Review of Village Health Committee Functions and Their Impact on Primary Care Strengthening Efforts

FUNMI EKO EZEH[1], STEPHANIE ONYEKACHI OPARAH[2]
[1]*Sickle Cell Foundation, Lagos Nigeria*
[2]*Independent Researcher, Lagos Nigeria*

Abstract- ***Village Health Committees have emerged as critical institutional mechanisms for strengthening primary healthcare delivery systems in low- and middle-income countries, representing a pivotal bridge between formal healthcare infrastructure and community-level health needs. This comprehensive review examines the multifaceted functions of Village Health Committees and systematically analyzes their impact on primary care strengthening efforts across diverse geographical and socioeconomic contexts. The evolution of community-based health governance structures reflects a fundamental shift from top-down healthcare delivery models toward participatory approaches that recognize communities as active stakeholders in health system design, implementation, and monitoring (Zakus & Lysack, 1998; Bender & Pitkin, 1987). Village Health Committees perform essential functions including health needs assessment, resource mobilization, health worker supervision, community health education, and advocacy for improved service delivery (George et al., 2015). These committees serve as organizational platforms for translating national health policies into locally relevant interventions while simultaneously channeling community priorities upward to district and national health planning bodies (Marsh et al., 2008; Grundy, 2010). The effectiveness of Village Health Committees in strengthening primary care depends critically on factors such as governance structures, training adequacy, resource availability, intersectoral collaboration, and integration with formal health systems (Kok et al., 2015). Evidence demonstrates that well-functioning Village Health Committees contribute significantly to improved immunization coverage (Bonu et al., 2003; Ladner et al., 2014), enhanced maternal and child health outcomes (Black et al., 2017), increased health service utilization, and strengthened community ownership of health programs (Shediac-Rizkallah & Bone, 1998). However, substantial challenges persist including inadequate financial resources, insufficient training, unclear role delineation, political interference, and weak linkages with formal health facilities (Nkomazana et al., 2015). This review synthesizes evidence from multiple contexts to provide a comprehensive understanding of how Village Health Committees function as instrumental vehicles for primary care strengthening, identifies critical success factors, and proposes evidence-based recommendations for optimizing their contributions to health system resilience and community health improvement (Vanselow et al., 1996; Wallerstein et al., 2015).***

Keywords: ***Village Health Committees, Primary Healthcare, Community Participation, Health Governance, Health Systems Strengthening, Community Health Workers, Participatory Health Planning, Health Service Delivery***

I. INTRODUCTION

The revitalization of primary healthcare as the foundation of health systems represents one of the most significant developments in global health policy over the past several decades, with community participation recognized as an indispensable element of effective and sustainable health service delivery (Starfield et al., 2005). Village Health Committees have emerged as key institutional mechanisms for operationalizing community participation principles within primary healthcare frameworks, serving as organizational platforms that bridge the gap between formal health systems and community health needs (Bender & Pitkin, 1987). These committees represent structured attempts to institutionalize community voice in health planning, implementation, and accountability processes, moving beyond tokenistic

consultation toward genuine community empowerment in health governance (Rosato et al., 2008). The establishment of Village Health Committees reflects broader recognition that sustainable improvements in population health outcomes require active community engagement rather than passive receipt of externally designed health interventions (Farnsworth et al., 2014).

Primary healthcare strengthening efforts have increasingly focused on creating enabling environments for community participation, recognizing that technical interventions alone cannot address the complex social, economic, and political determinants of health that operate at community levels (Bitton et al., 2017). Village Health Committees function as critical nodes in health system architecture, performing diverse roles that include health needs assessment, priority setting, resource mobilization, health worker support and supervision, health promotion, disease surveillance, and advocacy for improved service quality (Haines et al., 2007). The effectiveness of these committees in fulfilling their multiple mandates depends on numerous factors including governance structures, capacity building investments, resource availability, political commitment, and integration with formal health system structures (Kok et al., 2015). Understanding how Village Health Committees function and identifying factors that enhance or constrain their contributions to primary care strengthening remains essential for optimizing their potential as vehicles for health system transformation (George et al., 2015).

The conceptual foundations of Village Health Committees derive from longstanding recognition that health is produced through interactions between formal healthcare services and broader community conditions, requiring collaborative approaches that engage multiple actors beyond health facilities (Longlett et al., 2001). Community participation in health has evolved from early vertical disease control programs toward more comprehensive approaches that recognize communities as partners in health system design and governance rather than merely recipients of services (Atkinson et al., 2011). Village Health Committees operationalize this partnership by creating formal structures through which community members can contribute to health system functioning, bringing local knowledge, social networks, and accountability mechanisms into health planning and delivery processes (Draper et al., 2010). These committees represent attempts to democratize health governance by ensuring that community voices influence resource allocation decisions, service delivery priorities, and quality improvement initiatives (Chaskin, 2001).

The global health landscape has witnessed renewed emphasis on strengthening primary healthcare systems as essential foundations for achieving universal health coverage and health security, with community participation recognized as a core principle of effective primary care (Kuruvilla et al., 2016). Village Health Committees contribute to primary care strengthening through multiple pathways including enhancing service accessibility, improving cultural appropriateness of interventions, strengthening demand for health services, mobilizing community resources, and creating accountability mechanisms that improve service quality (Shi, 2012). These committees serve as platforms for integrating vertical disease-specific programs into comprehensive primary care approaches, helping to overcome fragmentation that undermines health system efficiency and effectiveness (Iwelunmor et al., 2015). The proliferation of Village Health Committees across diverse contexts reflects growing consensus that sustainable health improvements require institutional mechanisms for sustained community engagement rather than episodic participation in specific projects (Sacks et al., 2019).

Empirical evidence regarding Village Health Committee effectiveness in strengthening primary care remains mixed, with substantial variation in outcomes across different contexts and implementation models (George et al., 2015). Some studies demonstrate significant improvements in health service utilization, immunization coverage, maternal and child health outcomes, and community satisfaction with health services in settings with active Village Health Committees (Olayo et al., 2014). Other research highlights persistent challenges including inadequate training, insufficient resources, unclear mandates, weak linkages with formal health systems, and elite capture of committee functions by local power brokers (Nkomazana et al., 2015). Understanding this variation requires careful analysis

of contextual factors, implementation processes, and enabling conditions that determine whether Village Health Committees function effectively as community participation mechanisms or become symbolic structures with limited substantive impact (Kolopack et al., 2015). Systematic examination of Village Health Committee functions and their relationship to primary care outcomes can inform efforts to optimize these structures as vehicles for health system strengthening (O'Mara-Eves et al., 2013).

The relationship between Village Health Committees and health worker performance represents a particularly important dimension of primary care strengthening, as these committees often play supervisory and support roles for community health workers and other frontline providers (Kok et al., 2015). Effective Village Health Committees can enhance health worker motivation through community recognition, provide problem-solving support for operational challenges, mobilize resources that enable health workers to perform their duties, and create accountability mechanisms that improve service quality (Dieleman et al., 2003). However, unclear role delineation between Village Health Committees and health workers can create tensions, while inadequately trained committee members may provide unhelpful direction that undermines rather than supports health worker effectiveness (Strachan et al., 2012). Examining how Village Health Committees interact with health workforce elements provides insights into mechanisms through which community participation structures influence primary care delivery quality and continuity (Gilmore & McAuliffe, 2013).

Financial sustainability represents a critical challenge for Village Health Committee functioning, as many committees lack dedicated budgets and depend on volunteer contributions of time and resources from committee members (Shediac-Rizkallah & Bone, 1998). This resource constraint limits committee capacity to undertake activities, creates dependency on external project funding that may not be sustained, and contributes to volunteer fatigue that undermines committee continuity (Sarriot et al., 2004). Some successful models demonstrate that even modest financial allocations to Village Health Committees can significantly enhance their functionality by enabling transportation for supervisory visits, materials for health education activities, and recognition of volunteer contributions (McArthur-Lloyd et al., 2016). Understanding resource requirements for effective Village Health Committee functioning and identifying sustainable financing mechanisms represents an important priority for strengthening community participation in primary care (Iwelunmor et al., 2015).

The governance dimensions of Village Health Committees substantially influence their effectiveness as primary care strengthening mechanisms, including committee composition, selection processes, decision-making procedures, and accountability relationships (Bossert & Beauvais, 2002). Democratic selection processes that ensure representation of marginalized groups including women, ethnic minorities, and economically disadvantaged populations enhance committee legitimacy and effectiveness in addressing health equity (Balarajan et al., 2011). Clear delineation of roles, responsibilities, and authority between Village Health Committees and formal health system structures prevents confusion and conflict that can undermine committee functioning (Grundy, 2010). Regular elections, transparent decision-making processes, and accountability mechanisms that make committees answerable to both communities and health authorities contribute to sustained effectiveness over time (Minkler et al., 2001). Examining governance arrangements that enable Village Health Committees to function effectively as community participation mechanisms provides practical guidance for strengthening these structures (Jagosh et al., 2012).

Integration of Village Health Committees with formal health system structures represents another critical determinant of their impact on primary care strengthening, as isolated committees disconnected from health planning and resource allocation processes have limited influence on health service delivery (Li et al., 2017). Effective integration requires establishing clear communication channels between Village Health Committees and health facilities, incorporating committee input into district health planning processes, and creating feedback mechanisms that demonstrate responsiveness to community priorities (Ryman et al., 2010). Some health systems have developed systematic frameworks for Village Health Committee engagement in health facility management committees, district health

boards, and national health policy dialogues, creating nested governance structures that amplify community voice (Hutchison et al., 2011). Understanding how to effectively integrate Village Health Committees into broader health governance architecture without co-opting them into bureaucratic structures that diminish their community accountability represents an ongoing challenge (Tripathy et al., 2010).

The capacity building requirements for effective Village Health Committee functioning have received increasing attention, as committees composed of volunteers with limited formal education require substantial training and ongoing support to perform their multiple functions competently (Patel & Nowalk, 2010). Training needs include understanding of primary healthcare principles, health needs assessment methodologies, basic epidemiology for disease surveillance, financial management, meeting facilitation, conflict resolution, and advocacy skills (Stamidis et al., 2019). However, one-time training events have proven insufficient for sustaining committee capacity, with successful models emphasizing ongoing mentorship, refresher training, and peer learning networks that enable committees to continuously improve their effectiveness (Assegaai & Schneider, 2019). Examining effective approaches to Village Health Committee capacity building and identifying sustainable support mechanisms represents an important area for strengthening community participation in primary care (Dubé et al., 2018).

This comprehensive review examines Village Health Committee functions and their impact on primary care strengthening efforts by synthesizing evidence from diverse geographical contexts and implementation models. The review analyzes how Village Health Committees perform their multiple functions including health needs assessment, planning, resource mobilization, health worker supervision, health promotion, and advocacy. It examines factors that enable or constrain committee effectiveness including governance arrangements, capacity building approaches, resource availability, and integration with formal health systems. The review identifies evidence regarding Village Health Committee impact on primary care outcomes including service utilization, health outcomes, equity, and sustainability. It explores challenges and barriers that limit committee effectiveness and proposes evidence-based recommendations for optimizing Village Health Committee contributions to primary care strengthening. By providing comprehensive analysis of Village Health Committee functioning and impact, this review aims to inform policy and practice efforts to strengthen community participation as a foundation for resilient and responsive primary healthcare systems (Vanselow et al., 1996).

II. LITERATURE REVIEW

The literature on community participation in health has evolved substantially over recent decades, moving from conceptual advocacy for participation toward empirical examination of specific mechanisms through which communities engage with health systems and the impacts of such engagement on health outcomes (Wallerstein et al., 2015). Village Health Committees represent one of the most widely implemented institutional mechanisms for operationalizing community participation, yet systematic evidence regarding their functioning and effectiveness remains scattered across diverse studies from multiple disciplines including public health, health policy, sociology, and development studies (George et al., 2015). Early literature on community participation emphasized normative arguments regarding democratic rights of communities to participate in decisions affecting their health, while more recent scholarship has focused pragmatically on identifying conditions under which participatory mechanisms produce measurable improvements in health system performance and population health outcomes (Draper et al., 2010).

Foundational work on primary healthcare established community participation as a core principle, arguing that sustainable health improvements require active community involvement rather than passive receipt of externally delivered services (Vanselow et al., 1996). This principle found expression in numerous international declarations and national health policies, with Village Health Committees emerging as practical structures for implementing participation commitments (World Health Organization, 2012). However, early implementations often reflected confusion between genuine participation involving community power in decision-making and more

limited forms of community involvement such as volunteering for program activities or attending health education sessions (Zakus & Lysack, 1998). Scholarly critiques highlighted risks of tokenistic participation that created appearance of community engagement without substantive transfer of decision-making authority, leading to refined conceptualizations distinguishing degrees and types of participation (Chaskin, 2001).

Systematic reviews examining community participation interventions have documented significant heterogeneity in both intervention designs and outcome measures, making synthesis challenging (O'Mara-Eves et al., 2013). Some reviews focused specifically on community health worker programs found positive effects on immunization coverage, maternal and child health outcomes, and communicable disease control, with community participation structures enhancing health worker effectiveness through supervision, support, and accountability mechanisms (Lewin et al., 2010). Other reviews examining broader community participation interventions identified improvements in health service utilization, patient satisfaction, and health system responsiveness to community needs, though effect sizes varied substantially across contexts (Mockford et al., 2012). Meta-analyses have been complicated by diversity of participation models, outcome measures, and study designs, with calls for more standardized approaches to measuring and reporting community participation interventions (Brunton et al., 2017).

Literature examining Village Health Committee functions has identified multiple roles these structures perform within primary healthcare systems, though the specific configuration of functions varies across contexts (Kok et al., 2015). Commonly identified functions include conducting health needs assessments to identify community priorities, participating in health planning processes at village and district levels, mobilizing community resources including finances and volunteer labor for health activities, supervising and supporting community health workers, conducting health education and promotion activities, participating in disease surveillance and outbreak response, advocating with health authorities for improved service delivery, and monitoring health service quality (Olayo et al., 2014). The breadth of functions assigned to Village Health Committees reflects ambitious expectations regarding their contributions to health systems, though questions persist regarding whether volunteer committees can realistically perform all assigned responsibilities without adequate training and resources (Nkomazana et al., 2015).

Research on Village Health Committee composition and governance has examined how committee structure influences effectiveness in representing community interests and performing assigned functions (Minkler et al., 2001). Studies document substantial variation in committee size, selection processes, term lengths, meeting frequencies, and decision-making procedures across different countries and health systems (Bossert & Beauvais, 2002). Some evidence suggests that committees selected through democratic community processes demonstrate greater legitimacy and effectiveness than those appointed by external authorities, though democratic processes require investments in civic education and electoral management (Hodgkinson et al., 2017). Representation of marginalized groups including women, ethnic minorities, and economically disadvantaged populations on Village Health Committees appears important for ensuring committees address health equity concerns, though achieving inclusive representation often requires deliberate affirmative action measures (Balarajan et al., 2011). Research has also examined optimal committee size, with larger committees offering broader representation but facing coordination challenges, while smaller committees enable more efficient decision-making but risk excluding important constituencies (Chen et al., 2014).

The relationship between Village Health Committees and health workforce elements has received substantial scholarly attention, given the central role many committees play in supporting and supervising community health workers (Haines et al., 2007). Literature documents that Village Health Committees can enhance health worker motivation through community recognition and support, provide problem-solving assistance for operational challenges, mobilize resources that enable health workers to perform their functions, and create accountability mechanisms that

improve service quality (Gilmore & McAuliffe, 2013). However, studies also identify potential tensions arising from unclear role delineation, with health workers sometimes resenting supervision by committee members they perceive as lacking relevant expertise (Strachan et al., 2012). Research examining successful models of committee-health worker collaboration emphasizes importance of clear role definition, mutual respect, regular communication, and recognition that both committees and health workers contribute complementary competencies to primary care delivery (Dieleman et al., 2003).

Empirical evidence regarding Village Health Committee impact on health outcomes and health system performance demonstrates mixed results across different contexts and implementation models (George et al., 2015). Studies from South Asia have documented improvements in immunization coverage, maternal health service utilization, and neonatal mortality in areas with active Village Health Committees implementing participatory women's groups (Manandhar et al., 2004). Research from sub-Saharan Africa has shown that Village Health Committees contribute to improved TB case detection, enhanced malaria prevention, and increased uptake of HIV services when effectively integrated with disease control programs (Anyebe et al., 2018). However, other studies have found limited impact of Village Health Committees on health outcomes in contexts characterized by inadequate training, insufficient resources, weak integration with formal health systems, or elite capture of committee functions (Nkomazana et al., 2015). This variation highlights importance of implementation quality and contextual enabling factors in determining Village Health Committee effectiveness (Kolopack et al., 2015).

Literature on capacity building for Village Health Committees emphasizes that committees composed of volunteers with limited formal education require substantial training and ongoing support to perform their multiple functions competently (Patel & Nowalk, 2010). Training content commonly includes primary healthcare principles, health needs assessment methodologies, basic epidemiology, financial management, meeting facilitation, conflict resolution, and advocacy skills (Stamidis et al., 2019). However, research consistently demonstrates that one-time training events prove insufficient for sustained capacity, with effective models emphasizing ongoing mentorship, refresher training, performance feedback, and peer learning networks (Assegaai & Schneider, 2019). Studies have also examined optimal training modalities, with evidence suggesting that experiential learning through supervised practice proves more effective than classroom instruction alone, and that training of entire committees as units enhances collective capacity more than training individual members (Dubé et al., 2018).

The sustainability of Village Health Committees represents a significant concern in literature, with many committees becoming inactive after initial enthusiasm wanes or external project support ends (Shediac-Rizkallah & Bone, 1998). Research has identified multiple factors contributing to committee sustainability including secure financing mechanisms, ongoing capacity building, clear integration with formal health systems, visible impact on community health, community recognition of committee contributions, and political support from local government (Sarriot et al., 2004). Studies document that volunteer fatigue represents a major threat to sustainability, with committee members becoming discouraged when their efforts produce limited results due to resource constraints or when their recommendations receive no response from health authorities (McArthur-Lloyd et al., 2016). Some successful models demonstrate that even modest financial allocations to Village Health Committees for operational expenses significantly enhance sustainability by reducing burden on volunteers and enabling committees to undertake planned activities (Iwelunmor et al., 2015).

Literature examining Village Health Committee integration with formal health systems highlights that isolated committees disconnected from health planning and resource allocation processes exert limited influence on health service delivery (Li et al., 2017). Effective integration requires establishing clear communication channels between committees and health facilities, incorporating committee input into district health planning processes, creating feedback mechanisms demonstrating responsiveness to community priorities, and including committee representatives in health facility management

structures (Ryman et al., 2010). Research from countries with well-developed community health strategies shows that systematic frameworks creating nested governance structures from village to national levels amplify community voice in health policy while maintaining community accountability (Hutchison et al., 2011). However, integration efforts must carefully balance incorporation of community perspectives into formal structures while avoiding co-optation that transforms committees into government arms detached from community constituencies (Tripathy et al., 2010).

Scholarly work examining political economy dimensions of Village Health Committees recognizes that these structures operate within broader political contexts characterized by power differentials, resource competition, and conflicting interests (Menson et al., 2018). Research documents risks of elite capture whereby local power brokers dominate committees to advance personal agendas rather than community health interests (Umoren et al., 2019). Studies also examine how Village Health Committees interact with traditional leadership structures, religious authorities, and other community institutions, with evidence suggesting that committees function most effectively when they complement rather than compete with existing governance structures (Marsh et al., 2008). Literature on Village Health Committees in decentralized health systems explores how devolution of authority to local governments creates opportunities for enhanced community participation but also risks fragmenting health systems and exacerbating inequities if local capacity and resources prove inadequate (Bossert & Beauvais, 2002).

Gender dimensions of Village Health Committee functioning have received increasing scholarly attention, recognizing that women often comprise majority of committee members yet may face barriers to exercising leadership due to patriarchal social norms (Patel et al., 2010). Research documents that women's participation in Village Health Committees can enhance attention to maternal and child health priorities and improve cultural appropriateness of reproductive health interventions (Prost et al., 2013). However, studies also show that women committee members often face time constraints due to domestic responsibilities, exclusion from decision-making despite formal membership, and social sanctions for challenging traditional authority structures (Manandhar et al., 2004). Literature examining strategies for strengthening women's voice in Village Health Committees emphasizes importance of leadership training specifically for women members, deliberate creation of space for women to speak in meetings, and engagement with male community members to build support for women's participation (Tripathy et al., 2010).

Technology adoption by Village Health Committees represents an emerging area of literature, examining how mobile phones, tablets, and digital platforms can enhance committee functioning (Menson et al., 2018). Studies document that mobile technology can facilitate communication between committees and health workers, enable real-time disease surveillance reporting, support data-driven decision-making, and strengthen supervision of community health activities (Nwaimo et al., 2019). However, research also identifies barriers to technology adoption including limited digital literacy, inadequate infrastructure, costs of devices and connectivity, and concerns regarding data privacy (Uzozie et al., 2019). Literature examining successful technology integration emphasizes importance of user-centered design, adequate training and technical support, and alignment of technology tools with committee workflows and needs (Bukhari et al., 2019).

Evaluation challenges represent a persistent theme in Village Health Committee literature, with scholars noting difficulties in attributing health outcomes to committee activities given multiple confounding factors and long causal chains between committee functions and population health impacts (Fasasi et al., 2019). Methodological literature emphasizes value of theory-driven evaluation approaches that articulate how Village Health Committees are expected to influence health system functioning and health outcomes, enabling assessment of whether anticipated mechanisms operate as theorized (Jagosh et al., 2012). Some researchers advocate for realist evaluation methods that examine what works for whom in which circumstances, recognizing that Village Health Committee effectiveness depends on contextual factors and implementation processes (Greenhalgh et al., 2016). Literature also discusses importance of

evaluating process indicators including committee meeting frequency, member attendance, community participation in committee activities, and relationships with health workers, in addition to outcome indicators, to understand how committees function and identify improvement opportunities (Draper et al., 2010).

Comparative literature examining Village Health Committees across different countries and health systems provides insights into how macro-level factors influence committee functioning (Li et al., 2017). Studies document that centralized health systems often struggle to create space for genuine community participation, while decentralized systems provide opportunities for community engagement but may lack coordination and equity (Hutchison et al., 2011). Research comparing Village Health Committees in different political regimes suggests that democratic governance contexts enable more authentic community participation, while authoritarian contexts tend toward co-optation of committees as government implementation arms (Umezurike & Iwu, 2017). Literature examining economic determinants shows that well-resourced health systems can provide financial and technical support enabling effective committee functioning, while resource-constrained systems often establish committees without adequate investment in their capacity and sustainability (Balogun et al., 2019; Umezurike and Ogunnubi, 2016). Cross-national research emphasizes importance of adapting Village Health Committee models to local contexts rather than implementing standardized approaches without attention to political, economic, social, and cultural conditions (Hunter et al., 2018).

III. METHODOLOGY

This comprehensive review employed a systematic approach to identifying, analyzing, and synthesizing evidence regarding Village Health Committee functions and their impact on primary care strengthening efforts. The methodological framework integrated elements of systematic review methodology with narrative synthesis approaches to accommodate the diverse nature of evidence on this topic, which spans multiple disciplines and employs varied research designs (O'Mara-Eves et al., 2013). The review process encompassed multiple stages including development of conceptual framework, comprehensive literature search, study selection and quality assessment, data extraction and synthesis, and interpretation of findings in relation to primary care strengthening objectives (Brunton et al., 2017). This multi-stage approach enabled rigorous examination of Village Health Committee functioning while maintaining flexibility to incorporate diverse types of evidence including quantitative studies, qualitative research, mixed-methods investigations, and program evaluation reports (Greenhalgh et al., 2016).

The conceptual framework guiding this review drew upon established theories of community participation, health systems strengthening, and primary healthcare to articulate anticipated relationships between Village Health Committee functions and primary care outcomes (Wallerstein et al., 2015). The framework conceptualized Village Health Committees as organizational structures situated at the interface between communities and formal health systems, performing bridging functions that connect community health needs with health service delivery (Bender & Pitkin, 1987). Key functions identified in the framework included health needs assessment and priority setting, health planning and resource allocation, community resource mobilization, health worker supervision and support, health education and promotion, disease surveillance and outbreak response, advocacy for improved services, and health system accountability (George et al., 2015). The framework posited that these functions contribute to primary care strengthening through multiple pathways including enhanced service accessibility, improved service quality, increased community ownership, strengthened health workforce performance, and more equitable resource allocation (Starfield et al., 2005).

The literature search strategy employed multiple complementary approaches to maximize identification of relevant studies given the scattered nature of Village Health Committee literature across diverse publication venues (Farnsworth et al., 2014). Database searches encompassed major health and social science databases recognizing the multidisciplinary nature of community participation research (Mockford et al., 2012). Search terms combined concepts related to community participation, primary healthcare, health committees, and health system strengthening using

both controlled vocabulary and free-text terms adapted for each database (George et al., 2015). The search strategy deliberately employed broad terms to capture literature using diverse terminologies for similar community participation structures across different countries and contexts (Draper et al., 2010). Supplementary search strategies included hand-searching key journals focusing on primary healthcare and health systems, reviewing reference lists of included studies and relevant reviews to identify additional sources, and consulting with experts to identify unpublished reports and grey literature (O'Mara-Eves et al., 2013).

Study selection proceeded through multiple stages employing explicit inclusion and exclusion criteria to ensure systematic and transparent decision-making (Brunton et al., 2017). Initial screening based on titles and abstracts excluded clearly irrelevant citations while retaining potentially relevant studies for full-text review (Greenhalgh et al., 2016). Full-text screening applied detailed inclusion criteria including focus on Village Health Committees or analogous community health governance structures, examination of committee functions or health system impacts, and publication prior to the review reference year to ensure temporal appropriateness (Jagosh et al., 2012). Studies were included regardless of research design to capture diverse types of evidence, with separate quality assessment procedures applied to different study types (Kolopack et al., 2015). Exclusion criteria eliminated studies focusing exclusively on community health workers without examining committee governance structures, studies examining only provider-level quality improvement committees rather than community-based structures, and studies published after the review reference date (O'Mara-Eves et al., 2013).

Quality assessment procedures adapted established critical appraisal tools to diverse study designs represented in the included literature (George et al., 2015). Quantitative studies underwent assessment of methodological rigor including study design appropriateness, sample size adequacy, measurement validity, confounding control, and completeness of reporting (Brunton et al., 2017). Qualitative studies were evaluated regarding methodological transparency, data collection appropriateness, analytical rigor, reflexivity, and credibility of findings (Greenhalgh et al., 2016). Mixed-methods studies received assessment of both quantitative and qualitative components plus evaluation of integration between methodological approaches (Kolopack et al., 2015). Program evaluation reports and case studies underwent assessment of descriptive completeness, analytical depth, and transferability of findings to other contexts (Draper et al., 2010). Quality assessment informed synthesis by highlighting studies with strong methodological foundations while noting limitations that might affect confidence in findings (O'Mara-Eves et al., 2013).

Data extraction employed structured templates capturing key information from each included study while maintaining flexibility to accommodate diverse study types and reporting formats (Brunton et al., 2017). Extracted information included study characteristics such as geographical location, healthcare system context, population characteristics, and time period (George et al., 2015). Methodological details encompassed research design, sampling approach, data collection methods, analytical techniques, and study limitations (Greenhalgh et al., 2016). Substantive data extraction focused on Village Health Committee characteristics including composition, governance arrangements, functions performed, and integration with health systems (Jagosh et al., 2012). Information regarding committee impacts on primary care encompassed effects on service utilization, health outcomes, service quality, equity, community satisfaction, health worker performance, and sustainability (Kolopack et al., 2015). Extraction templates also captured information on implementation challenges, enabling factors, and recommendations for strengthening Village Health Committee contributions to primary care (O'Mara-Eves et al., 2013).

The synthesis approach combined systematic tabulation of extracted data with narrative synthesis methods appropriate for heterogeneous evidence bases (Brunton et al., 2017). Tabulation organized studies by key characteristics enabling identification of patterns across contexts, populations, and implementation models (George et al., 2015). Narrative synthesis employed structured procedures including developing preliminary synthesis of findings, exploring

relationships within and between studies, and assessing robustness of synthesis through sensitivity analyses considering study quality and methodological approach (Greenhalgh et al., 2016). The synthesis examined Village Health Committee functions systematically, analyzing how committees perform each key function, factors influencing performance, and relationships between functional performance and primary care outcomes (Jagosh et al., 2012). Synthesis of impact evidence organized findings by outcome domains including health service utilization, population health outcomes, service quality, equity, and sustainability, while attending to contextual factors that might explain variation in impacts across settings (Kolopack et al., 2015).

Methodological challenges encountered during the review included substantial heterogeneity in terminology used to describe community health governance structures across different countries and health systems, requiring careful assessment to determine whether structures described using varied names performed functions comparable to Village Health Committees (Draper et al., 2010). Studies also varied considerably in their focus, with some examining committee structure and processes while others assessed impacts on specific health outcomes, necessitating integration of process and outcome evidence from different studies (O'Mara-Eves et al., 2013). The quality of included studies ranged from rigorously designed evaluations to descriptive program reports, requiring careful consideration of appropriate weight to assign different types of evidence (George et al., 2015). Geographic concentration of available evidence in certain regions while other areas remained understudied complicated efforts to develop generalizable conclusions, highlighting need for caution in extrapolating findings across diverse contexts (Li et al., 2017).

Addressing these methodological challenges required several strategic decisions regarding synthesis approach and interpretation (Brunton et al., 2017). The review adopted an inclusive approach to study selection, incorporating diverse evidence types while using quality assessment to inform confidence in findings rather than arbitrarily excluding studies based on design features (Greenhalgh et al., 2016). Synthesis distinguished between strongly supported findings based on multiple high-quality studies and tentative conclusions based on limited or methodologically weak evidence (Jagosh et al., 2012). The review explicitly considered contextual factors that might influence Village Health Committee functioning and impact, avoiding simplistic generalizations while identifying patterns that appeared relatively consistent across settings (Kolopack et al., 2015). Interpretation of findings emphasized practical implications for strengthening Village Health Committee contributions to primary care while acknowledging persistent evidence gaps requiring additional research (O'Mara-Eves et al., 2013).

3.1 VILLAGE HEALTH COMMITTEE ORGANIZATIONAL STRUCTURES AND GOVERNANCE MODELS

Village Health Committees exhibit considerable diversity in organizational structures and governance arrangements across different health systems, reflecting adaptation to local political, social, and administrative contexts while maintaining core participatory principles (Bossert & Beauvais, 2002). Understanding structural and governance variations provides essential insights into how different configurations influence committee functioning and effectiveness in strengthening primary care delivery (Minkler et al., 2001). Committee composition typically ranges from seven to fifteen members, with deliberate attention to ensuring representation of key community constituencies including women, youth, ethnic minorities, religious groups, and economically disadvantaged populations (Balarajan et al., 2011). Many health systems mandate minimum female representation on committees recognizing that women comprise majority of health service users and possess particular insights regarding maternal and child health needs, though achieving meaningful women's participation beyond tokenistic representation requires addressing broader gender equity issues (Patel et al., 2010). Some models designate specific positions for traditional leaders, religious authorities, or teachers to leverage their community influence for health promotion, while other models emphasize democratic selection without predetermined positions to allow communities to choose representatives based on local considerations (Chaskin, 2001).

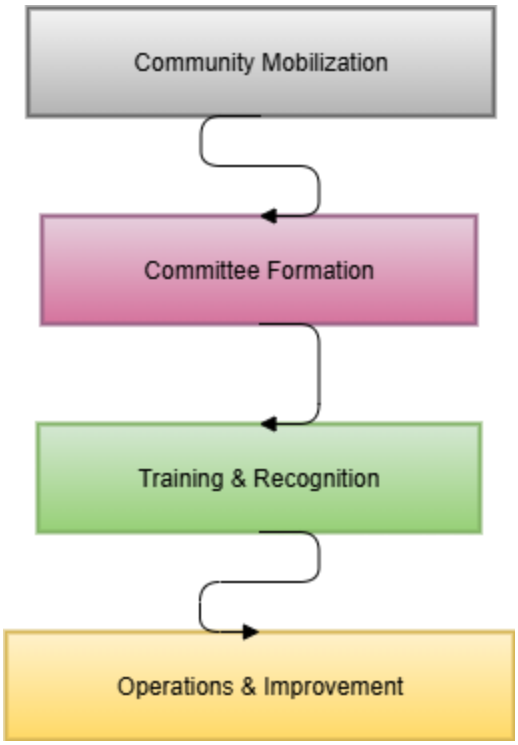

Figure 1: Village Health Committee Formation and Operational Framework
Source: Author

Selection processes for Village Health Committee members vary substantially, with important implications for committee legitimacy and accountability (Minkler et al., 2001). Democratic election through community meetings represents the most common approach in health systems emphasizing participatory governance, with communities convening to nominate and select committee members through voting or consensus processes (Hodgkinson et al., 2017; Didi et al., 2019). This approach enhances committee legitimacy by ensuring members possess community mandate, though it requires facilitation to prevent domination by local elites or capture by political factions (Umoren et al., 2019). Some models employ a mixed approach whereby communities elect majority of members while health authorities appoint specific members with relevant expertise such as health workers or individuals with health education backgrounds (Grundy, 2010; Umezurike & Ogunnubi, 2016). Appointment by local government officials represents another approach, more common in centralized health systems or areas with weak civil society, though appointed committees may lack community accountability and struggle to mobilize community engagement (Umezurike & Iwu, 2017).

Table 1: Comparative Analysis of Village Health Committee Governance Models

Governance Model	Selection Mechanism	Term Length	Accountability Structure	Strengths	Limitations
Community-Elected Democratic	Open community meeting with voting	2–3 years with re-election possibility	Primarily to community with reporting to health authorities	High legitimacy, strong community ownership, responsive to local priorities, sustainable motivation	Risk of elite capture, potential for political interference, variability in member capacity
Government-Appointed Administrative	District health office appointment based on criteria	3–5 years at discretion of authorities	Primarily to health authorities with community information sharing	Consistent membership criteria, easier coordination with health system, predictable structure	Weak community accountability, lower legitimacy, reduced community mobilization, sustainability concerns

Mixed Participatory	Partial community election plus designated positions for key stakeholders	2–4 years staggered terms	Dual accountability to community and health system	Balances representation and expertise, bridges community-system divide, maintains legitimacy while enabling coordination	Complexity in selection process, potential role confusion, requires careful balance of composition
Health Worker-Led Service Model	Ex-officio membership for health facility staff with community member co-option	Indefinite based on health worker assignment	Primarily to health system with community consultation	Strong technical capacity, close health facility linkage, consistent membership	Limited community empowerment, risk of provider domination, reduced community ownership

Committee term lengths and leadership structures similarly demonstrate variation across contexts, with implications for institutional memory, continuity, and democratic accountability (Bossert & Beauvais, 2002). Fixed terms ranging from two to five years with eligibility for re-election represent common practice, balancing benefits of continuity through experienced members with democratic accountability through regular elections (Minkler et al., 2001). Some models establish term limits to prevent entrenchment of particular individuals and create opportunities for broader community participation, though this risks loss of institutional knowledge and relationships with health system partners (Chaskin, 2001). Leadership structures typically include chairperson, vice-chairperson, secretary, and treasurer positions, with some models rotating these positions among members to distribute responsibility and build broader leadership capacity (Hodgkinson et al., 2017). Gender considerations in leadership selection have gained attention, with evidence suggesting that male dominance of leadership positions can marginalize women members even when women constitute numerical majority, leading some systems to mandate female chairpersons or rotate leadership between men and women (Balarajan et al., 2011).

Meeting frequency and procedures represent important governance dimensions influencing Village Health Committee effectiveness in fulfilling their multiple functions (Draper et al., 2010). Most committees conduct monthly meetings to review health activities, discuss community health concerns, plan upcoming activities, and coordinate with health workers, though actual meeting frequency often falls short of intended schedules due to competing member demands and limited resources for meeting facilitation (Nkomazana et al., 2015). Meeting procedures vary from highly structured approaches following formal parliamentary procedures to more informal participatory processes emphasizing consensus-building, with appropriateness depending on cultural context and member literacy levels (Minkler et al., 2001). Some successful models employ participatory meeting methodologies that ensure all members contribute to discussions and decisions rather than deferring to dominant personalities, using techniques such as small group discussions, visual tools for illiterate members, and explicit solicitation of input from quieter members (Jagosh et al., 2012).

Documentation and reporting requirements for Village Health Committees serve accountability functions while potentially imposing bureaucratic burdens that overwhelm volunteer committees with limited literacy and administrative capacity (Sarriot et al., 2004). Many health systems require committees to maintain meeting minutes, activity reports, and financial records, with periodic submission to district health authorities for oversight and planning purposes (Grundy, 2010). However, research documents that documentation requirements often go unfulfilled due

to limited secretarial capacity, lack of materials, and poor understanding of record-keeping importance, undermining both committee accountability and ability of health authorities to learn from committee experiences (Nkomazana et al., 2015). Some models address this challenge by providing simplified reporting templates, training specifically focused on documentation, and regular review of records by district mentors who provide supportive feedback rather than punitive oversight (Assegaai & Schneider, 2019).

Financial governance arrangements critically influence Village Health Committee sustainability and effectiveness, with most committees operating on minimal or zero budgets that constrain their ability to undertake planned activities (Shediac-Rizkallah & Bone, 1998). Funding models vary from complete reliance on volunteer contributions and community resource mobilization to provision of government grants or integration into decentralized health financing mechanisms (Sarriot et al., 2004). Evidence suggests that even modest financial allocations enabling committees to cover meeting expenses, transportation for supervisory visits, and materials for health education activities significantly enhance functionality and sustainability compared to entirely voluntary arrangements (McArthur-Lloyd et al., 2016). Some successful models provide quarterly disbursements to committees based on approved work plans and satisfactory performance of assigned functions, creating incentives for effectiveness while maintaining accountability (Iwelunmor et al., 2015). Financial management training represents an essential component of committee capacity building, as mismanagement of funds can undermine community trust and committee legitimacy regardless of resource amounts involved (Stamidis et al., 2019).

Integration mechanisms linking Village Health Committees with formal health system structures substantially determine their influence on primary care delivery and policy (Li et al., 2017). Vertical integration through hierarchical reporting relationships connecting village committees to facility health committees, sub-district health management teams, district health boards, and potentially national health councils creates channels for community voice to influence health system functioning at multiple levels (Ryman et al., 2010). Horizontal integration through partnerships with other village-level structures such as local government councils, school management committees, water committees, and agricultural extension services enables comprehensive approaches addressing social determinants of health beyond healthcare services alone (National Academies of Sciences, Engineering, and Medicine, 2019). Some health systems have developed sophisticated integration frameworks specifying how Village Health Committee priorities should inform facility work plans, how committee performance should be assessed by district authorities, and how resources should flow from central to village level based on demonstrated needs and capacities (Hutchison et al., 2011). However, integration efforts must carefully balance incorporation into formal structures with maintenance of community accountability that distinguishes Village Health Committees from government bureaucracies (Tripathy et al., 2010).

Legal and policy frameworks governing Village Health Committees vary substantially across countries, with implications for committee authority, sustainability, and integration into health systems (Bossert & Beauvais, 2002). Some countries have enacted specific legislation establishing Village Health Committees as statutory bodies with defined roles, responsibilities, and rights including access to health information and participation in facility management (Department of Health, 2006). National health policies in other countries incorporate Village Health Committees as core components of community health strategies without specific enabling legislation, relying on health sector regulations and administrative circulars to operationalize committee functions (Kuruvilla et al., 2016). The presence of clear legal or policy frameworks appears to strengthen Village Health Committee functioning by clarifying expectations, legitimizing committee authority, and providing basis for resource allocation, though formal frameworks alone prove insufficient without accompanying implementation support and political commitment (Grundy, 2010). Some researchers caution that overly prescriptive frameworks may constrain local adaptation necessary for committees to respond to diverse community contexts and needs (Vanselow et al., 1996).

Political economy considerations fundamentally shape Village Health Committee governance and functioning, operating within broader political structures characterized by power differentials, resource competition, and conflicting interests (Menson et al., 2018). Elite capture whereby local power brokers dominate committees to advance personal agendas rather than community health interests represents a persistent risk, particularly in contexts with weak civil society oversight and limited democratic culture (Umoren et al., 2019). Political interference in committee selection or functioning by local officials seeking to control community resources or suppress criticism of health services undermines committee independence and effectiveness (Umezurike & Iwu, 2017). Conversely, political support from local government leaders can significantly enhance committee effectiveness by facilitating resource access, legitimizing committee authority, and enabling intersectoral collaboration for health (Hunter et al., 2018). Understanding and navigating political dynamics represents an essential skill for effective Village Health Committee functioning, requiring strategic thinking about building supportive coalitions while maintaining independence to advocate for community health priorities (Marsh et al., 2008).

The relationship between Village Health Committees and traditional governance structures requires careful negotiation in many contexts, as committees represent new participatory structures introduced alongside existing traditional authorities (Chaskin, 2001). In some settings, traditional leaders serve as Village Health Committee members or provide crucial endorsement enabling committees to mobilize communities, while in other contexts tensions arise when committees challenge traditional authority or traditional structures resist sharing power with democratically selected bodies (Minkler et al., 2001). Successful models emphasize respectful engagement with traditional authorities, clear communication regarding complementary roles, and demonstration of committee benefits for entire community including traditional leaders (Marsh et al., 2008). Some health systems deliberately create linkages requiring Village Health Committee plans to be reviewed by traditional authorities before implementation, ensuring coordination while potentially constraining committee autonomy (Hodgkinson et al., 2017). Cultural sensitivity regarding appropriate forms of community organization and decision-making represents an important consideration in designing Village Health Committee governance arrangements that fit local contexts (Wallerstein et al., 2015).

Gender dynamics within Village Health Committee governance merit particular attention given that women often constitute numerical majority of committee members yet face barriers to exercising leadership and influence in patriarchal contexts (Patel et al., 2010). Research documents multiple forms of gendered exclusion including men dominating speaking time in meetings, women deferring to male members in decision-making, exclusion of women from leadership positions despite strong performance, and social sanctions against women who challenge male authority or traditional gender norms (Manandhar et al., 2004). Strategies for strengthening women's voice within committees include leadership training specifically for women members, deliberate facilitation ensuring women contribute to discussions, rotation of meeting facilitation among all members, women-only pre-meetings to build confidence and prepare contributions, and community engagement to build support for women's participation (Tripathy et al., 2010). Evidence suggests that when women exercise genuine influence within Village Health Committees, attention to maternal and child health increases, reproductive health services become more culturally appropriate, and health equity concerns receive greater priority (Prost et al., 2013).

Youth engagement in Village Health Committee governance has received increasing attention as health systems recognize that youth bring energy, new perspectives, and particular insights regarding adolescent health needs (Evans-Uzosike & Okatta, 2019). Some models designate specific positions for youth representatives on committees, while others encourage youth participation without reserved positions (Hodgkinson et al., 2017). Youth committee members can serve as bridges to adolescent populations often missed by adult-oriented health programs, contribute innovative ideas for health communication using social media and entertainment approaches, and develop leadership skills preparing them for future community roles (Lim et al., 2018).

However, power dynamics whereby adults dismiss youth contributions, scheduling conflicts between committee meetings and school or work obligations, and inadequate preparation of youth for committee roles represent common challenges requiring deliberate strategies to enable meaningful youth participation (Committee on Psychosocial Aspects of Child and Family Health, 2012).

Capacity building requirements for effective Village Health Committee governance extend beyond technical health knowledge to encompass leadership, management, advocacy, and political skills (Patel & Nowalk, 2010). Governance training should address meeting facilitation, participatory decision-making, conflict resolution, transparent financial management, inclusive communication, strategic planning, and advocacy with health authorities (Stamidis et al., 2019). However, research consistently demonstrates that one-time training events prove insufficient, with effective capacity building requiring ongoing mentorship, peer learning networks, refresher training, and learning from practice with regular feedback (Assegaai & Schneider, 2019). Some successful models pair Village Health Committees with district-level mentors who provide monthly supportive supervision, facilitate quarterly learning forums where committees share experiences, and connect committees facing similar challenges to enable mutual support (Dubé et al., 2018). Building governance capacity represents a long-term investment requiring sustained commitment rather than quick inputs, with evidence suggesting that committees require two to three years of intensive support before functioning independently (Kok et al., 2015).

Accountability mechanisms ensuring Village Health Committees remain responsive to communities while fulfilling health system responsibilities represent essential governance elements (Minkler et al., 2001). Downward accountability to communities can be strengthened through regular community meetings where committees report activities and solicit feedback, participatory evaluation processes engaging community members in assessing committee performance, and accessible complaint mechanisms enabling communities to raise concerns regarding committee functioning (Draper et al., 2010). Upward accountability to health authorities typically operates through quarterly reporting, participation in district health review meetings, and monitoring visits by supervisors (Grundy, 2010). Some models implement mutual accountability frameworks whereby communities and health facilities jointly assess each other's performance, creating constructive dialogue regarding respective responsibilities rather than one-directional accountability (Olayo et al., 2014). Transparency in committee operations including public posting of meeting minutes, financial reports, and activity plans enhances accountability by enabling community scrutiny of committee functioning (Chaskin, 2001).

3.2 VILLAGE HEALTH COMMITTEE CORE FUNCTIONS IN PRIMARY HEALTHCARE DELIVERY

Village Health Committees perform multiple interrelated functions that collectively strengthen primary healthcare through enhanced community engagement, improved health system responsiveness, and strengthened accountability mechanisms (Haines et al., 2007). Understanding these core functions and how they contribute to primary care improvements provides essential insights for optimizing committee effectiveness (George et al., 2015). Health needs assessment represents a foundational function enabling Village Health Committees to identify priority health concerns requiring attention and ensuring health services respond to actual community needs rather than externally determined priorities (Draper et al., 2010). Committees conduct needs assessments through diverse approaches including community meetings soliciting input on health problems, household surveys documenting disease burden and service utilization patterns, key informant interviews with community leaders and health workers, and analysis of health facility data regarding common health conditions (Olayo et al., 2014). Effective needs assessment requires training committee members in participatory assessment methodologies, supporting committees with simple survey tools and data collection materials, and linking assessment findings to health planning processes to ensure communities see their input influences service delivery (Jagosh et al., 2012).

Priority setting based on needs assessment findings represents another critical function whereby Village Health Committees facilitate community dialogue to determine which health issues should receive immediate attention given limited resources (Chaskin, 2001). This function requires committees to balance diverse stakeholder perspectives including health workers emphasizing technical priorities, community members focusing on felt needs, and health authorities highlighting disease control program targets (Minkler et al., 2001). Some committees employ participatory ranking methodologies enabling community members to vote on priorities, while others use consensus-building approaches seeking agreement through facilitated discussion (Hodgkinson et al., 2017). Effective priority setting connects identified needs with realistic assessment of available resources and committee capacity, avoiding overambitious plans that create frustration when implementation proves impossible (Sarriot et al., 2004). Research documents that when communities participate meaningfully in priority setting, commitment to supporting agreed priorities increases substantially compared to externally imposed programs (Wallerstein et al., 2015).

Health planning represents a function whereby Village Health Committees translate identified priorities into concrete action plans specifying activities, responsibilities, timelines, resource requirements, and expected outcomes (Grundy, 2010). Effective planning requires committees to develop realistic strategies addressing priority health needs within resource constraints while leveraging community assets and external support (Shediac-Rizkallah & Bone, 1998). Many committees develop annual health plans synchronized with district health planning cycles, enabling integration of community priorities into broader health system planning (Ryman et al., 2010). Planning processes should engage health workers to ensure technical feasibility, involve community members to maintain ownership, and secure commitment from implementers regarding their respective responsibilities (Jagosh et al., 2012). Some successful models employ visual planning tools such as wall calendars, activity matrices, and resource maps to enable illiterate committee members to participate fully in planning processes (Draper et al., 2010). Documentation of plans and periodic review of progress against plans strengthen accountability and enable adaptive adjustments when implementation encounters obstacles (Minkler et al., 2001).

Community resource mobilization represents a vital function through which Village Health Committees harness local resources including finances, materials, labor, and expertise to support primary healthcare activities (Bender & Pitkin, 1987). Mobilization strategies vary across contexts based on community economic capacity and social organization, ranging from household contributions for health facility improvement to in-kind donations of land for health posts to volunteer labor for health campaigns (McArthur-Lloyd et al., 2016). Effective mobilization requires transparent communication regarding resource needs and intended uses, inclusive processes ensuring contributions do not burden vulnerable households disproportionately, and visible results demonstrating that mobilized resources produce tangible health improvements (Chaskin, 2001). Research documents that communities willingly contribute to health initiatives when they perceive services as responsive to their needs, trust that resources will be used appropriately, and see committee members modeling contributions through their own volunteerism (Iwelunmor et al., 2015). Some committees develop innovative financing mechanisms such as community health insurance schemes, rotating savings groups for health emergencies, or income-generating activities funding health activities (Shediac-Rizkallah & Bone, 1998).

Health worker supervision and support represents a particularly important function given the central role of community health workers and other frontline providers in primary care delivery (Kok et al., 2015). Village Health Committees typically perform supervision through regular meetings with health workers to review activities and address challenges, accompanied supervisory visits to observe service delivery and provide encouragement, assessment of health worker availability and responsiveness to community needs, and facilitation of problem-solving for operational difficulties constraining health worker effectiveness (Gilmore & McAuliffe, 2013). Effective supervision requires clear understanding of respective roles whereby committees provide supportive oversight focusing on worker motivation and

community accountability while health facility supervisors address technical competencies (Strachan et al., 2012). Research documents that health workers value community recognition of their contributions, committee assistance mobilizing resources enabling them to perform duties, and problem-solving support addressing challenges beyond their individual control (Dieleman et al., 2003). However, tensions can arise when inadequately trained committee members provide inappropriate direction or when supervision becomes punitive rather than supportive (Nkomazana et al., 2015).

Health education and promotion activities represent highly visible functions through which Village Health Committees directly contribute to health improvement (Bitton et al., 2017). Committees organize and conduct health education sessions on priority topics such as immunization importance, maternal and newborn care, nutrition, sanitation, disease prevention, and health service utilization (Patel & Nowalk, 2010). Education approaches range from formal talks at community meetings to household visits, drama performances, peer education groups, and mass media programs (Lim et al., 2018). Effective health education requires training committee members in communication skills, providing appropriate educational materials, ensuring messages are culturally appropriate and understandable, and employing participatory methods enabling community members to actively engage with health information rather than passively receiving messages (Dubé et al., 2018). Some committees develop health education calendars aligning topics with seasonal disease patterns and health system campaign schedules (Stamidis et al., 2019). Research emphasizes importance of moving beyond knowledge transmission to address behavioral and environmental barriers requiring broader community action (Wallerstein et al., 2015).

Disease surveillance and outbreak response functions enable Village Health Committees to contribute to early disease detection and rapid containment of outbreaks (Scholten et al., 2018). Committees participate in surveillance through monitoring unusual disease patterns in communities, reporting suspected outbreaks to health authorities, mobilizing rapid community response to disease threats, and supporting health worker investigations of suspected cases (Anyebe et al., 2018). Some health systems provide Village Health Committees with simple surveillance tools and reporting mechanisms enabling timely notification of priority diseases (Lapiz et al., 2012). During outbreaks, committees play crucial roles mobilizing communities for prevention measures, dispelling rumors and misinformation, supporting contact tracing and isolation measures, and maintaining essential health services during emergencies (Stamidis et al., 2019). Research from settings with functional Village Health Committee surveillance demonstrates improved outbreak detection and response compared to reliance solely on facility-based surveillance (Scholten et al., 2018). Integration of Village Health Committee surveillance into broader disease surveillance systems requires clear reporting channels, feedback to committees regarding investigation findings, and recognition of committee contributions to disease control (Mihigo et al., 2017).

Advocacy represents an important function whereby Village Health Committees voice community health concerns to health authorities and mobilize action addressing health system weaknesses (Draper et al., 2010). Committees advocate for improved health facility infrastructure and equipment, adequate staffing and health worker motivation, reliable drug and supply availability, respectful and quality service delivery, and resource allocation addressing community priorities (Minkler et al., 2001). Effective advocacy requires committees to document health system problems systematically, present evidence-based arguments to health authorities, build coalitions with other communities facing similar challenges, and maintain constructive relationships with health officials while asserting community rights (Hodgkinson et al., 2017). Some committees employ diverse advocacy strategies including formal written submissions to district health offices, delegation visits to engage officials directly, media engagement highlighting health access problems, and participation in public health forums (Chaskin, 2001). Research documents that advocacy efforts prove most successful when backed by solid evidence, maintain respectful tone while being persistent, offer constructive suggestions rather than only criticizing, and recognize resource constraints facing health authorities (Jagosh et al., 2012).

Monitoring and quality assurance functions enable Village Health Committees to assess health service delivery quality and hold providers accountable for performance (Mockford et al., 2012). Committees conduct monitoring through periodic facility visits observing service delivery conditions, exit interviews with service users regarding satisfaction and experiences, review of health facility records and reports, investigation of complaints regarding poor treatment or service denial, and assessment of health worker availability during scheduled service hours (Olayo et al., 2014). Effective monitoring requires training committees in observation techniques, providing standardized checklists or guides, ensuring monitoring remains constructive rather than punitive, and establishing mechanisms for addressing identified problems (Assegaai & Schneider, 2019). Some health systems integrate Village Health Committee monitoring findings into facility performance assessments, creating formal accountability for responsiveness to community concerns (Ryman et al., 2010). Research suggests that when communities monitor services systematically, provider behavior improves substantially even without external enforcement, reflecting power of community oversight to incentivize quality (Mockford et al., 2012).

Resource management functions involve Village Health Committees in overseeing health facility resources including budgets, drugs, supplies, equipment, and infrastructure to ensure appropriate utilization serving community health needs (Grundy, 2010). Committees participate in resource management through representation on health facility management committees with responsibility for financial oversight, participation in procurement decisions for drugs and supplies, monitoring of drug availability and prevention of stockouts, oversight of user fee collection and expenditure where applicable, and advocacy for adequate resource allocation to health facilities (Ryman et al., 2010). Effective resource management requires financial literacy training for committee members, transparent sharing of budget and expenditure information by health facilities, clear procedures for committee involvement in resource decisions, and accountability mechanisms addressing mismanagement when identified (Stamidis et al., 2019). Research documents that community involvement in resource management can reduce corruption and misappropriation while ensuring resources align with community priorities, though committees require sustained support to perform these technical functions competently (Bossert & Beauvais, 2002).

Coordination functions whereby Village Health Committees facilitate intersectoral collaboration addressing social determinants of health represent increasingly important though often underutilized aspects of committee potential (Sacks et al., 2019). Health outcomes depend not only on healthcare services but also on water and sanitation, nutrition, education, housing, livelihoods, and environmental conditions that village-level coordination can address (National Academies of Sciences, Engineering, and Medicine, 2019). Committees perform coordination through participation in village development planning processes ensuring health considerations inform broader development, collaboration with water and sanitation committees addressing environmental health, partnership with schools implementing health education and school health services, engagement with agricultural extension addressing nutrition, and linkage with social protection programs supporting vulnerable populations (Mossialos et al., 2015). Effective intersectoral coordination requires health systems to encourage and support Village Health Committee engagement beyond narrow health facility oversight, training in collaborative approaches, and recognition that coordination consumes time and energy requiring support (Hunter et al., 2018; Xyrichis & Lowton, 2008). Research from settings with strong intersectoral coordination demonstrates substantially greater health impacts compared to committees focused exclusively on healthcare services, highlighting value of comprehensive primary healthcare approaches (Sacks et al., 2019).

Emergency preparedness and response functions position Village Health Committees as crucial elements of community resilience to health emergencies ranging from disease outbreaks to natural disasters (Kuruvilla et al., 2016). Committees contribute to emergency preparedness through community emergency planning identifying vulnerable populations, health risks, and response resources, participation in emergency drills and

simulations, maintenance of community emergency supply stocks, training community volunteers in emergency response procedures, and communication systems enabling rapid alert and mobilization (Department of Health, 2006). During emergencies, committees mobilize communities for prevention and response measures, support health worker activities, maintain surveillance and reporting, address misinformation threatening response effectiveness, and ensure vulnerable populations receive assistance (Stamidis et al., 2019). Some health systems have developed frameworks explicitly integrating Village Health Committees into national emergency preparedness plans, recognizing their knowledge of communities and existing community trust (Kuruvilla et al., 2016). Research from emergency contexts demonstrates that communities with active Village Health Committees mounted more effective emergency responses with better population coverage and fewer adverse outcomes compared to communities without such structures (Lapiz et al., 2012).

Performance of these multiple functions simultaneously represents substantial demands on volunteer committee members with limited time, resources, and often limited formal education (Sarriot et al., 2004). Evidence suggests that successful Village Health Committees prioritize functions based on context and capacity rather than attempting all functions equally, with priorities evolving as committees mature and develop capabilities (Kok et al., 2015). Some researchers advocate for staged approaches whereby new committees initially focus on basic functions such as needs assessment, health worker support, and health education before gradually expanding to more complex functions such as surveillance, advocacy, and resource management (Assegaai & Schneider, 2019). Regular performance review and adaptive management enable committees to assess functioning honestly, identify areas requiring strengthening, adjust workplans to realistic levels, and continuously improve effectiveness over time (Jagosh et al., 2012). Understanding Village Health Committee functions as interconnected elements of comprehensive primary healthcare engagement rather than discrete activities highlights synergies whereby effective performance of core functions strengthens capacity for additional functions (Starfield et al., 2005).

3.3 VILLAGE HEALTH COMMITTEE CONTRIBUTIONS TO HEALTH SERVICE DELIVERY AND OUTCOMES

Village Health Committees contribute to strengthening primary healthcare delivery and improving population health outcomes through multiple interconnected pathways operating at individual, community, health facility, and health system levels (Starfield et al., 2005). Understanding these contribution mechanisms and examining empirical evidence regarding committee impacts provides crucial insights for maximizing their potential as vehicles for health system transformation (George et al., 2015). Improvements in immunization coverage represent one of the most consistently documented impacts of effective Village Health Committees, reflecting their roles in health education, community mobilization, and demand generation for vaccination services (National Vaccine Advisory Committee, 1999). Committees contribute to immunization improvements through educating communities regarding vaccine importance and safety, identifying un-immunized children and mobilizing them for vaccination sessions, supporting health workers in conducting outreach immunization, addressing vaccine hesitancy through community dialogue, and advocating for reliable vaccine supplies and consistent immunization schedules (Fields et al., 2013). Research from diverse contexts documents significant increases in full immunization coverage following Village Health Committee activation, with some studies reporting coverage improvements of fifteen to thirty percentage points over two to three year periods (Bonu et al., 2003).

Maternal and child health outcomes demonstrate substantial improvements in settings with active Village Health Committees performing functions supporting reproductive health services (Manandhar et al., 2004). Committees contribute through promoting antenatal care attendance, encouraging facility delivery rather than home births without skilled attendance, supporting postnatal home visits by health workers, identifying maternal complications requiring urgent care, conducting nutrition education and

monitoring child growth, and promoting family planning services (Tripathy et al., 2010). Evidence from controlled studies shows that participatory women's groups facilitated by Village Health Committees achieved significant reductions in maternal mortality and neonatal mortality compared to control areas without such structures (Prost et al., 2013). Research documents improvements in antenatal care coverage, skilled birth attendance, postpartum care, contraceptive prevalence, and child nutritional status in intervention areas with Village Health Committee maternal and child health activities (Black et al., 2017). The mechanisms through which committees influence maternal and child health include both supply-side improvements in service quality and accessibility and demand-side increases in care-seeking resulting from education and social norm change (Lewin et al., 2010).

Table 2: Evidence of Village Health Committee Impacts on Primary Care Outcomes

Outcome Domain	Specific Indicators	Documented Impact Range	Key Contributing Committee Functions	Evidence Quality
Immunization Coverage	Full immunization by age 1, coverage equity, timeliness	+15% to +35% improvement in coverage	Community mobilization, defaulter tracking, health education, vaccine supply monitoring	Strong (multiple controlled studies)
Maternal Health	ANC attendance, facility delivery, PNC utilization	+20% to +40% increase in service use	Women's group facilitation, birth preparedness, emergency transport, quality monitoring	Strong (cluster RCTs)
Child Health	Neonatal mortality, child morbidity, growth monitoring	30–45% mortality reduction in intervention areas	Home visits support, care-seeking promotion, nutrition education, sick child identification	Strong (controlled trials)
Communicable Disease Control	TB case detection, malaria prevention, outbreak response	+25% to +50% improved detection and response	Active case finding, contact tracing, treatment support, prevention campaigns	Moderate (observational studies)
Service Accessibility	Distance to services, wait times, service hour compliance	Improved access for 20–40% more population	Outreach organization, transport schemes, operating hour advocacy, satellite clinics	Moderate (program evaluations)
Health Service Quality	Patient satisfaction, respectful care, clinical quality	+15% to +25% satisfaction improvements	Quality monitoring, complaint handling, provider feedback, resource advocacy	Moderate (mixed methods)

Communicable disease control demonstrates significant benefits from Village Health Committee involvement in case finding, treatment support, and prevention activities (Scholten et al., 2018). For tuberculosis control, committees conduct active case finding identifying symptomatic individuals for testing, support treatment adherence through patient monitoring and encouragement, reduce stigma through community education, and address social determinants such as poor housing and malnutrition that increase TB risk (Anyebe et al., 2018). Research documents substantially higher case detection rates and treatment success rates in areas with active Village Health Committee TB activities compared to areas

relying solely on passive case finding at facilities (Scholten et al., 2018). Similar patterns emerge for malaria control where committees distribute and promote insecticide-treated bed nets, conduct environmental management eliminating mosquito breeding sites, identify and refer suspected cases promptly, and participate in larviciding campaigns (Vanlerberghe et al., 2009). Community engagement through Village Health Committees has proven essential for successful control and elimination of neglected tropical diseases including rabies, dengue, and lymphatic filariasis, where community participation in prevention measures determines program success (Lapiz et al., 2012).

Mental health represents an emerging area where Village Health Committees demonstrate potential to strengthen primary care addressing substantial treatment gaps for common mental disorders (World Health Organization, 2008). Committees contribute by reducing mental health stigma through community education, identifying individuals with mental health conditions requiring care, supporting linkage to services for those experiencing mental health problems, monitoring adherence to mental health treatment, addressing social determinants such as poverty and violence that affect mental health, and advocating for integration of mental health into primary care (Patel et al., 2010). Research examining lay health counselor programs supervised by Village Health Committees found significant improvements in depression and anxiety outcomes compared to usual care, demonstrating feasibility of community-based mental health support (Patel et al., 2010). However, mental health remains underemphasized in most Village Health Committee activities, suggesting substantial untapped potential for committee contributions to comprehensive primary care addressing mental health needs (Saraceno et al., 2007).

Non-communicable disease management increasingly requires Village Health Committee engagement as chronic conditions such as diabetes, hypertension, and cardiovascular disease rise in low and middle-income countries (American Diabetes Association, 2018). Committees contribute to chronic disease management through promoting healthy behaviors including nutrition and physical activity, supporting screening programs identifying undiagnosed conditions, encouraging treatment adherence for patients with diagnosed conditions, facilitating peer support groups for patients managing chronic diseases, addressing barriers to continued care such as transportation and costs, and advocating for reliable medication supplies (Stellefson et al., 2013). Evidence regarding Village Health Committee impact on non-communicable disease outcomes remains limited compared to maternal and child health and communicable diseases, reflecting relatively recent inclusion of chronic disease management in primary care priorities (Bodenheimer et al., 2002). However, emerging evidence suggests that community-based approaches facilitated by Village Health Committees can achieve improvements in blood pressure control, diabetes management, and cardiovascular risk reduction (Rothman & Wagner, 2003).

Health service utilization patterns demonstrate significant changes in areas with active Village Health Committees, reflecting both supply-side service improvements and demand-side increases in care-seeking (Olayo et al., 2014). Committees contribute to increased utilization through educating communities regarding available services and their benefits, addressing financial and transportation barriers through community support mechanisms, improving service quality through monitoring and advocacy, extending service access through support for outreach activities, and building trust between communities and health workers (Shi, 2012). Research documents increased utilization across multiple service areas including curative care visits, preventive services, deliveries at facilities, family planning consultations, and child wellness visits in intervention areas with Village Health Committees compared to control areas (Black et al., 2017). However, utilization increases must be interpreted carefully, as they may reflect previously unmet need rather than unnecessary service use, and should be accompanied by outcome improvements demonstrating that increased utilization translates into health benefits (George et al., 2015).

Health equity improvements represent important Village Health Committee contributions, as effective committees deliberately address barriers facing marginalized populations including women, ethnic minorities, economically disadvantaged households, and geographically isolated communities (Balarajan et

al., 2011). Committees promote equity through identifying underserved populations and ensuring services reach them, advocating for resource allocation addressing equity gaps, organizing targeted interventions for vulnerable groups, addressing discrimination in service delivery, and mobilizing community support for households unable to afford healthcare (Chen et al., 2014). Evidence demonstrates that areas with active Village Health Committees experience narrower gaps in service coverage between advantaged and disadvantaged populations compared to areas without community participation structures (Bonu et al., 2003). However, achieving equity through Village Health Committees requires deliberate attention, as committees dominated by local elites may reinforce rather than challenge existing inequities unless inclusion of marginalized groups is explicitly prioritized (Umoren et al., 2019).

Patient satisfaction and perceived quality of care demonstrate improvements in settings with Village Health Committee quality monitoring and provider accountability functions (Mockford et al., 2012). Committees contribute to quality improvements through regular facility visits observing service delivery conditions, collecting patient feedback through exit interviews and community consultations, addressing patient complaints regarding poor treatment or disrespectful care, advocating for improvements in facility infrastructure and equipment, and recognizing health workers providing quality care (Bitton et al., 2017). Research using patient satisfaction surveys and qualitative interviews documents higher satisfaction scores in facilities with active Village Health Committee oversight compared to facilities without community monitoring (George et al., 2015). Specific quality dimensions showing improvement include reduced waiting times, better health worker availability during scheduled hours, more respectful provider behavior, clearer communication of diagnoses and treatment plans, and improved cleanliness of health facilities (Mockford et al., 2012).

Community ownership and sustainability of health programs demonstrate strengthening when Village Health Committees participate actively in program design and implementation (Shediac-Rizkallah & Bone, 1998). Committees contribute to sustainability through mobilizing local resources reducing dependence on external funding, building community commitment to maintaining health improvements, developing local capacity for program management reducing reliance on external expertise, and creating accountability mechanisms ensuring programs remain responsive to community needs (Sarriot et al., 2004). Research examining sustainability of community health interventions finds that programs with meaningful Village Health Committee engagement demonstrate higher rates of continuation after external support ends compared to programs implemented without authentic community participation (Iwelunmor et al., 2015). However, sustainability remains challenging even with committee involvement when systemic issues such as health system underfunding, inadequate health workforce, or political instability undermine health programs regardless of community commitment (Saraceno et al., 2007).

Health system strengthening represents the ultimate goal of Village Health Committee activities, with cumulative impacts on multiple system functions including service delivery, health workforce, health information, medical products and technologies, health financing, and leadership and governance (Bitton et al., 2017). Committees strengthen service delivery through expanding access and improving quality as previously discussed (Shi, 2012). Workforce strengthening occurs through committee support and supervision of health workers enhancing their motivation and effectiveness (Kok et al., 2015). Health information systems benefit from community-based surveillance and committee participation in monitoring and evaluation activities (Scholten et al., 2018). Medical product availability improves through committee advocacy and monitoring of drug supplies (Ryman et al., 2010). Health financing receives community contributions mobilized by committees and improved efficiency through community oversight (Shediac-Rizkallah & Bone, 1998). Leadership and governance strengthens through participatory decision-making and community accountability mechanisms (Minkler et al., 2001). Research examining health system strengthening holistically finds that Village Health Committees contribute across multiple system dimensions simultaneously,

with synergies whereby improvements in one area reinforce progress in others (Bitton et al., 2017).

3.4 FACTORS ENABLING VILLAGE HEALTH COMMITTEE EFFECTIVENESS

Multiple interconnected factors determine whether Village Health Committees function effectively as mechanisms for strengthening primary healthcare or remain symbolic structures with limited substantive impact (Kolopack et al., 2015). Understanding these enabling factors provides practical guidance for designing implementation strategies that optimize Village Health Committee contributions to health systems (Jagosh et al., 2012). Training adequacy represents a critical enabling factor, as committees composed of volunteers with limited formal education require substantial capacity building to perform their multiple functions competently (Patel & Nowalk, 2010). Effective training addresses multiple domains including primary healthcare principles and priorities, health system organization and how committees fit within broader structures, specific functions committees are expected to perform and how to perform them effectively, participatory meeting facilitation and inclusive decision-making, financial management and accountability, health data interpretation and evidence-based decision-making, advocacy and communication with health authorities, and conflict resolution (Stamidis et al., 2019). Research demonstrates that training duration, quality, and pedagogical approach substantially affect knowledge retention and translation into improved committee functioning, with interactive participatory training producing better outcomes than didactic lecture approaches (Assegaai & Schneider, 2019).

Ongoing mentorship and support beyond initial training represents an essential enabling factor given complexity of committee functions and challenges volunteers face performing them consistently (Dubé et al., 2018). Effective support systems include district-level mentors providing monthly supportive supervision to committees, quarterly learning forums where committees share experiences and collectively solve problems, refresher training addressing areas where committee performance falls short, technical assistance for specialized functions such as data analysis or advocacy, and rapid response support when committees encounter obstacles they cannot resolve independently (Assegaai & Schneider, 2019). Research comparing committees receiving ongoing mentorship with those trained but provided no follow-up support demonstrates substantially better performance on process indicators including meeting regularity, activity implementation, reporting completion, and relationships with health workers in mentored committees (Kok et al., 2015). However, providing quality mentorship at scale represents substantial challenge given supervision demands on already overstretched district health teams, requiring creative approaches such as peer mentorship and technology-enabled remote support (Nwaimo et al., 2019).

Resource availability represents another critical enabling factor, as committees require basic resources to perform their functions including stationery for record keeping, transportation for supervisory visits, communication airtime for coordinating activities, materials for health education, and modest financial allocations for operational expenses (Shediac-Rizkallah & Bone, 1998). Research documents that committees with access to even small quarterly allocations demonstrate higher activity levels and better sustainability compared to entirely volunteer committees, as modest funding enables transportation to facilities, materials for meetings, and recognition of volunteer contributions (McArthur-Lloyd et al., 2016). However, resource allocation must be accompanied by financial management training and accountability mechanisms to prevent misuse that undermines committee legitimacy (Stamidis et al., 2019). Some models successfully leverage mobile money platforms for transparent fund transfers and expenditure tracking, enabling financial accountability even in committees with limited literacy (Nwaimo et al., 2019).

Clear role delineation between Village Health Committees and other health system actors represents an enabling factor preventing confusion and conflict that can undermine committee functioning (Grundy, 2010). Clarity regarding committee relationships with health workers, health facility management committees, district health authorities, local government structures, and traditional authorities helps committees understand their authority and

responsibilities while avoiding overreach or duplication (Bossert & Beauvais, 2002). Written terms of reference specifying committee functions, authority limits, reporting relationships, and accountability requirements provide essential reference points, though these must be developed through participatory processes ensuring committees understand and accept their roles rather than externally imposed without consultation (Minkler et al., 2001). Research identifies role ambiguity as a major source of committee dysfunction and conflict with health system partners, highlighting importance of investing effort in clarifying roles during committee formation (Strachan et al., 2012).

Integration with formal health system structures enables Village Health Committee influence on health service delivery and resource allocation while maintaining community accountability (Li et al., 2017). Effective integration mechanisms include regular joint meetings between committees and health facility staff reviewing performance and planning activities, committee representation on health facility management committees participating in facility governance, incorporation of committee priorities into district health plans ensuring community voice influences resource allocation, systematic feedback from health authorities regarding actions taken on committee recommendations, and committee participation in district health review meetings enabling direct engagement with decision-makers (Ryman et al., 2010). Research demonstrates that committees with clear integration mechanisms exert substantially greater influence on health service delivery compared to isolated committees disconnected from health system decision-making processes, though integration must avoid co-opting committees into bureaucratic structures that diminish community accountability (Hutchison et al., 2011).

Political support from local government leaders and national health authorities represents an important enabling factor legitimizing Village Health Committee authority and facilitating their functioning (Hunter et al., 2018). Political support manifests through leaders publicly endorsing committee roles and encouraging community participation, resource allocation acknowledging committee functions as essential rather than optional add-ons, integration of committees into official health system structures rather than treating them as temporary project appendages, responsiveness to committee advocacy demonstrating that community voice influences decisions, and protection of committee independence from political interference (Umezurike & Iwu, 2017). Research documents that committees operating in environments with strong political support demonstrate better sustainability and greater impact compared to committees established through project initiatives without government ownership, as political support enables committee continuation beyond project lifetimes (Iwelunmor et al., 2015). However, political support must respect committee independence, as excessive government control can undermine the community accountability that distinguishes Village Health Committees from government implementation units (Tripathy et al., 2010).

Community awareness regarding Village Health Committee existence, functions, and achievements enables committees to mobilize community engagement and maintain accountability to constituents (Wallerstein et al., 2015). Awareness-building requires ongoing communication through multiple channels including community meetings where committees report activities and solicit input, use of local radio programs and community information boards publicizing committee work, engagement with schools and religious institutions reaching diverse community segments, and visible activities such as health campaigns demonstrating committee contributions to community health (Lim et al., 2018). Research demonstrates that communities with high awareness of Village Health Committee functions show greater participation in committee activities, higher utilization of health services promoted by committees, and stronger accountability relationships with committees compared to communities where awareness remains low (Farnsworth et al., 2014). However, awareness must be accompanied by demonstrated impact, as communities quickly lose interest in committees that generate activity without producing tangible health improvements (Sarriot et al., 2004).

Health worker attitudes toward Village Health Committees substantially influence committee effectiveness, as health workers can either facilitate or

obstruct committee functioning depending on whether they perceive committees as supportive partners or threatening overseers (Dieleman et al., 2003). Positive health worker attitudes develop through early engagement of health workers in committee formation processes, clear communication regarding how committees support rather than undermine health workers, training emphasizing complementary roles and mutual accountability, regular joint planning creating shared ownership of activities, and recognition of health worker expertise and professionalism by committee members (Gilmore & McAuliffe, 2013). Research identifies health worker resistance as a major barrier to effective Village Health Committee functioning in some contexts, often stemming from perceived threats to professional autonomy or concerns that committees will criticize workers without understanding constraints they face (Strachan et al., 2012). Successful models invest substantial effort in building constructive relationships between committees and health workers through team-building activities, joint problem-solving, and celebration of shared achievements (Kok et al., 2015).

Cultural appropriateness of Village Health Committee structures and processes represents an enabling factor often overlooked in standardized implementation approaches (Wallerstein et al., 2015). Committees function most effectively when organized in ways consistent with local decision-making traditions, employ communication styles appropriate to cultural context, schedule meetings at times accommodating local livelihood patterns and cultural practices, and engage traditional and religious authorities in ways respecting local power structures (Marsh et al., 2008). Some cultures emphasize consensus decision-making through extended discussion while others value efficiency and quick decisions, requiring adaptation of committee procedures (Hodgkinson et al., 2017). Gender norms regarding appropriate roles for women and youth in public leadership require navigation, with some contexts necessitating deliberate strategies to create space for inclusion while others provide more enabling environments (Patel et al., 2010). Research examining Village Health Committee adaptations across diverse cultural contexts demonstrates that locally appropriate modifications to standard models enhance committee legitimacy and effectiveness compared to rigid adherence to external blueprints (Vanselow et al., 1996).

Technology access and digital literacy increasingly represent enabling factors as health systems adopt electronic data systems, mobile health communication platforms, and digital reporting tools (Nwaimo et al., 2019). Committees with access to mobile phones demonstrate improved coordination with health workers, more timely reporting of surveillance data, and enhanced ability to document activities and maintain records (Menson et al., 2018). Some health systems provide committee members with smartphones loaded with applications for reporting health data, accessing clinical guidelines, and coordinating immunization campaigns (Nwaimo et al., 2019). However, technology adoption requires attention to digital literacy barriers, ongoing technical support, infrastructure limitations in rural areas, and costs of devices and connectivity that may be prohibitive for volunteer committees (Uzozie et al., 2019). Research suggests that technology tools designed specifically for low literacy users employing visual interfaces and voice options prove most successful for Village Health Committee adoption (Bukhari et al., 2019).

Community social capital including trust, reciprocity norms, and associational networks represents an important contextual enabling factor influencing Village Health Committee effectiveness (Chaskin, 2001). Communities with strong social capital demonstrate greater capacity for collective action through committees, more sustained volunteer commitment, better resource mobilization, and stronger social accountability of health workers (Minkler et al., 2001). Village Health Committees can both draw upon and strengthen community social capital, creating virtuous cycles whereby committee activities build trust and cooperation that in turn enable more effective committee functioning (Wallerstein et al., 2015). However, social capital can also be exclusionary when strong internal bonds marginalize outsiders, requiring deliberate efforts to ensure committees bridge social divides rather than reinforcing them (Umoren et al., 2019). Research examining Village Health Committee functioning across communities with varying social capital levels demonstrates substantially better committee

performance in high social capital contexts, suggesting that social capital strengthening may be necessary precursor to effective committee establishment in some settings (Kolopack et al., 2015).

Health system decentralization and local governance arrangements shape the environment within which Village Health Committees operate, with implications for their effectiveness (Bossert & Beauvais, 2002). Decentralized systems providing local governments authority over health resources and decision-making create opportunities for Village Health Committee influence on local health priorities and resource allocation (Hutchison et al., 2011). However, decentralization can also fragment health systems and exacerbate inequities if local capacity and resources prove inadequate (Balogun et al., 2019). Research examining Village Health Committee functioning under different governance arrangements demonstrates that committees thrive when decentralization includes genuine transfer of authority and resources to local levels but struggle when decentralization represents unfunded mandates without corresponding capacity (Li et al., 2017). Effective decentralization for Village Health Committee empowerment requires capacity building for local health authorities to engage with communities productively, clear frameworks delineating central and local responsibilities, and equalization mechanisms preventing decentralization from widening disparities (Hutchison et al., 2011).

Village size and population characteristics influence optimal Village Health Committee design and expectations regarding what committees can accomplish (Guagliardo, 2004). Larger villages may require multiple committees or sub-committees addressing different geographical areas or health priorities, while small villages may struggle to identify sufficient volunteers or generate adequate resources (Chen et al., 2014). Population characteristics including literacy levels, ethnic composition, economic conditions, and health needs affect committee capacity and priorities (Balarajan et al., 2011). Research demonstrates that standardized committee models applied without attention to local variation often produce poor results, with successful implementations adapting structures and expectations to local contexts (Vanselow et al., 1996). Some health systems develop tiered committee structures with larger coordinating committees at higher levels and smaller action committees at grassroots levels, enabling appropriate scale for different functions (Ryman et al., 2010).

Monitoring and evaluation systems providing committees with data regarding health conditions and service performance enable evidence-based decision-making and accountability (George et al., 2015). Committees function most effectively when they receive regular feedback regarding immunization coverage, disease trends, service utilization, and other indicators relevant to their priorities, enabling them to assess whether their activities produce desired effects and adjust strategies accordingly (Olayo et al., 2014). Simple visual displays of data using charts, graphs, and maps accessible to members with limited formal education prove most useful for committee decision-making (Draper et al., 2010). Research demonstrates that committees receiving regular performance feedback show greater goal-orientation, more adaptive management adjusting strategies when initial approaches prove ineffective, and stronger accountability relationships with communities compared to committees lacking performance information (Jagosh et al., 2012). However, data systems must be designed for committee usability rather than exclusively serving external reporting requirements, requiring attention to what data committees need, how frequently, and in what formats (Scholten et al., 2018).

Learning and adaptation mechanisms enabling Village Health Committees to continuously improve performance represent important enabling factors often absent in rigid implementation frameworks (Greenhalgh et al., 2016). Effective learning mechanisms include regular self-assessment by committees identifying strengths and improvement areas, peer learning forums where committees share innovations and solutions, documentation and dissemination of promising practices, incorporation of committee experiences into policy and program refinement, and research partnerships enabling systematic evaluation of committee functioning (Jagosh et al., 2012). Research employing realist evaluation approaches demonstrates that Village Health Committee effectiveness depends heavily on

contextual factors and implementation processes, highlighting importance of adaptive approaches that enable continuous refinement based on experience rather than static blueprints (Kolopack et al., 2015). Some health systems have developed systematic learning agendas for Village Health Committees including regular documentation of innovations, multi-stakeholder review meetings analyzing committee performance, and policy dialogue forums where lessons inform system strengthening efforts (Hunter et al., 2018).

External support from non-governmental organizations, academic institutions, and development partners has historically played important roles in Village Health Committee establishment and strengthening, though sustainability requires transition to government ownership (Iwelunmor et al., 2015). External partners contribute technical assistance for committee development, training and mentorship capacity exceeding what government systems can provide, financial resources for committee operations, research documenting committee impacts, and advocacy promoting policy attention to community participation (Farnsworth et al., 2014). However, excessive dependence on external support creates sustainability risks when partners exit or shift priorities, highlighting importance of building government capacity and commitment from the outset (Shediac-Rizkallah & Bone, 1998). Research examining Village Health Committee sustainability after project support ends demonstrates substantially better continuation when implementation includes deliberate transition planning, gradual handover to government systems, and integration into government budgets and management structures rather than abrupt project termination (Sarriot et al., 2004).

3.5 CHALLENGES AND BARRIERS TO VILLAGE HEALTH COMMITTEE EFFECTIVENESS

Despite their potential contributions to primary healthcare strengthening, Village Health Committees face substantial challenges and barriers that limit their effectiveness in many contexts, requiring honest acknowledgment and strategic responses (Nkomazana et al., 2015). Inadequate financial resources represent perhaps the most fundamental constraint, as most committees operate on minimal or zero budgets while expected to perform multiple functions requiring transportation, materials, and operational expenses (Shediac-Rizkallah & Bone, 1998). Volunteer committee members often must pay transportation costs from personal funds to conduct supervisory visits, purchase materials for health education activities, or attend district meetings, creating unsustainable financial burdens particularly for economically disadvantaged members (McArthur-Lloyd et al., 2016). The absence of dedicated budgets forces committees to spend disproportionate time on fundraising rather than health activities, limits ability to respond to emerging needs requiring resources, and contributes to volunteer fatigue when members perceive their sacrifice produces minimal impact due to resource constraints (Sarriot et al., 2004). Research consistently identifies inadequate financing as the primary challenge undermining Village Health Committee sustainability, with committees becoming inactive when volunteer enthusiasm wanes without tangible support (Iwelunmor et al., 2015).

Insufficient training and capacity building represents another pervasive challenge, as one-time training events prove inadequate for developing competencies required to perform complex committee functions effectively (Patel & Nowalk, 2010). Many committees receive brief initial orientation lasting only a few days before assuming responsibility for health needs assessment, planning, supervision, advocacy, and financial management, functions that require substantial knowledge and skills (Stamidis et al., 2019). Training gaps include lack of understanding regarding how health systems function and how committees fit within broader structures, limited competencies in participatory facilitation and inclusive decision-making, inadequate financial management skills leading to poor documentation and accountability problems, insufficient understanding of disease prevention and health promotion messages they are expected to communicate, weak advocacy skills limiting ability to effectively engage health authorities, and absence of conflict resolution capacities necessary when tensions arise (Assegaai & Schneider, 2019). Research documents that inadequately trained committees often implement activities poorly, make decisions without adequate information, struggle to maintain records, and lose credibility with both communities and health

authorities due to perceived incompetence (Dubé et al., 2018).

Volunteer fatigue and committee member turnover undermine continuity and institutional memory, particularly when committees function for extended periods without adequate support or visible impact (Strachan et al., 2012). Volunteer committee work demands substantial time including regular meetings, supervisory visits, health campaign participation, community mobilization activities, and district engagement, creating tensions with livelihood activities and family responsibilities particularly for women members who face double burdens (Patel et al., 2010). The absence of compensation or even nominal allowances for transportation and meal expenses during committee activities creates resentment particularly when health workers and district officials receive salaries and allowances for similar work (Dieleman et al., 2003). When committee efforts produce limited visible impact due to health system constraints beyond committee control, volunteers become discouraged and reduce participation or resign entirely (Sarriot et al., 2004). Research examining Village Health Committee trajectories over time documents common patterns of initial enthusiasm followed by declining participation as challenges mount, with many committees becoming defunct within three to five years without sustained external support (Shediac-Rizkallah & Bone, 1998).

Unclear roles and responsibilities create confusion regarding what committees should actually do, leading to either committee passivity waiting for external direction or overreach into areas beyond their authority (Grundy, 2010). Many committees receive vague mandates to "support health activities" without specific guidance regarding which activities, how frequently, using what approaches, or with what authority (Minkler et al., 2001). Ambiguity regarding relationships with health workers proves particularly problematic, with confusion about whether committees supervise health workers or merely support them, what authority committees have to address health worker problems, and how conflicts between committees and workers should be resolved (Strachan et al., 2012). Role confusion also arises regarding committee relationships with health facility management committees where both exist, traditional authorities who may perceive committees as threats to their influence, and local government officials who may try to control committees for political purposes (Umoren et al., 2019). Research identifies role ambiguity as a major source of committee dysfunction and conflict, with successful implementations investing substantial effort in clarifying roles through participatory processes during committee establishment (Kok et al., 2015).

Weak linkages with health facilities and district health systems limit Village Health Committee influence on service delivery and create frustration when committee recommendations receive no response (Li et al., 2017). Many committees operate in isolation from health planning and resource allocation processes, conducting needs assessments and developing priorities that never inform actual health system decisions (Ryman et al., 2010). Health workers may view committees as bothersome outsiders rather than supportive partners, providing minimal information and resisting committee oversight (Gilmore & McAuliffe, 2013). District health offices often lack systems for receiving committee input, providing feedback on committee recommendations, or incorporating community priorities into planning (Hutchison et al., 2011). The absence of regular communication channels, joint planning mechanisms, and mutual accountability frameworks means committees and health systems function as parallel structures with limited interaction rather than integrated partnerships (Bitton et al., 2017). Research documents that isolated committees disconnected from health system decision-making demonstrate limited impact regardless of their internal functioning quality, highlighting integration as essential for effectiveness (George et al., 2015).

Elite capture and lack of representativeness undermine Village Health Committee legitimacy and responsiveness to marginalized populations' needs (Umoren et al., 2019). Local power brokers often dominate committee selection processes, ensuring their allies control committees to advance personal agendas rather than community health interests (Menson et al., 2018). Elite-dominated committees may prioritize health concerns of advantaged populations while neglecting needs of women, ethnic minorities, disabled persons, or economically

disadvantaged groups (Balarajan et al., 2011). Committee selection processes that rely on community meetings disadvantage those unable to attend due to work obligations, childcare responsibilities, or social exclusion, resulting in committees that poorly represent community diversity (Chaskin, 2001). Some committee members treat positions as opportunities for personal benefit through corruption or privileged access to health services rather than service to community (Minkler et al., 2001). Research examining Village Health Committee composition and decision-making patterns documents that elite capture represents a significant problem in contexts with high inequality and weak governance, requiring deliberate strategies to ensure inclusive representation (Chen et al., 2014).

Political interference by local government officials or political parties undermines Village Health Committee independence and accountability to communities (Umezurike & Iwu, 2017). Politicians may attempt to control committee selection to reward supporters, direct committee priorities toward visible activities generating political credit regardless of health impact, divert committee resources for political purposes, or suppress committee advocacy criticizing government health services (Hunter et al., 2018). In some contexts, committee positions become patronage opportunities distributed to political loyalists rather than community representatives genuinely committed to health improvement (Umoren et al., 2019). Political cycles create instability when committee membership turns over with changes in local government, losing institutional memory and community relationships (Bossert & Beauvais, 2002). Fear of political repercussions may prevent committees from honestly reporting health system problems or advocating for improvements that might embarrass officials (Tripathy et al., 2010). Research documents that political interference represents a particularly intractable challenge requiring civil society advocacy for legal frameworks protecting committee independence and community accountability (Umezurike & Iwu, 2017).

Gender barriers limit women's participation and leadership in Village Health Committees despite women comprising majority of health service users and possessing particular insights regarding maternal and child health needs (Patel et al., 2010). Patriarchal norms in many contexts discourage women from speaking in mixed-gender forums, exclude women from leadership positions, require women to defer to male authority even when women possess relevant expertise, and sanction women who challenge traditional gender roles through public leadership (Manandhar et al., 2004). Women committee members face time constraints due to domestic responsibilities limiting their availability for meetings and activities, limited mobility restricting their participation in supervisory visits and district engagement, and social pressure from husbands or family members opposing their involvement (Tripathy et al., 2010). Male committee members and health workers may dismiss women's contributions or exclude women from decision-making despite formal committee membership (Balarajan et al., 2011). Research documents that women's numerical majority on committees does not automatically translate into substantive influence without deliberate strategies addressing gender barriers, including women-specific training, facilitation ensuring women's voices are heard, and community engagement building support for women's leadership (Prost et al., 2013).

Limited literacy and education levels among committee members create challenges for record-keeping, data analysis, financial management, and engaging with written health system documents and reports (Nkomazana et al., 2015). Many village-level volunteers have limited formal schooling, affecting their ability to maintain meeting minutes, complete reporting forms, interpret health statistics, understand policy documents, or communicate effectively in writing with district health authorities (Chen et al., 2014). Illiterate or semi-literate committee members may be embarrassed to admit difficulties understanding written materials, leading them to avoid tasks requiring literacy or make decisions without adequate information (Draper et al., 2010). Some health systems have developed visual tools and simplified documentation systems enabling low-literacy committees to function effectively, but many continue using formats designed for educated health professionals that prove inaccessible to volunteers (Jagosh et al., 2012). Research highlights that literacy challenges require deliberate accommodation through appropriate tools and support rather than assuming literate committee members, as education

requirements that exclude community members with limited schooling may prevent most capable and respected community members from participating (Wallerstein et al., 2015).

Health worker resistance and poor relationships between committees and health workers undermine collaboration essential for effective primary care delivery (Strachan et al., 2012). Some health workers perceive Village Health Committees as threatening their professional autonomy or likely to unfairly criticize their performance without understanding resource and systemic constraints they face (Dieleman et al., 2003). Health workers may view committee members as lacking expertise to provide meaningful oversight and resent supervision by volunteers they perceive as less qualified (Gilmore & McAuliffe, 2013). Professional medical culture emphasizing technical expertise can lead health workers to dismiss community participation as irrelevant to quality care (Rosenthal, 2008). Limited health worker understanding of community participation principles and committee roles contributes to resistance (Lewin et al., 2010). Personality conflicts between individual committee members and health workers can poison relationships affecting entire committee functioning (Strachan et al., 2012). Research documents that constructive committee-health worker relationships require ongoing investment including joint training, regular communication, team-building activities, clear role delineation, and recognition of complementary contributions rather than competition (Kok et al., 2015).

Inadequate supervision and support from district health systems leave committees struggling without guidance or assistance when facing challenges (Dubé et al., 2018). Many district health teams lack capacity or motivation to provide regular supportive supervision to Village Health Committees given competing demands on their time (Nkomazana et al., 2015). Supervision that does occur often takes form of fault-finding and criticism rather than constructive problem-solving support (Assegaai & Schneider, 2019). District supervisors may lack understanding of community participation approaches, viewing committees as simply additional reporting structures rather than genuine partners in health system strengthening (Wallerstein et al., 2015). The absence of systematic support systems means committees must navigate challenges independently without technical assistance, reducing effectiveness and contributing to frustration (Sarriot et al., 2004). Research examining factors enabling Village Health Committee effectiveness consistently identifies ongoing supervision and mentorship as critical, yet notes that most committees receive inadequate support, highlighting need for health systems to develop feasible supervision strategies given resource constraints (Kok et al., 2015).

Unrealistic expectations regarding what volunteer committees can accomplish without adequate resources and support set committees up for failure (Shediac-Rizkallah & Bone, 1998). Health systems often assign Village Health Committees responsibility for numerous functions including needs assessment, planning, resource mobilization, health worker supervision, health education, surveillance, advocacy, and monitoring while providing minimal resources or capacity building to perform these complex tasks (George et al., 2015). Communities and health authorities both become disappointed when committees cannot fulfill unrealistic mandates, blaming committee members rather than acknowledging systemic failures in providing necessary support (Sarriot et al., 2004). Project-driven implementations sometimes create elaborate committee structures and ambitious work plans during project periods that prove unsustainable when external support ends, demonstrating apparent failure of community participation rather than project design flaws (Iwelunmor et al., 2015). Research emphasizes importance of right-sizing expectations regarding committee functions based on realistic assessment of volunteer capacity, available resources, and health system support, with gradual expansion of functions as committees mature rather than overwhelming new committees with comprehensive mandates (Vanselow et al., 1996).

Lack of tangible incentives for committee members compared to compensated positions in health systems creates motivational challenges, particularly in economically disadvantaged communities where volunteer time represents significant opportunity cost (McArthur-Lloyd et al., 2016). While intrinsic motivations including community service, social

recognition, and personal satisfaction drive many committee members, these prove insufficient to sustain participation over extended periods without any tangible benefits (Strachan et al., 2012). Some committee members expect that volunteering will lead to employment opportunities or preferential treatment in accessing health services, becoming disillusioned when these benefits do not materialize (Dieleman et al., 2003). The absence of even modest allowances for transportation and meals during committee activities creates financial hardship particularly for poor volunteers, effectively excluding those who might contribute most authentically to representing disadvantaged community perspectives (Chaskin, 2001). Research examining incentives for community health volunteers documents tensions between desires to recognize contributions and concerns that monetary compensation will undermine volunteer ethos or create unsustainable funding requirements, with no consensus regarding optimal approaches (Strachan et al., 2012).

Cultural and religious beliefs sometimes conflict with health interventions promoted by Village Health Committees, creating dilemmas regarding how committees navigate traditional practices and introduced health recommendations (Wallerstein et al., 2015). Beliefs regarding causes of illness and appropriate treatments may differ from biomedical understandings underlying health worker recommendations, creating potential for committee members to transmit mixed or contradictory messages (Longlett et al., 2001). Religious opposition to certain health interventions such as family planning or immunization may limit committee willingness to promote these services despite their importance for maternal and child health (Guignard et al., 2019). Traditional practices harmful to health may be deeply embedded in cultural identity, making committee efforts to discourage them sensitive and potentially divisive (Committee on Psychosocial Aspects of Child and Family Health, 2012). Gender norms rooted in cultural or religious traditions may constrain committee efforts to promote women's health seeking and empowerment (Patel et al., 2010). Research examining community health interventions in diverse cultural contexts emphasizes importance of respectful engagement with traditional beliefs, identifying compatible elements while gradually building understanding regarding harmful practices, rather than confrontational approaches that provoke resistance (Marsh et al., 2008).

Geographic and infrastructure challenges particularly in rural and remote areas limit Village Health Committee functioning by creating transportation barriers, communication difficulties, and resource access problems (Guagliardo, 2004; Andrew et al 2012). Committee members in dispersed rural communities must travel long distances on foot or unreliable transport to conduct supervisory visits, attend meetings, or engage with district health authorities, consuming substantial time and energy (Nkomazana et al., 2015). Poor road conditions during rainy seasons may isolate committees from support systems and prevent participation in training or coordination activities (Balogun et al., 2019). Limited communication infrastructure makes contact between committee members difficult for activity coordination and prevents timely reporting of disease outbreaks or health emergencies (Menson et al., 2018). Distance from district headquarters reduces frequency of supervision visits and separates committees from information and resource flows (Li et al., 2017). Research examining rural health challenges documents that geographic barriers significantly constrain Village Health Committee effectiveness unless deliberately addressed through context-appropriate strategies such as clustering multiple village committees for joint activities, utilizing technology for remote communication and supervision, and providing transportation support (Nwaimo et al., 2019).

CONCLUSION

Village Health Committees represent critical institutional mechanisms for strengthening primary healthcare through enhanced community participation, improved health system responsiveness, and strengthened accountability (Starfield et al., 2005). This comprehensive review has examined Village Health Committee functions, analyzed their contributions to primary care delivery and health outcomes, identified factors enabling or constraining their effectiveness, and synthesized evidence-based recommendations for optimizing their impact (George et al., 2015). The synthesis demonstrates that well-

functioning Village Health Committees contribute meaningfully across multiple dimensions of primary healthcare strengthening including improved service access and utilization, enhanced service quality and responsiveness, better health outcomes particularly for maternal and child health, strengthened health workforce performance and motivation, more equitable resource allocation and health outcomes, and increased sustainability through community ownership (Shi, 2012). However, realizing this potential requires deliberate attention to numerous implementation factors including adequate training and ongoing mentorship, modest but reliable financial resources, clear role delineation and integration with health systems, political support and protection of committee independence, inclusive governance ensuring representation of marginalized groups, constructive relationships with health workers, and realistic expectations regarding volunteer capacity (Kok et al., 2015).

The evidence reviewed reveals substantial variation in Village Health Committee effectiveness across different contexts, implementation models, and time periods, highlighting that community participation structures alone do not guarantee positive outcomes without supportive enabling environments (Kolopack et al., 2015). Contextual factors including political governance systems, health system decentralization arrangements, community social capital, cultural norms regarding participation and gender, and resource availability substantially influence committee functioning and impact (Bossert & Beauvais, 2002). Implementation quality including formation processes, capacity building approaches, supervision systems, integration mechanisms, and adaptive management significantly determines whether committees realize their theoretical potential or remain symbolic structures with limited substantive influence (Jagosh et al., 2012). This variation underscores that Village Health Committees should not be viewed as technical interventions with predictable uniform effects, but rather as social institutions whose functioning depends critically on political, social, and organizational contexts within which they operate (Wallerstein et al., 2015).

Critical success factors emerging from the synthesis include community ownership established through participatory formation processes and ongoing accountability to constituents, adequate investment in capacity building through comprehensive training and continuous mentorship, provision of basic operational resources enabling committees to undertake planned activities, effective integration with health systems ensuring committee influence on service delivery and resource allocation, supportive supervision providing problem-solving assistance when committees encounter challenges, constructive relationships with health workers based on complementary roles and mutual respect, inclusive governance ensuring meaningful participation of women and marginalized groups, political support legitimizing committee authority while protecting independence from interference, realistic expectations matching committee responsibilities to volunteer capacity, and sustained commitment reflected in integration into government budgets and management systems (George et al., 2015). Programs implementing Village Health Committees without attention to these success factors risk creating structures that appear to operationalize community participation while producing minimal health impacts, potentially discrediting community participation approaches rather than demonstrating their potential (O'Mara-Eves et al., 2013).

The relationship between Village Health Committees and health system strengthening emerges as fundamentally bidirectional, with committees both contributing to and depending upon broader health system functionality (Bitton et al., 2017). Committees strengthen health systems through expanding community participation in governance, enhancing service responsiveness to community needs, improving accountability mechanisms, mobilizing additional resources, strengthening health workforce motivation and performance, extending service access through community mobilization and outreach support, and building community capacity for sustained health action (Shi, 2012). Simultaneously, committee effectiveness depends upon health system investments including supportive policies creating space for community voice, organizational structures enabling integration rather than isolation, capacity building providing knowledge and skills volunteers need, supervision systems offering ongoing support, financial allocations acknowledging committee

operational needs, and responsiveness demonstrating that community input influences decisions (Li et al., 2017). This interdependence suggests that Village Health Committees cannot be viewed as solutions to health system weaknesses, but rather as components of comprehensive health system strengthening requiring investments across multiple system elements (Starfield et al., 2005).

The sustainability of Village Health Committees represents a persistent concern requiring systematic strategies rather than assuming initial enthusiasm will naturally translate into long-term functioning (Shediac-Rizkallah & Bone, 1998). Sustainable committees demonstrate several common characteristics including integration into government structures and budgets rather than dependence on temporary project funding, ongoing capacity building through regular refresher training and mentorship, visible impact on community health demonstrating value of committee contributions, community recognition and appreciation of volunteer efforts, responsive health systems showing community input influences service delivery, realistic mandates matching expectations to volunteer capacity, and adaptive management enabling continuous improvement based on experience (Sarriot et al., 2004). However, even well-designed sustainability strategies face challenges when broader health system dysfunction, political instability, or severe resource constraints undermine health programs regardless of community commitment (Saraceno et al., 2007). Sustainability planning should begin during initial committee formation rather than becoming an afterthought when external support ends, with deliberate strategies for transitioning to local ownership and financing (Iwelunmor et al., 2015).

Gender equity dimensions of Village Health Committee functioning merit particular attention given persistent challenges in translating women's numerical representation into substantive influence and leadership (Patel et al., 2010). While women often constitute majority of committee members reflecting their roles as primary health service users and family health managers, patriarchal social norms in many contexts constrain women's ability to speak freely in meetings, exercise leadership, challenge male authority, and influence major decisions (Manandhar et al., 2004). Addressing gender barriers requires comprehensive strategies including affirmative approaches ensuring women's leadership in committee structures, facilitation techniques creating space for women's voices, women-specific capacity building, community engagement challenging restrictive gender norms, attention to women's time constraints and mobility limitations, and monitoring of gender equity dimensions enabling continuous improvement (Tripathy et al., 2010). Evidence demonstrates that when women exercise genuine influence within Village Health Committees, maternal and child health priorities receive greater attention, reproductive health services become more culturally appropriate, and health equity concerns for marginalized populations strengthen (Prost et al., 2013). Gender-transformative approaches that use Village Health Committee platforms to challenge harmful gender norms while improving health represent promising directions for maximizing committee contributions to both health and social equity (Committee on Psychosocial Aspects of Child and Family Health, 2012).

Technology integration into Village Health Committee operations presents opportunities for enhanced functioning while requiring careful attention to accessibility and appropriateness (Nwaimo et al., 2019). Mobile phones enable improved communication between committee members and health workers, facilitate real-time disease surveillance reporting, support data collection and documentation, and connect committees with information and support networks (Menson et al., 2018; Jagosh, et al 2012). Digital health applications can provide committees with clinical decision support, health education materials, reporting tools, and performance feedback (Nwaimo et al., 2019). However, technology adoption faces barriers including limited digital literacy among committee members, inadequate infrastructure in rural areas, costs of devices and connectivity, concerns regarding data privacy and security, and risks of exacerbating digital divides excluding those without technology access (Uzozie et al., 2019). Successful technology integration emphasizes user-centered design accommodating low literacy, provision of devices and connectivity support, training and technical assistance, integration with existing workflows rather than technology for its own sake, and maintaining non-

digital alternatives ensuring inclusion (Bukhari et al., 2019).

Research gaps and future directions for Village Health Committee scholarship include several important areas requiring additional investigation (George et al., 2015). Rigorous evaluations employing experimental and quasi-experimental designs examining committee impacts on health outcomes remain limited, with most evidence deriving from observational studies subject to selection bias and confounding (Brunton et al., 2017). Long-term studies tracking committee functioning and sustainability beyond typical three to five year project evaluation periods would provide insights into factors enabling persistent effectiveness versus common patterns of declining activity (Shediac-Rizkallah & Bone, 1998). Comparative research examining how different governance models, financing approaches, integration mechanisms, and capacity building strategies influence committee performance would inform optimal implementation approaches (Jagosh et al., 2012). Economic evaluations assessing costs and cost-effectiveness of Village Health Committee investments compared to alternative health system strengthening strategies would provide evidence for resource allocation decisions (Iwelunmor et al., 2015). Implementation research employing realist evaluation and other theory-driven approaches exploring how and why committees work in some contexts but not others would strengthen understanding of contextual enabling factors (Kolopack et al., 2015). Participatory research engaging committees themselves in investigating their functioning and co-producing knowledge would honor community expertise while generating locally relevant insights (Greenhalgh et al., 2016).

Policy implications emerging from this review emphasize several key recommendations for governments and health system leaders seeking to strengthen primary healthcare through Village Health Committee engagement (Vanselow et al., 1996). First, policy frameworks should establish clear legal or regulatory foundations for committees specifying their roles, authority, and integration into health governance structures while protecting independence from political interference (Department of Health, 2006). Second, national and district health budgets should include dedicated allocations for Village Health Committee operational support and capacity building, acknowledging that effective community participation requires investment rather than functioning on volunteers' goodwill alone (McArthur-Lloyd et al., 2016). Third, health system organizational structures should create formal integration mechanisms linking committees into planning, resource allocation, monitoring, and accountability processes rather than treating community participation as peripheral add-on (Ryman et al., 2010). Fourth, comprehensive capacity building systems providing initial training, ongoing mentorship, peer learning networks, and performance support should be developed and resourced adequately (Stamidis et al., 2019). Fifth, monitoring and evaluation frameworks should include Village Health Committee process and outcome indicators enabling systematic assessment of committee functioning and impact (Olayo et al., 2014).

Additional policy recommendations address specific implementation dimensions critical for committee effectiveness (George et al., 2015). Health workforce development policies should incorporate Village Health Committee engagement into pre-service and in-service training for health workers, building understanding of community participation principles and skills for constructive collaboration (Rosenthal, 2008). Decentralization policies should ensure that transfer of authority to local levels includes genuine decision-making power and adequate resources rather than unfunded mandates, while maintaining equity safeguards (Hutchison et al., 2011). Health information system policies should ensure committees receive timely access to data necessary for evidence-based decision-making while contributing surveillance information to broader systems (Scholten et al., 2018). Financing policies should explore sustainable funding mechanisms including health insurance schemes, local government transfers, and community co-financing arrangements (Shediac-Rizkallah & Bone, 1998). Gender equity policies should mandate inclusive committee composition and leadership while addressing broader social norms constraining women's participation (Balarajan et al., 2011). Quality assurance policies should recognize community monitoring as legitimate component of quality improvement systems alongside professional peer review (Mockford et al., 2012).

Practical guidance for program implementers emphasizes importance of adapting evidence-based approaches to local contexts rather than rigidly replicating standardized models (Wallerstein et al., 2015). Implementation should begin with thorough situational analysis assessing community characteristics, health system capacity, political environment, and social context informing appropriate adaptations (Kolopack et al., 2015). Formation processes should invest adequate time in community sensitization and participatory selection rather than rushing to establish committees quickly (Hodgkinson et al., 2017). Initial capacity building should provide comprehensive training plus immediate follow-up support during early implementation when committees face steepest learning curves (Assegaai & Schneider, 2019). Integration should be negotiated carefully through dialogue with health facility staff and district authorities building shared understanding rather than imposing committee oversight on resistant providers (Gilmore & McAuliffe, 2013). Supervision systems should emphasize supportive mentorship facilitating problem-solving rather than inspectorial fault-finding (Dubé et al., 2018). Monitoring should track both process indicators regarding committee functioning and outcome indicators regarding health impacts, with regular review informing continuous improvement (Jagosh et al., 2012). Adaptation should be expected and encouraged based on implementation experience rather than assuming initial designs will prove optimal (Greenhalgh et al., 2016).

The COVID-19 pandemic has highlighted both opportunities and challenges for Village Health Committees in health emergency preparedness and response (Kuruvilla et al., 2016). Committees with strong pre-existing functioning rapidly mobilized communities for prevention measures including mask use, physical distancing, and hand hygiene (Department of Health, 2006). They supported contact tracing, isolation, and quarantine measures leveraging community knowledge and trust (Stamidis et al., 2019). They addressed misinformation through credible community health education (Lim et al., 2018). They identified vulnerable populations requiring assistance during lockdowns and economic disruptions (National Academies of Sciences, Engineering, and Medicine, 2019). However, the pandemic also disrupted normal committee activities, created fear among volunteers regarding disease exposure, and diverted attention from ongoing health priorities including routine immunization and maternal health services (Mihigo et al., 2017). Post-pandemic recovery requires deliberate efforts to re-energize committees, address accumulated health needs, and strengthen emergency preparedness for future health threats (Kuruvilla et al., 2016). The pandemic experience underscores Village Health Committee potential as crucial elements of community resilience when adequately prepared and supported (Sacks et al., 2019).

Climate change and environmental health represent emerging areas where Village Health Committee engagement could significantly strengthen primary healthcare responses to environmental health threats (Uwadiae et al., 2011). Committees can contribute to climate adaptation through health education regarding heat-related illness prevention, vector-borne disease prevention responding to changing disease ecology, water and sanitation improvements addressing contamination risks, early warning systems for extreme weather events, and advocacy for environmental health protections (Osabuohien, 2019). Their community knowledge positions them to identify local environmental health hazards and mobilize responses. However, most Village Health Committees currently lack training in environmental health and climate-health linkages, representing an important capacity building priority (Fasasi et al., 2019). As climate change increasingly affects health patterns and service delivery requirements, intentional strengthening of Village Health Committee environmental health engagement will become increasingly critical (Uwadiae et al., 2011; Didi, et al 2019).

Mental health and non-communicable disease management represent priority areas where Village Health Committee potential remains substantially underutilized despite growing disease burden (World Health Organization, 2008). Committees can contribute to mental health through reducing stigma, identifying individuals requiring care, supporting treatment adherence, addressing social determinants, and advocating for service integration into primary care (Saraceno et al., 2007). For chronic diseases, committees can promote healthy behaviors, support

screening, facilitate peer support groups, encourage treatment adherence, and advocate for reliable medication supplies (Stellefson et al., 2013). However, committee capacity building has traditionally emphasized maternal and child health and communicable diseases, with mental health and chronic disease receiving inadequate attention (Rothman & Wagner, 2003). As epidemiological transitions bring non-communicable diseases to prominence, deliberate expansion of Village Health Committee engagement in these areas represents an important direction for strengthening comprehensive primary healthcare (American Diabetes Association, 2018).

Universal health coverage goals cannot be achieved without robust primary healthcare systems incorporating effective community participation mechanisms such as Village Health Committees (Kuruvilla et al., 2016). Coverage expansion requires not only financial risk protection but also service delivery improvements ensuring accessible, acceptable, quality care reaching all population segments including marginalized groups (Balogun et al., 2019). Village Health Committees contribute to coverage expansion through identifying underserved populations, mobilizing demand for services, improving quality and responsiveness, addressing inequities, and building community ownership supporting sustainability (Starfield et al., 2005). Their grassroots positioning enables them to identify and address last-mile access barriers that national planning often overlooks (Guagliardo, 2004). However, universal health coverage financing schemes must explicitly include resources for community participation infrastructure rather than focusing exclusively on clinical service provision, recognizing that community engagement represents essential component of effective coverage (McArthur-Lloyd et al., 2016).

REFERENCES

[1] Abass, O.S., Balogun, O. & Didi P.U., 2019. A Predictive Analytics Framework for Optimizing Preventive Healthcare Sales and Engagement Outcomes. IRE Journals, 2(11), pp.497–503.

[2] Adenuga, T., Ayobami, A.T. & Okolo, F.C., 2019. Laying the Groundwork for Predictive Workforce Planning Through Strategic Data Analytics and Talent Modeling. IRE Journals, 3(3), pp.159–161. ISSN: 2456-8880.

[3] Aduwo, M. O., & Nwachukwu, P. S. (2019). Dynamic Capital Structure Optimization in Volatile Markets: A Simulation-Based Approach to Balancing Debt and Equity Under Uncertainty. IRE Journals, 3(2), 783–792.

[4] Aduwo, M. O., Akonobi, A. B., & Okpokwu, C. O. (2019). A Predictive HR Analytics Model Integrating Computing and Data Science to Optimize Workforce Productivity Globally. IRE Journals, 3(2), 798–807.

[5] Aduwo, M. O., Akonobi, A. B., & Okpokwu, C. O. (2019). Strategic Human Resource Leadership Model for Driving Growth, Transformation, and Innovation in Emerging Market Economies. IRE Journals, 2(10), 476–485.

[6] American Diabetes Association, 2018. Standards of medical care in diabetes—2018 abridged for primary care providers. Clinical diabetes: a publication of the American Diabetes Association, 36(1), p.14.

[7] Andrew S. Garner, Jack P. Shonkoff, Benjamin S. Siegel, Mary I. Dobbins, Marian F. Earls, Andrew S. Garner, Laura McGuinn, John Pascoe, and David L. Wood. "Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics,.(2012):" Pediatrics 129, no. 1 e224-e231.

[8] Anyebe, B.N.V., Dimkpa, C., Aboki, D., Egbule, D., Useni, S. and Eneogu, R., 2018. Impact of active case finding of tuberculosis among prisoners using the WOW truck in North central Nigeria. The international Union

Against Tuberculosis and Lung Disease, 11, p.22.

[9] Assegaai, T. and Schneider, H., 2019. The supervisory relationships of community health workers in primary health care: social network analysis of ward-based outreach teams in Ngaka Modiri Molema District, South Africa. BMJ Global Health, 4(6), p.e001839.

[10] Atkinson, J.A., Vallely, A., Fitzgerald, L., Whittaker, M. and Tanner, M., 2011. The architecture and effect of participation: a systematic review of community participation for communicable disease control and elimination. Implications for malaria elimination. Malaria journal, 10(1), p.225.

[11] Balarajan, Y., Selvaraj, S. and Subramanian, S.V., 2011. Health care and equity in India. The Lancet, 377(9764), pp.505-515.

[12] Balogun, O., Abass, O.S. & Didi P.U., 2019. A Multi-Stage Brand Repositioning Framework for Regulated FMCG Markets in Sub-Saharan Africa. IRE Journals, 2(8), pp.236–242.

[13] Bender, D.E. and Pitkin, K., 1987. Bridging the gap: the village health worker as the cornerstone of the primary health care model. Social Science & Medicine, 24(6), pp.515-528.

[14] Bitton, A., Ratcliffe, H.L., Veillard, J.H., Kress, D.H., Barkley, S., Kimball, M., Secci, F., Wong, E., Basu, L., Taylor, C. and Bayona, J., 2017. Primary health care as a foundation for strengthening health systems in low-and middle-income countries. Journal of general internal medicine, 32(5), pp.566-571.

[15] Black, R.E., Taylor, C.E., Arole, S., Bang, A., Bhutta, Z.A., Chowdhury, A.M.R., Kirkwood, B.R., Kureshy, N., Lanata, C.F., Phillips, J.F. and Taylor, M., 2017. Comprehensive review of the evidence regarding the effectiveness of community–based primary health care in improving maternal, neonatal and child health: 8. summary and recommendations of the Expert Panel. Journal of global health, 7(1), p.010908.

[16] Bodenheimer, T., Wagner, E.H. and Grumbach, K., 2002. Improving primary care for patients with chronic illness. Jama, 288(14), pp.1775-1779.

[17] Bonu, S., Rani, M. and Baker, T.D., 2003. The impact of the national polio immunization campaign on levels and equity in immunization coverage: evidence from rural North India. Social science & medicine, 57(10), pp.1807-1819.

[18] Bossert, T.J. and Beauvais, J.C., 2002. Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space. Health policy and planning, 17(1), pp.14-31.

[19] Brunton, G., Thomas, J., O'Mara-Eves, A., Jamal, F., Oliver, S. and Kavanagh, J., 2017. Narratives of community engagement: a systematic review-derived conceptual framework for public health interventions. BMC Public Health, 17(1), p.944.

[20] Bukhari, T.T., Oladimeji, O., Etim, E.D. & Ajayi, J.O., 2019. Toward Zero-Trust Networking: A Holistic Paradigm Shift for Enterprise Security in Digital Transformation Landscapes. IRE Journals, 3(2), pp.822-831. DOI: 10.34256/irevol1922

[21] Chaskin, R.J., 2001. Building community capacity: A definitional framework and case studies from a comprehensive community initiative. Urban affairs review, 36(3), pp.291-323.

[22] Chen, Y., Yin, Z. and Xie, Q., 2014. Suggestions to ameliorate the inequity in urban/rural allocation of healthcare resources in China. International Journal for Equity in Health, 13(1), p.34.

[23] Department of Health, 2006. Our health, our care, our say: a new direction for community services (Vol. 6737). The Stationery Office.

[24] Didi P.U., Abass, O.S. & Balogun, O., 2019. A Multi-Tier Marketing Framework for Renewable Infrastructure Adoption in

Emerging Economies. IRE Journals, 3(4), pp.337–345.

[25] Dieleman, M., Cuong, P.V., Anh, L.V. and Martineau, T., 2003. Identifying factors for job motivation of rural health workers in North Viet Nam. Human resources for health, 1(1), p.10.

[26] Draper, A.K., Hewitt, G. and Rifkin, S., 2010. Chasing the dragon: developing indicators for the assessment of community participation in health programmes. Social science & medicine, 71(6), pp.1102-1109.

[27] Dubé, E., Leask, J., Wolff, B., Hickler, B., Balaban, V., Hosein, E. and Habersaat, K., 2018. The WHO Tailoring Immunization Programmes (TIP) approach: review of implementation to date. Vaccine, 36(11), pp.1509-1515.

[28] Evans-Uzosike, I.O. & Okatta, C.G., 2019. Strategic Human Resource Management: Trends, Theories, and Practical Implications. Iconic Research and Engineering Journals, 3(4), pp.264-270.

[29] Farnsworth, S.K., Böse, K., Fajobi, O., Souza, P.P., Peniston, A., Davidson, L.L., Griffiths, M. and Hodgins, S., 2014. Community engagement to enhance child survival and early development in low-and middle-income countries: an evidence review. Journal of health communication, 19(sup1), pp.67-88.

[30] Fasasi, S.T., Adebowale, O.J., Abdulsalam, A.B.D.U.L.M.A.L.I.Q. and Nwokediegwu, Z.Q.S., 2019. Benchmarking performance metrics of methane monitoring technologies in simulated environments. Iconic Research and Engineering Journals, 3(3), pp.193-202.

[31] Fields, R., Dabbagh, A., Jain, M. and Sagar, K.S., 2013. Moving forward with strengthening routine immunization delivery as part of measles and rubella elimination activities. Vaccine, 31, pp.B115-B121.

[32] George, A.S., Mehra, V., Scott, K. and Sriram, V., 2015. Community participation in health systems research: a systematic review assessing the state of research, the nature of interventions involved and the features of engagement with communities. PloS one, 10(10), p.e0141091.

[33] Gilmore, B. and McAuliffe, E., 2013. Effectiveness of community health workers delivering preventive interventions for maternal and child health in low-and middle-income countries: a systematic review. BMC public health, 13(1), p.847.

[34] Greenhalgh, T., Jackson, C., Shaw, S. and Janamian, T., 2016. Achieving research impact through co-creation in community-based health services: literature review and case study. The Milbank Quarterly, 94(2), pp.392-429.

[35] Grundy, J., 2010. Country-level governance of global health initiatives: an evaluation of immunization coordination mechanisms in five countries of Asia. Health Policy and Planning, 25(3), pp.186-196.

[36] Guagliardo, M.F., 2004. Spatial accessibility of primary care: concepts, methods and challenges. International journal of health geographics, 3(1), p.3.

[37] Guignard, A., Praet, N., Jusot, V., Bakker, M. and Baril, L., 2019. Introducing new vaccines in low-and middle-income countries: challenges and approaches. Expert review of vaccines, 18(2), pp.119-131.

[38] Haines, A., Sanders, D., Lehmann, U., Rowe, A.K., Lawn, J.E., Jan, S., Walker, D.G. and Bhutta, Z., 2007. Achieving child survival goals: potential contribution of community health workers. The lancet, 369(9579), pp.2121-2131.

[39] Hardt, K., Bonanni, P., King, S., Santos, J.I., El-Hodhod, M., Zimet, G.D. and Preiss, S., 2016. Vaccine strategies: Optimising outcomes. Vaccine, 34(52), pp.6691-6699.

[40] Hodgkinson, S., Godoy, L., Beers, L.S. and Lewin, A., 2017. Improving mental health access for low-income children and families in the primary care setting. Pediatrics, 139(1), p.e20151175.

[41] Hunter, C.L., Funderburk, J.S., Polaha, J., Bauman, D., Goodie, J.L. and Hunter, C.M., 2018. Primary Care Behavioral Health (PCBH) model research: Current state of the science and a call to action. Journal of Clinical Psychology in Medical Settings, 25(2), pp.127-156.

[42] Hutchison, B., Levesque, J.F., Strumpf, E. and Coyle, N., 2011. Primary health care in Canada: systems in motion. The Milbank Quarterly, 89(2), pp.256-288.

[43] Iwelunmor, J., Blackstone, S., Veira, D., Nwaozuru, U., Airhihenbuwa, C., Munodawafa, D., Kalipeni, E., Jutal, A., Shelley, D. and Ogedegbe, G., 2015. Toward the sustainability of health interventions implemented in sub-Saharan Africa: a systematic review and conceptual framework. Implementation Science, 11(1), p.43.

[44] Jagosh, J., Macaulay, A.C., Pluye, P., Salsberg, J.O.N., Bush, P.L., Henderson, J.I.M., Sirett, E., Wong, G., Cargo, M., Herbert, C.P. and Seifer, S.D., 2012. Uncovering the benefits of participatory research: implications of a realist review for health research and practice. The Milbank Quarterly, 90(2), pp.311-346.

[45] Kok, M.C., Dieleman, M., Taegtmeyer, M., Broerse, J.E., Kane, S.S., Ormel, H., Tijm, M.M. and De Koning, K.A., 2015. Which intervention design factors influence performance of community health workers in low-and middle-income countries? A systematic review. Health policy and planning, 30(9), pp.1207-1227.

[46] Kolopack, P.A., Parsons, J.A. and Lavery, J.V., 2015. What makes community engagement effective?: lessons from the eliminate dengue program in Queensland Australia. PLoS neglected tropical diseases, 9(4), p.e0003713.

[47] Kuruvilla, S., Bustreo, F., Kuo, T., Mishra, C.K., Taylor, K., Fogstad, H., Gupta, G.R., Gilmore, K., Temmerman, M., Thomas, J. and Rasanathan, K., 2016. The Global strategy for women's, children's and adolescents' health (2016–2030): a roadmap based on evidence and country experience. Bulletin of the World Health Organization, 94(5), p.398.

[48] Ladner, J., Besson, M.H., Rodrigues, M., Audureau, E. and Saba, J., 2014. Performance of 21 HPV vaccination programs implemented in low and middle-income countries, 2009–2013. BMC public health, 14(1), p.670.

[49] Lapiz, S.M.D., Miranda, M.E.G., Garcia, R.G., Daguro, L.I., Paman, M.D., Madrinan, F.P., Rances, P.A. and Briggs, D.J., 2012. Implementation of an intersectoral program to eliminate human and canine rabies: the Bohol Rabies Prevention and Elimination Project. PLoS neglected tropical diseases, 6(12), p.e1891.

[50] Lewin, S., Munabi-Babigumira, S., Glenton, C., Daniels, K., Bosch-Capblanch, X., Van Wyk, B.E., Odgaard-Jensen, J., Johansen, M., Aja, G.N., Zwarenstein, M. and Scheel, I.B., 2010. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. Cochrane database of systematic reviews, (3).

[51] Li, X., Lu, J., Hu, S., Cheng, K.K., De Maeseneer, J., Meng, Q., Mossialos, E., Xu, D.R., Yip, W., Zhang, H. and Krumholz, H.M., 2017. The primary health-care system in China. The Lancet, 390(10112), pp.2584-2594.

[52] Lim, R., Tripura, R., Peto, T.J., Sareth, M., Sanann, N., Davoeung, C., Nguon, C. and Cheah, P.Y., 2018. Drama as a community engagement strategy for malaria in rural Cambodia. Wellcome open research, 2, p.95.

[53] Longlett, S.K., Kruse, J.E. and Wesley, R.M., 2001. Community-oriented primary care: historical perspective. The Journal of the American Board of Family Practice, 14(1), pp.54-63.

[54] Manandhar, D.S., Osrin, D., Shrestha, B.P., Mesko, N., Morrison, J., Tumbahangphe, K.M., Tamang, S., Thapa, S., Shrestha, D., Thapa, B. and Shrestha, J.R., 2004. Effect of a participatory intervention with women's groups

on birth outcomes in Nepal: cluster-randomised controlled trial. The Lancet, 364(9438), pp.970-979.

[55] Marsh, V., Kamuya, D., Rowa, Y., Gikonyo, C. and Molyneux, S., 2008. Beginning community engagement at a busy biomedical research programme: experiences from the KEMRI CGMRC-Wellcome Trust Research Programme, Kilifi, Kenya. Social science & medicine, 67(5), pp.721-733.

[56] McArthur-Lloyd, A., McKenzie, A., Findley, S.E., Green, C. and Adamu, F., 2016. Community engagement, routine immunization, and the polio legacy in northern Nigeria. Global Health Communication, 2(1), pp.1-10.

[57] Menson, W.N.A., Olawepo, J.O., Bruno, T., Gbadamosi, S.O., Nalda, N.F., Anyebe, V., Ogidi, A., Onoka, C., Oko, J.O. and Ezeanolue, E.E., 2018. Reliability of self-reported Mobile phone ownership in rural north-Central Nigeria: cross-sectional study. JMIR mHealth and uHealth, 6(3), p.e8760.

[58] Mihigo, R., Okeibunor, J., Anya, B., Mkanda, P. and Zawaira, F., 2017. Challenges of immunization in the African Region. The Pan African Medical Journal, 27(Suppl 3), p.12.

[59] Minkler, M., Thompson, M., Bell, J. and Rose, K., 2001. Contributions of community involvement to organizational-level empowerment: The federal healthy start experience. Health Education & Behavior, 28(6), pp.783-807.

[60] Mockford, C., Staniszewska, S., Griffiths, F. and Herron-Marx, S., 2012. The impact of patient and public involvement on UK NHS health care: a systematic review. International journal for quality in health care, 24(1), pp.28-38.

[61] Mossialos, E., Courtin, E., Naci, H., Benrimoj, S., Bouvy, M., Farris, K., Noyce, P. and Sketris, I., 2015. From “retailers” to health care providers: transforming the role of community pharmacists in chronic disease management. Health policy, 119(5), pp.628-639.

[62] National Academies of Sciences, Medicine, Medicine Division and Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health, 2019. Integrating social care into the delivery of health care: Moving upstream to improve the nation's health.

[63] National Vaccine Advisory Committee and National Vaccine Advisory Committee, 1999. Strategies to sustain success in childhood immunizations. Jama, 282(4), pp.363-370.

[64] Nelson, A.E., Allen, K.D., Golightly, Y.M., Goode, A.P. and Jordan, J.M., 2014, June. A systematic review of recommendations and guidelines for the management of osteoarthritis: the chronic osteoarthritis management initiative of the US bone and joint initiative. In Seminars in arthritis and rheumatism (Vol. 43, No. 6, pp. 701-712). WB Saunders.

[65] Nkomazana, O., Mash, R., Shaibu, S. and Phaladze, N., 2015. Stakeholders’ perceptions on shortage of healthcare workers in primary healthcare in Botswana: focus group discussions. PloS one, 10(8), p.e0135846.

[66] Nwaimo, C.S., Oluoha, O.M. & Oyedokun, O., 2019. Big Data Analytics: Technologies, Applications, and Future Prospects. Iconic Research and Engineering Journals, 2(11), pp.411-419.

[67] Nwaimo, C.S., Oluoha, O.M. and Oyedokun, O.Y.E.W.A.L.E., 2019. Big data analytics: technologies, applications, and future prospects. Iconic Research and Engineering Journals, 2(11), pp.411-419.

[68] Okenwa, O.K., Uzozie, O.T. & Onaghinor, O., 2019. Supply Chain Risk Management Strategies for Mitigating Geopolitical and Economic Risks. IRE Journals, 2(9), pp.242-249. ISSN: 2456-88801709805

[69] Olayo, R., Wafula, C., Aseyo, E., Loum, C. and Kaseje, D., 2014. A quasi-experimental

assessment of the effectiveness of the Community Health Strategy on health outcomes in Kenya. BMC health services research, 14(Suppl 1), p.S3.

[70] Osabuohien, F.O., 2017. Review of the environmental impact of polymer degradation. Communication in Physical Sciences, 2(1).

[71] Osabuohien, F.O., 2019. Green Analytical Methods for Monitoring APIs and Metabolites in Nigerian Wastewater: A Pilot Environmental Risk Study. Communication In Physical Sciences, 4(2), pp.174-186.

[72] O'Connell, M.E., Boat, T. and Warner, K.E., 2009. Committee on the prevention of mental disorders and substance abuse among children, youth, and young adults: Research advances and promising interventions. Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.

[73] O'Mara-Eves, A., Brunton, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F., Matosevic, T., Harden, A. and Thomas, J., 2013. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Public Health Research, 1(4), pp.1-526.

[74] Patel, A.R. and Nowalk, M.P., 2010. Expanding immunization coverage in rural India: a review of evidence for the role of community health workers. Vaccine, 28(3), pp.604-613.

[75] Patel, V., Weiss, H.A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., De Silva, M.J., Bhat, B., Araya, R., King, M. and Simon, G., 2010. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. The Lancet, 376(9758), pp.2086-2095.

[76] Paul, P. and Fabio, A., 2014. Literature review of HPV vaccine delivery strategies: considerations for school-and non-school based immunization program. Vaccine, 32(3), pp.320-326.

[77] Prost, A., Colbourn, T., Seward, N., Azad, K., Coomarasamy, A., Copas, A., Houweling, T.A., Fottrell, E., Kuddus, A., Lewycka, S. and MacArthur, C., 2013. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. The Lancet, 381(9879), pp.1736-1746.

[78] Rosato, M., Laverack, G., Grabman, L.H., Tripathy, P., Nair, N., Mwansambo, C., Azad, K., Morrison, J., Bhutta, Z., Perry, H. and Rifkin, S., 2008. Community participation: lessons for maternal, newborn, and child health. The Lancet, 372(9642), pp.962-971.

[79] Rosenthal, T.C., 2008. The medical home: growing evidence to support a new approach to primary care. The Journal of the American Board of Family Medicine, 21(5), pp.427-440.

[80] Rothman, A.A. and Wagner, E.H., 2003. Chronic illness management: what is the role of primary care?. Annals of Internal Medicine, 138(3), pp.256-261.

[81] Ryman, T., Macauley, R., Nshimirimana, D., Taylor, P., Shimp, L. and Wilkins, K., 2010. Reaching every district (RED) approach to strengthen routine immunization services: evaluation in the African region, 2005. Journal of public health, 32(1), pp.18-25.

[82] Sacks, E., Morrow, M., Story, W.T., Shelley, K.D., Shanklin, D., Rahimtoola, M., Rosales, A., Ibe, O. and Sarriot, E., 2019. Beyond the building blocks: integrating community roles into health systems frameworks to achieve health for all. BMJ global health, 3(Suppl 3), p.e001384.

[83] Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D. and Underhill, C., 2007. Barriers to improvement of mental health services in low-income and middle-income countries. The Lancet, 370(9593), pp.1164-1174.

[84] Sarriot, E.G., Winch, P.J., Ryan, L.J., Bowie, J., Kouletio, M., Swedberg, E., LeBan, K., Edison, J., Welch, R. and Pacqué, M.C., 2004. A methodological approach and framework for sustainability assessment in NGO-implemented primary health care programs. The International journal of health planning and management, 19(1), pp.23-41.

[85] Scholten, J., Eneogu, R., Ogbudebe, C., Nsa, B., Anozie, I., Anyebe, V., Lawanson, A. and Mitchell, E., 2018. Ending the TB epidemic: role of active TB case finding using mobile units for early diagnosis of tuberculosis in Nigeria. The international Union Against Tuberculosis and Lung Disease, 11, p.22.

[86] Shediac-Rizkallah, M.C. and Bone, L.R., 1998. Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. Health education research, 13(1), pp.87-108.

[87] Shen, A.K., Fields, R. and McQuestion, M., 2014. The future of routine immunization in the developing world: challenges and opportunities. Global Health: Science and Practice, 2(4), pp.381-394.

[88] Shi, L., 2012. The impact of primary care: a focused review. Scientifica, 2012(1), p.432892.

[89] Stamidis, K.V., Bologna, L., Bisrat, F., Tadesse, T., Tessema, F. and Kang, E., 2019. Trust, communication, and community networks: how the CORE Group Polio Project community volunteers led the fight against polio in Ethiopia's most at-risk areas. The American Journal of Tropical Medicine and Hygiene, 101(4 Suppl), p.59.

[90] Starfield, B., Shi, L. and Macinko, J., 2005. Contribution of primary care to health systems and health. The milbank quarterly, 83(3), pp.457-502.

[91] Stellefson, M., Dipnarine, K. and Stopka, C., 2013. The chronic care model and diabetes management in US primary care settings: a systematic review. Preventing chronic disease, 10, p.E26.

[92] Strachan, D.L., Källander, K., Ten Asbroek, A.H., Kirkwood, B., Meek, S.R., Benton, L., Conteh, L., Tibenderana, J. and Hill, Z., 2012. Interventions to improve motivation and retention of community health workers delivering integrated community case management (iCCM): stakeholder perceptions and priorities. The American journal of tropical medicine and hygiene, 87(5 Suppl), p.111.

[93] Tripathy, P., Nair, N., Barnett, S., Mahapatra, R., Borghi, J., Rath, S., Rath, S., Gope, R., Mahto, D., Sinha, R. and Lakshminarayana, R., 2010. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. The Lancet, 375(9721), pp.1182-1192.

[94] Umezurike, S.A. and Iwu, C.G., 2017. Democracy and majority rule in South Africa: Implications for good governance. Acta Universitatis Danubius. Relationes Internationales, 10(1).

[95] Umezurike, S.A. and Ogunnubi, O., 2016. Counting the Cost? A Cautionary Analysis of South Africa's BRICS Membership. Journal of Economics and Behavioral Studies, 8(5), pp.211-221.

[96] Umoren, O., Didi, P.U., Balogun, O., Abass, O.S. & Akinrinoye, O.V., 2019. Linking Macroeconomic Analysis to Consumer Behavior Modeling for Strategic Business Planning in Evolving Market Environments. IRE Journals, 3(3), pp.203–213

[97] Uwadiae, R.E., Okunade, G.O. and Okosun, A.O., 2011. Community structure, biomass and density of benthic phytomacrofauna communities in a tropical lagoon infested by water hyacinth (Eichhornia crassipes). Pan-American Journal of Aquatic Sciences, 6(1), pp.44-56.

[98] Uzozie, O.T., Onaghinor, O. & Okenwa, O.K., 2019. The Influence of Big Data Analytics on

Supply Chain Decision-Making. IRE Journals, 3(2), pp.754-761. ISSN: 2456-8880

[99] Vanlerberghe, V.E.E.R.L.E., Toledo, M.E., Rodriguez, M., Gomez, D., Baly, A., Benitez, J.R. and Van Der Stuyft, P., 2009. Community involvement in dengue vector control: cluster randomised trial. Bmj, 338.

[100] Vanselow, N.A., Lohr, K.N., Yordy, K.D. and Donaldson, M.S. eds., 1996. Primary care: America's health in a new era.

[101] Wallerstein, N., Minkler, M., Carter-Edwards, L., Avila, M. and Sanchez, V., 2015. Improving health through community engagement, community organization, and community building. Health behavior: theory, research and practice, 5.

[102] World Health Organization, 2012. Global measles and rubella strategic plan: 2012.

[103] World Health Organization, World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians, 2008. Integrating mental health into primary care: a global perspective. World Health Organization.

[104] Xyrichis, A. and Lowton, K., 2008. What fosters or prevents interprofessional teamworking in primary and community care? A literature review. International journal of nursing studies, 45(1), pp.140-153.

[105] Zakus, J.D.L. and Lysack, C.L., 1998. Revisiting community participation. Health policy and planning, 13(1), pp.1-12.

[106] In conclusion, Village Health Committees represent valuable but underutilized mechanisms for strengthening primary healthcare when implemented with adequate attention to enabling factors and realistic expectations regarding their contributions (George et al., 2015). They offer pathways for enhancing community participation in health governance, improving health system responsiveness and accountability, mobilizing community resources and action, strengthening health workforce performance, and building community capacity for sustained health improvement (Wallerstein et al., 2015). However, their effectiveness depends critically on supportive policy frameworks, adequate investments in capacity building and operational support, integration with health systems, constructive relationships with health workers, inclusive governance, and sustained political commitment (Kok et al., 2015). Moving forward requires shifting from viewing Village Health Committees as low-cost substitutes for health system investments toward recognizing them as essential components of comprehensive primary healthcare requiring dedicated support (Starfield et al., 2005). When appropriately designed, implemented, and supported, Village Health Committees can contribute substantially to building resilient, responsive, equitable primary healthcare systems serving all community members effectively (Bitton et al., 2017). The evidence synthesized in this review provides roadmaps for optimizing Village Health Committee contributions while honestly acknowledging persistent challenges requiring ongoing attention and innovation (Vanselow et al., 1996).