributes to a proliferation of erroneous judgments that undermine their legitimacy. The CLHCs are expected to do what they cannot do. This situation is understandable in a context where people expect more from the State. The capacity to understand, the previous experiences of a certain period, the behaviors and the promises of poli-

ticians make it difficult to change the relationship with the State. The prevailing conception of the welfare state reinforces the local population's view that the CLHCs should intervene like technical services, i.e., assist them. One CLHCs leader noted:

> "The problem in our societies is that people think that the state should do everything. There are people who think that they should get free treatment and the CLHCs should pay for the consultation and medication. This is how many people think. This is why people spend time saying that the members of the CLHCs embezzle money from the CSPS. Many people think that millions of dollars are being earned from the sale of medicines. And yet, this is not true. When we ask them to participate in meetings to understand how things work, they don't come. So, it is very complicated." (Member CLHCs_5)

There is a discrepancy between the expectations of the population with regard to the CLHCs and the actual missions assigned to this community structure. An inadequate information and sensitization process for the population at the time of the creation and installation of these structures, a failure to review the texts that govern the operation of the CLHCs in order to take into account the evolution of the political, administrative and social context, an increase in difficulties in accessing quality care at reduced costs, are all factors that contribute to a poor image among the population. This situation means that the population does not appreciate the structure at its true value. The information on which their judgments are based does not reflect reality. The lack of knowledge of the real role of the CLHCs does not allow for an objective assessment of this community body, which has a crucial role to play in the process of promoting community participation in health. The majority of the population continues to think that the CLHCs are not bodies that meet their expectations and needs.

3.2. The Profiles of the Board Members of CLHCs

The characteristics of the actors involved in an action are also elements that serve to build legitimacy. Certain types of resources carried by the actors can be mobilized in specific situations to establish their legitimacy (Dubnick, 2002; Tyler, 2006). In each social position, the actors consciously or unconsciously determine at their level the capacities and competences that the persons in charge should have in order to be able to play their roles properly and succeed in the missions that have been entrusted to them. Trust in those who have been empowered will stem from the assessment that each individual involved in the interactions will make based on his or her own experience. In the discourse of the interviewees, a number of elements related to the characteristics of the CLHCs board members were mentioned as entering the process of social construction of the legitimacy of these community structures. They are presented and analyzed in the following lines.

3.2.1. Level of Education

The results of a previous study (Sombié et al., 2017) conducted in the same area indicated that more than the majority of CLHCs' members had not attended modern school. Of the 120 people involved in the study, only 3% had attended school. The level of education according to the respondents remains an important element for the CLHCs' office members. In fact, they are responsible for managing a body that must take part in health-related decisions. In the context of Burkina Faso, all documents and exchanges with government structures are conducted in French, the official language of communication. Thus, if people who have been made responsible do not have this resource, it is obvious that they will have difficulty fully assuming their function. The lack of schooling of the CLHCs' members does not reassure the heads of household about their ability to manage the structure properly. One head of household complained:

> "If you take the office of our CLHCs, we have chosen only people who did not go to school. So, how can these people manage well. They don't know how to read; how can they control what happens in the clinic. This is a serious problem. How can we trust such people. Everything they say and ask, people don't believe. I think that's why they can't mobilize. In reality, with illiterate board members, people do not take the CLHCs seriously." (Head of household_Man_42).

The majority of the people interviewed (head of household and member of the CLHCs' office) believe that the level of education is an essential attribute to allow CLHCs' members to fully play their roles, to assume their missions to the extent expected. One CLHCs' member regretted:

> "What complicates our work is that we did not go to school. It is difficult for us to understand our work. We are obliged to entrust everything to the nurse, which is not good. So there are things that happen that we don't understand. We can't explain it to the people. It is not easy. For example, when we go to meetings in the districts, the exchanges are done in French, and then we are translated. Really, if there were people among us who had a good level, it would help the CLHCs a lot. That is why people do not trust us. When I take the example of the CLHCs of Cella, it is different because the president is a retired civil servant and the other members of the office have a good level, the behavior of the populations is different. People mobilize when the CLHCs conducts an activity." (CLHCs' member_6)

It could be said that the level of education is recognized by the populations as an important value for good management and efficiency of the CLHCs. The lack of education has a negative influence on the process of recognition and acceptance of this structure by the local population.

3.2.2. Age

One criticism that many of the people interviewed have of some CLHCs offices is the age of the members of the office. In some cases, it was noted that the board

members were elderly. In two of the three CLHCs involved in the study, the two most important positions (president, treasurer) are held by people over 60. This situation is not well appreciated by the people.

> "In our case, the problem is that it is two old people who have taken the CLHCs hostage. They are tired people who are not able to understand the evolution of things. They have been in these positions for a long time. You see! So the young people avoid approaching them so that they don't say that they have come to disrespect them. In reality, the CLHCs do not carry out any activities. Since the people are not interested, they do what they want. They can't mobilize." (Household head Man_18).

Some of the people we met, who could be described as young (25 to 35 years old), suggest that in some localities, older people want to control all the spaces of power. In doing so, they put in place strategies that do not encourage young people to take an interest in the CLHCs. It was found that the office of some CLHCs were set up without an assembly as provided for by the texts. Some people have been chosen by notables without taking into account their capacities and competences to hold the positions. This situation also explains the presence of elderly people as members of the CLHCs office in some cases.

Even within the CLHCs' offices, it is noted that the fact that the CLHCs' office is headed by an elderly person is not without causing difficulties in operation and efficiency. It is common for some to use their right of eldership to avoid contradictions and debates, which are necessary for the vitality of the structure. A CLHCs' member explains:

> "The president of our CLHCs is over 70 years old and has been there for over 15 years. He likes to decide on his own without the opinion of the other members. It's not easy and since he is also a leader, we have to let him do it. The other members of the CLHCs let him do this and are no longer interested in the activities of the structure. And since the people know about it, they don't care to know what is going on. In reality, the people do not consider the CLHCs to be their business." (CLHCs_4 member)

A significant part of the population considers that the older the age of the first leaders, the less their actions fit into the dynamics of the evolution of things. These leaders are out of step with the aspirations of young people, whose mobilization for health actions is the most requested and expected. The populations believe that the CLHCs should be led by the younger generation. A mix of old and young people could be a source of disagreement and leadership conflicts, which will naturally be a stumbling block to the union that is needed to mobilize everyone. Both the members of the CLHCs' office and a significant proportion of the heads of household interviewed consider age to be an important element in the process of appreciation and support for the activities of this community body. The high age of the first officials is considered a factor that negatively influences the functioning of the CLHCs.

3.2.3. Board Members' Backgrounds

The term "background" is used here to refer to the history of board members in holding leadership positions in associations and other community organizations in their area of residence. Indeed, several studies (Bhattacharyya et al., 2001; Lainez et al., 2012; Lopes et al., 2012; Pérez & Martinez, 2008; Ministry of Health Uganda, 2010; Van Ginneken, Lewin, & Berridge, 2010) have shown that CLHCs' members, community health workers (CHWs), generally hold leadership positions in many of the community-based organizations in their villages. They mostly have cumulative responsibilities or experience from previous years. This is an important element that was mentioned by the participants in the study. The background of those who hold responsibilities is taken into account in the social evaluation of the structure. It is noted that people are particularly interested in what people did when they were empowered. One study participant recounted:

> "There is an important element that people take into account when they talk about CLHCs' offices, it is the past of some presidents or treasurers. In our villages, you have people who have always held positions in several associations. For example, the treasurer of our CLHCs was the treasurer of the parents' association for a long time, and he was also in the office that manages the boreholes. He is someone who is a little bit everywhere. There are people like that in the village. And their name is spoiled. So, if you see them somewhere, people start to doubt, they don't trust them anymore. This is a problem we have here. When we ask people to contribute, many refuse because they think about what happened before. For the CLHCs to work, it is better to find people who have not done anything bad." (Household head Man_16).

The past history of board members plays a major role in the support of the population for associations and other groups in the study area. It is a major factor in the process of evaluating the credibility of the organization, the level of honesty and transparency of the leaders, and the process of building trust. A treasurer of a CLHCs' office explained:

> "It's true that people pay attention to who is appointed as a leader in the associations. In the past, there have been many problems in our villages with the associations. People have made contributions, or money or materials have been given to the groups and members of the board have embezzled. If you ask people, they will tell you many stories. So, if we see the same people who are still presidents or treasurers, people no longer trust them. If we force them to do so, people lose interest in what the structure is doing. We have this problem with the CLHCs, the CVD (Village Development Committees) in many villages. The people want us to give responsibility to people who are honest and who have not yet been involved in embezzlement. This is a big problem that we face in the villages." (CLHCs_1 member).

The retention of certain people, whose careers have been criticized as com-

promising, is linked to their proximity to those in power. Indeed, it appears that most of the people in this situation are close to certain traditional chiefs, relatives of certain political leaders or senior officials in the public administration. Their inclusion in the networks of power facilitates their imposition without regard for the general interest. A member of the CLHCs' office explains further:

> "The real problem with the CLHCs is that it is the chiefs and other personalities who impose people who are not liked by the people. So people can't mobilize to support people who don't want to. This is the problem that makes things not work well for the CLHCs." (CLHCs Member_9)

3.3. Previous Experiences

Well before independence and with a view to better organizing the rural world for better involvement in the development process, structuring work was undertaken by both the political authorities and development promotion agencies. Initially started in the agricultural sector, with the creation of agricultural groups, the process has continued and diversified, affecting practically all sectors of activity. Designated under several names (group, association, tontine, etc.), new forms of organization of the population have appeared in the villages. These structures, which are essentially composed of members of the population, were created to facilitate the achievement of certain major community objectives. The results of the study highlight the three localities that make up the study area are experiencing the process of structuring the towns and villages that began several years ago. It appears that these villages have experience with groups and other forms of community organization. It seems that the village of Loanga had its first agricultural group before independence, while Ouéguédo and Soumangou had their first group just after independence. Since then, the creation of associations and their management have followed one another with varying fortunes. The organizational past of each locality is very rich in positive but also negative results. These varied experiences, with successes and failures, are often used to explain or justify participation in community health promotion activities. They remain references in the process of building the legitimacy of the CLHCs.

The relative success of the Ouéguédo CLHCs in mobilizing the population around health promotion activities is due in part to the trust that the communities place in local community structures. Whether it is the agricultural groups, the multisectoral associations, or the parents' associations, it is said that the people who have been given responsibility have always demonstrated seriousness in their management. Transparency and putting the interest first have always prevailed in the management of community structures. A member of the CLHCs' office explains:

> "(...) It must be said that here, we don't have problems with the associations as is the case in other villages. For a long time, it is very rare to hear that someone has embezzled money or material from an association. To avoid

these kinds of problems, we do everything to choose honest people to manage. That's how things are done here. It is also because of this that the groups and associations work here. The people continue to have confidence and there are no problems. As the associations work, it is easy to mobilize people (...) At the level of the CLHCs, we really don't have any problems. If we ask people to contribute, they give what they have. It's the same thing for the common interest work. Every time we choose a date, we invite the population to come out and clean the health center and it always goes well." (CLHCs_6 member).

The situation in Ouéguédo is totally different from what is happening in Soumangou. In fact, this locality has experienced several different fortunes in the management of community structures. The stories always end on notes of dissatisfaction made of suspicion, accusations of breach of trust, embezzlement of money and material goods for individual purposes. One head of household recounted:

"Back home, as I said before, people don't trust anything that is an association or a group. We have experienced many difficult situations here. All attempts always end in failure and this causes conflicts. Only last year, a tontine case created problems between families here and in a surrounding village. The minds of the people here do not favor doing things together. When a person in charge is appointed, people spend their time criticizing him or her, suspecting him or her of embezzlement, so there is no longer any trust. It's really difficult. People say everything about the CLHCs and they don't participate." (Householde Head Man_17)

The culture of collaboration, association and mutual aid is not rooted in the behavior of the people of Soumangou. This situation does not facilitate the establishment of trust, which is essential for building legitimacy. A member of CLHCs, a former president of an association, relates his experience.

"I was the first president of the parents' association. As soon as the school opened, the headmaster and others asked me to take the position. I accepted. When we got help to build a house for the teachers, some members of the office started to tell the village that I and the principal had embezzled money. It started a little bit and things started to get complicated. When we asked the families to contribute, they refused, saying that if they contribute, we will embezzle their money. It's a very complicated village and it's hard to get organized to do something together." (CLHCs member 2)

The results show that the villages involved in the study have had a significant number of experiences in organizing people and in various sectors of activity. The failures and successes of these community initiatives play an important role in the process of building the legitimacy of the CLHCs. They influence both positively and negatively.

3.4. Perceptions about health workers

Since the CLHCs' work closely with the health centers, it is common to find that some members of the population constantly consider them to be part of the health system. The interface role played by the CLHCs means that their members are frequently in contact with health personnel and present in the health facility. In addition, since the CLHCs' actions are essentially oriented towards health issues, a relationship is quickly established with the health center at the local level. In these conditions, it is difficult to make a judgment about the CLHCs without referring to what the population perceives in their relationship with the health workers and the health care structure. People's perceptions of the health care relationship could influence community behavior toward the CLHCS and their leaders. A CLHCs' member states:

> "It must be said that often the behaviors of health workers cause many problems, difficult situations at the CLHCs. We have noticed that if the health agents behave badly with the population, they are not interested in the CLHCs' activities at all. It must be said that many people do not distinguish between the health center and the CLHCs. So, if they are not happy with what the health workers are doing, they turn their backs on the CLHCs' activities. In our case, we had mobilization problems two years ago because the agents who were there (head nurse and auxiliary midwife) did not behave at all well. The CLHCs' office was obliged to go and see the chief doctor of the district to explain to him. As things were not going well, they were assigned." (CLHCs member_7).

The difficult relationships that populations have with health workers are taken into account in their evaluation and acceptance of the CLHCs. The more socially acceptable people find the health workers' behaviors and the health center's responses to their needs, the more likely they are to support the CLHCs' actions through their involvement. As this study participant put it:

> "We can't support people who are bullshitting the populations. If health workers spend their time unfairly charging people, how can people support the CLHCs? This is not possible. I think that even if we want the CLHCs to work well, some health agents must change their behavior. That's the truth. In some cases, it is the actions of health workers that discourage people. If they are correct, people mobilize around the CLHCs to help them." (Household head_49)

4. Discussion

It is noted that the creation of CLHCs to promote community participation in health can only be effective if communities recognize them as legitimate (McCoy, Hall, & Ridge, 2012). That is, a body whose membership, mode of operation, and outcomes are in line with the expectations and perceptions of the beneficiaries. Based on the above findings, the CLHCs face enormous challenges.

In some areas, they are so lethargic that we hear less and less reference to them in the discourse. The lack of social recognition of the CLHCs is a reality in many villages.

The crisis of legitimacy of the CLHCs could be explained by their lack of pragmatism. Indeed, this community structure fails to meet the health interests of the populations (George et al., 2015). The difficulties that obstruct the populations' path to care are numerous. First, there is the financial issue. Since the adoption of the Bamako Initiative, care is not free. Consultation fees that vary according to the type of health care facility have been introduced. All patients must pay a fee before having access to health personnel for consultation. The fees ranged from 200 FCFA to 5,000 FCFA. In addition, medicines are not free of charge. The sale of medicines is an essential pillar in the primary health care strategy. The profits generated are used for the maintenance of the health center, the supply of the pharmaceutical warehouse. In the case of hospitalization, each patient must pay a daily fee for the occupation of a bed and the services of health workers. All of these fees are considered exorbitant by the populations of rural areas whose incomes remain low. One of the major and recurrent expectations that the communities have of the various stakeholders is that they will receive financial support to exempt them from paying these fees. When the CLHCs were first established, many people thought that the CLHCs would work to facilitate financial access to health care. But this was not the case. On the contrary, the CLHCs constantly allow pressure to mobilize community resources to support the health center. The lack of trust in the CLHCs also stems from their inability to improve the relationship between the people and the health workers (Goodman et al., 2011). This is an important source of population dissatisfaction. As the literature indicates, relationships between caregivers and care recipients are a problem in health systems. The population generally complains about the lack of respect, attention and poor reception in health facilities. This is a situation that weighs heavily on care-seeking behavior. Some studies (Falisse & Ntakarutimana, 2020; Kapologwe et al., 2019; Molyneux et al., 2012) have shown that due to the perceived discourteous behavior of some health workers and in specific areas, local populations refuse to use health services. The advent of the CLHCs was seen by the population as an opportunity to improve relations between patients and health personnel. The populations quickly became disenchanted because, despite the establishment of the CLHCs, the populations did not notice a real change in the behavior of health workers. The CLHCs' lack of authority over health workers does not allow them to influence their attitudes towards the population. The pragmatic legitimacy of an institution derives from its ability to respond to the needs and interests of social actors in a specific environment. The recognition of the institution and the acceptance of its leaders would come from its effectiveness. It can be said that this crisis of legitimacy is also a crisis of effectiveness of the CLHCs (Boulle, 2013).

Another source of the CLHCs' legitimacy crisis stems from the fact that local

populations do not perceive them as structures capable of participating in the development of their locality, in the project of collective flourishing (Goodman et al., 2011; Kilewo & Frumence, 2015). The advent of a structure in a locality fosters much hope. Beyond individual interests, the structure is generally seen as an opportunity to facilitate access to certain amenities for the locality. Interactions between the CLHCs and partners could contribute to the realization of certain infrastructures for the locality, offer possibilities of access to training, create employment opportunities, and contribute to a greater visibility of the locality. We note that the CLHCs have not been able to include their actions in the dynamics of development actions so desired by the populations. The enthusiasm of the first hours has gradually faded, leaving room for doubt, discontent and even disappointment. The populations note that instead of bringing a plus in terms of support to the populations and collective projects, the CLHCs become sources of pressure on the weak means of the households, the resources of the community. The moral legitimacy based on the collective belief that the CLHCs' activities are part of the dynamics of societal well-being has had difficulty being built.

The conditions under which CLHCs were created are also a source of crisis in their legitimacy (Boulle, 2013; Kesale, Mahonge, & Muhanga, 2022; Waweru et al., 2013). They were created by the health system to facilitate the implementation of the primary health care promotion strategy. They were designed and implemented as an appendage to the health system, a mission structure that would enable health workers to achieve goals. The designers did not take into account the expectations and needs of the population in creating them. The intention was to create a structure composed of men and women from the localities where the health care facilities are located to organize and mobilize communities to serve the health care system. If we pay particular attention to their missions, we discover that the CLHCs are little concerned with the expectations of the populations. The texts that govern the CLHCs do not give them any power or resources to help local populations. Local expectations, norms and values, in short, local realities in terms of health needs have not been taken into account. This is one of the reasons for the failure of many of the so-called community structures to serve the development sectors due to lack of recognition.

5. Conclusion

Conceived as a strategy to mobilize communities and facilitate their involvement in the management of health services, with the objective of improving the provision of care, LHCCs have been a shadow of their former selves for years. They are in crisis and community participation is not working as intended. The results of the study show that the criteria that were used for their implementation did not take into account the real expectations and needs of the communities. As a result, they did not address the real and daily health problems faced by the population. As a result, they have not had the support they need to function

fully. Both their composition and their mode of operation did not meet the social norms and aspirations of the population. The CLHCs were not perceived as community structures that help improve conditions of access to health care, but rather as a mechanism put in place by health workers with the complicity of certain members of the population to use the resources of the health facilities for their own interests. The population has developed a relationship based on doubt, mistrust and, in some places, hostility towards the CLHCs. The conditions under which the CLHCs were created and operated did not favor the development of relationships of trust between the CLHCs and the population. This crisis of trust has led to a crisis of legitimacy.

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Data Availability

The article contains all of the data necessary to support the results. Thus, no additional data sources are required.

Conflicts of Interest

The authors state that no conflict of interest exists in connection with the publishing of this article.

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