

Social Accountability in the Health Sector: Toward Conceptual Clarity to Public Social Services Delivery in Chamwino District, Tanzania

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Abstract

The study analyzes the contribution of social accountability to public social service delivery. Its rationale was drawn in the aspect of human endeavor for the realization of human rights and capabilities. Although, accessibility and satisfaction of social services depend on a number of variables, however, citizens' capability to demand accountability is central. Thus, the study meant to examine the role of social accountability in health sector. Specifically, the study aimed to assess the level of the health service users' participation on the social accountability in public health service delivery; and explore the factors influencing social accountability to public health service users. The study findings reveals that there is significant relationship between social accountability and public health service delivery, and thus making it crucial determinant of health sector performance at primary health facility levels. The theoretical and practicability values of the study make its results authentic in understanding the existing relationship between social accountability and public social service delivery. This understanding can promote citizens' participation, accountability and transparency. The study therefore, recommends that social accountability is a vehicle towards improved public service delivery.

Keywords: social accountability, public social service, health service, citizens' participation, capabilities

INTRODUCTION

Social accountability simply means the broad range of actions and mechanisms beyond voting. Social accountability makes citizens more accountable, responsible and effective in assisting the government to take its responsibilities (ANSA, 2010). The concept of social accountability emerged and came into global discourse after the United Nations passed the universal declaration of human rights in 1948 (David, 1997). It was in this post-world war II period when the discourse of 'rights' went global. During that time states were required to translate their commitments into individual countries' laws and policy frameworks articulating an inalienability of human right, in which all human right and fundamental freedoms can be fully realized (Cornwall, 2001).

In response to the global call, Tanzania undertook its first decentralization reform in 1972. This led to moving from a centrally planned, one party socialist system toward a multi-party democratic state with an open economy (Yilmaz, 2010). Although the process has been painstakingly slow, the country had banked worth efforts in governance by enhancing citizens' engagement and local autonomy in fulfillment of basic needs. Significant efforts have gone into setting up decentralized planning over the years. Furthermore, funding modalities that ensure local-level participation in planning and service delivery has increase social accountability (Malena, 2004).

Despite achievement in devolving local autonomy and horizontal accountability, declarations and commitment by central government to devolve power to citizens has not been backed with effective and sustainable action (Yilmaz, 2010). Community participation in planning and priority setting is still limited despite the steps and effort that the government has put in place to strengthen district health service boards and governing committees, and established institutional arrangements for participation (Ravnkilde, 2013). Citizens have remained with little role in monitoring performance of public service delivery (Yilmaz, 2010; Mniki-Mangaliso, 2015).

Contrarily to inalienability commitment of human rights, progressive realization of human rights and capabilities is hardly realized by the majority of rural Tanzanians. Many fail to access public health services among the public social services because the social accountability avenues in spheres of socio-political and administrative are weak. As a result, the systems have limited the rights bearers from participatory governance, hence it catalyze more the 'top-down' rather than 'bottom-up' system.

In the same vein, fundamental problem in health sector in particular, lies with the broader health system and its ability to deliver interventions to those who need them. Weaknesses and obstacles exist across the system including service provision; and demand side issues such as people's participation, knowledge and behavior (Savigny, 2009). The study has thus, critically examined this systemic problem in the realization of human rights and capabilities.

SYNTHESIS OF METHODS

To achieve the study purpose, a cross sectional research design was employed in Chamwino District, Tanzania involving a total of 115 respondents. Data was collected using various tools including questionnaires, interview guide, and observation guide. The mixed tools approach was chosen to allow collection of both quantitative and qualitative data sequentially. The collected data were analyzed using content analysis and descriptive statistical analysis which involved cross tabulation and inferential statistics such as Chi Square and Pearson correlation coefficient.

The data collection phase consists of collecting information from the respondents on how service users and service providers perceive the quality of services delivered by a particular service delivery point, such as a health facility. The study units were selected through the use of probability and purposive sampling. This ensured every unit in a population to have an equal chance of being selected to ensure validity and reliability. That is at health facility level, the respondents were randomly selected from available demographic data. Furthermore, respondents for in-depth interviews that included key informants and influential people were purposively sampled basing on their position and title.

RESULTS AND DISCUSSION

The study findings, present mixed data with one generic end of the significant relationship between social accountability and public health service delivery. Furthermore, demographic information and characteristics were also important for finding correlation among age, sex, and level of education in respect to social accountability in health service delivery. This was meant to understand scientific reasons of variations among the respondents. The distinctive information in each feature provided sufficient reference point in the analysis and the respective definitive thought.

Age and sex are the most important factors that affect mortality and health (Calderwood, 2004). In this study, age was considered for the purpose of understanding, which exactly group to be involved, and their spinning effect on social accountability. Variation of age groups in the societies has significant implication in life. Age groups in communities has direct link with the level of participation, perception and attitudes. The vast majority groups of respondents were between the ages of 34 – 41. These were 40 (34.78%) respondents in total out of 115. This indicates that they are the major representation of age group with direct connection to health service delivery in Chamwino as compared to the rest of the youth, and elderly who were 31 (26.95%) and 22 (19.13%) respondents of the ages between 26 – 33 and 42 – 49 respectively. The younger respondents who ranged between the ages of 18 – 25 were 13 and constituted 11.30% while 9 respondents of the older age 50 and above represented only 7.82%.

The interesting explanation on this age distribution is that despite the orderly age group being the least in number, they are the most consumers of health services. This indicates that elderly people need more health services compared to other age groups in the study area, this is also supported in Briefings paper (2006). Underlining this expression, a doctor in-charge from Chamwino, narrated that:

“As you may see I have a bigger work load attending the kids and you may also wonder consumption is from them and the elderly who are the frequent users compared to the rest.”

Although the age group distribution was not a central to study, the leading age range of 34 – 41, which constituted 40 (34.78%) respondents provide significant scientific reason to have critical ideas and experience of the community engagement in social accountability. From the results, it is, therefore, fair to suggest that the UNDESA (2014) remark of young women and young men aged 15 to 24 years – should be an integral part of any post – 2015 accountability framework is contrary to what field data revealed. However, there is no doubt that young people make up one fifth of the world’s population, the majority of whom live in developing countries (Davis, 2014). However, results from this study present another in-depth understanding that majority of young adults in the community at age between 34 and 41 have major impact in demanding accountability.

Since the Pearson Chi square test is used to test whether a statistically significant relationship exists between two categorical variables (Devonish, 2015), Chi-square test was used to determine the relationship between the age of the respondents and demand of accountability in health services.

Table 1: Age of the Respondents and Demand of Accountability in Health Services

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	111.906 ^a	6	.000
Likelihood Ratio	102.269	6	.000
Fisher's Exact Test	85.505		
Linear-by-Linear Association	52.954 ^c	1	.000
N of Valid Cases	100		

In Table 1, a Pearson Chi-square test was used to examine whether there is a relationship between the age of the respondents and demand of accountability. The results reveals that there is a significant relationship between the two variables (Chi square value = 111.906a, df = 6, p = .000). The respondents of age between 31–

41 (34.78%) are significantly more likely to demand accountability, hence make age an imperative determinant of social accountability.

Relationship between gender and Social Accountability

It was also important to understand the distribution of sex among the respondents involved in the study. This was meant to have-in this variable for the purpose of ensuring optimal gender sensitivity and to enrich understanding of gender based social accountability. As Calderwood (2004) points out, sex is among the important variable that affect mortality and health. Sex of respondents was considered as an imperative variable in social accountability and one of the most crucial aspects of social accountability in the demand for justification and explanations from the officials by the service users (Sipondo, 2015).

Results indicate that a higher proportion of female (62.6%) were interviewed in this study compared to only 37.4% of male respondents. The ratio distribution between male and females gives a clear indication that health related issues are gendered. Despite of multicultural settings, in this study, females were available and ready to discuss health delivery issues compared to their male counterparts.

This is contrary to Bradshaw (2016) who argues that participating in gender-sensitive programming can present more costs of time to women than benefits, since women are shy of discussing sensitive issues. Bradshaw argue more that there is a cost of time involved in engaging women including distances they have to travel to attend events such as meetings or trainings. This is more suggesting that gender is more sensitive in social accountability and the focus should be drawn to female as indicated that they are the majority in number (62.6%) on participating in health issues. The Pearson Chi-square tested to find if there is a statistical significant between respondents' sex and social accountability, results are indicated in table 2 below:

Table 2: Sex of the Respondents and Demand of Accountability in Health Services

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.813 ^a	2	.000
Likelihood Ratio	41.429	2	.000
Fisher's Exact Test	35.224		
Linear-by-Linear Association	26.858 ^c	1	.000
N of Valid Cases	100		

Educational Level of the Respondents

Education has been widely perceived as one of the most important socio-economic determinants of health and mortality (Caldewood, 2004). Thus, the level of education is a crucial variable because it provides information about knowledge and reliability of health issues as reflected in social accountability in the study area. Since the study had a core presumption of *natural settings* (Norum, 2008), education level is the best variable to provide enough evidence of variability of practices and understanding of the respondents.

Table 3: Education Level of the Respondents

Level of Education	Number of Respondents	Percentage (%)
Never gone to school	19	16.52
Primary school	43	37.39
Secondary school	38	33.04
Certificate, diploma & above	15	13.04
Total	115	100

Source: Survey Data, 2017

The findings in Table 3 above shows that the majority 43 (37.39%) of the respondents had attended primary education, followed by 38 (33.04%) of the respondents who have at least secondary level of education. Those who had never acquired any formal education amounts to 19 (16.52%) of the respondents and the remaining 15 (13.04%) attained higher level of education. These were mostly in the category of civil servants. Significantly, the two levels of primary and secondary data imply that they are the majority (70.43%) of the respondents who have formal education are also the direct consumers of health services. Since they constitute a big share of group of society who engage mostly in health seeking behavior, it is scientifically fair to culminate that they are crucial to social accountability and thus their understanding of social accountability and practice has been in natural cause of life with influence from formal settings.

The study further reveals that 19 (16.52%) of the respondents have not been completely influenced by any external factors in their decision. Despite of being left out of the moving globe but they showed to breath alike, as they were the direct health service users too. This induced an imperative part in understanding social accountability in influenced environment. This is because the study has been conceptualized in with the notion that, civil servants are the service providers and are bound to respond and dispense health services in social accountability. Likewise, the results indicate that those with higher level of education are the mostly populate. This is crucial because it respond to a question of the relationship between social accountability and health service delivery. This was also evaluated using Pearson Chi-square to test statistical significant levels of the relation that exists between education of the respondents and demand of accountability.

Table 4: Demand of Accountability in relation to Education

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	66.642 ^a	4	.000
Likelihood Ratio	78.827	4	.000
Fisher's Exact Test	67.384		
Linear-by-Linear Association	43.751 ^c	1	.000
N of Valid Cases	100		

From the Pearson Chi-square test, we examined whether there is a relationship between education level of the respondents and demand of accountability. The results indicate that there is a significant relationship between the two variables (Chi square value = 66.642^a, df = 4, p < .001). A significantly larger proportion of primary education group (37.39%) followed by secondary education group show the likeliness of demanding accountability on health. It is statistically significant that they constitute a higher possibility of influencing health service delivery through social accountability. This connotes what was reflected by Calderwood (2004) that the low educational attainment is strongly correlated with diseases, health risks and mortality. These results indicate that the more the education the more likely a person will engage in accountability issues to address health risks around their community. Furthermore, in assessing the most influencing variable in the existing relationships, the nominal regression was applied to test the likelihood of multiple variables of age, sex and education in relation to social accountability, as indicated in the likelihood ratio in table 5 below.

Table 5: Likelihood Ratio Tests

Effect/Influencing	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	5.454 ^a	.000	0	.
Age	49.575	44.121	6	.000
Sex	5.454 ^b	.	2	.
Education	26.133 ^b	20.679	4	.000

The Chi-square test encounter unexpected singularities in the Hessian matrix which means sex (5.454^b) and education (26.133^b) predictor variables were merged. Nominal regression was conducted to examine the likelihood of whether age, sex and education are more influencing in social accountability. The likelihood ratio test of age (Chi-square = 44.121, df = 6, p < .001) is significantly higher compared to education (Chi-square = 20.679, df = 4, p < .001). Thus, age is the likely significant predictor of overall influencing variable. This shows that social accountability actors shouldn't downplay the role of age in a specific community, this is also supported by UNDESA (2014), who argue that young people should be included as key stakeholders.

The Role of Social Accountability in Health Sector at Chamwino District

In examining the role of social accountability, the consideration was meant in understanding the perception of respondents on social accountability and their knowledge on the contribution of social accountability to public health service delivery.

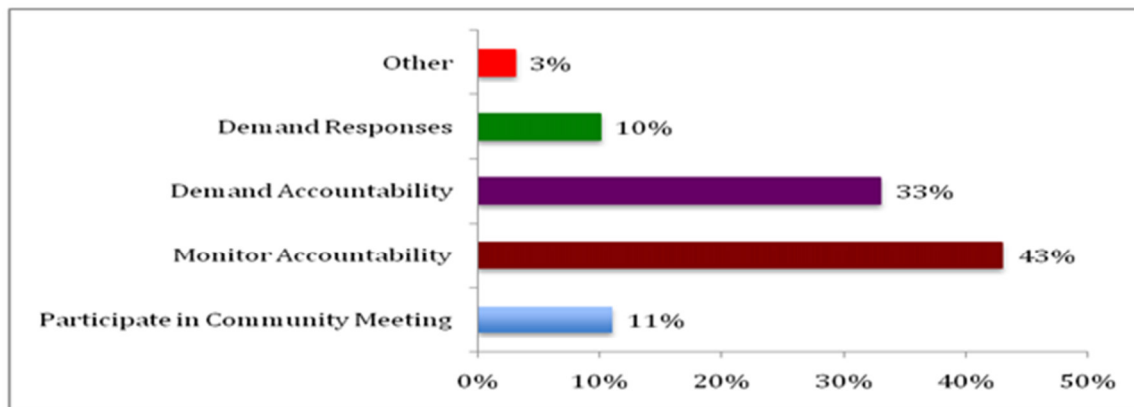


Figure 1: Respondents' Perception on Social Accountability

Figure 1 indicates that 43% of respondents perceive social accountability as a way of monitoring accountability. This definition goes hand-in-hand with that of Mniki-Mangaliso (2015) who acknowledges social accountability as a construct concept of demand driven monitoring mechanisms initiated and driven by citizens through different forms of structures. The interesting relation here is the responses and the presumed weight of categories given by the respondents. The category "demand accountability" was ranked as high understanding followed with "Monitor accountability, demand response and community participation". From the majority responses, the results are precise about high level of understanding and perception of social accountability among the citizens in Chamwino District. Debates on the understanding of social accountability, at different

times, involved other issues like citizenship, where they belong, contents of effectively to fulfill their rights and duties (Bellamy 2014). The debates seem to be influenced with social, economic and political developments, which have made the world to experience an increasing interconnectedness. Therefore, emerging issues are shaping the understanding, not only for entitlements and obligations of individuals, but also those of groups and extension beyond formal status to include informal one such as trans-state rights and duties (Nash 2009).

In this study 11% of respondents viewed participation as self help activity, which might offer opportunity for gaining knowledge and skills of executing mutual duties and responsibilities, and as opportunity for them to be served better by government or other responsible organs. They gave examples of them participating activities including community meeting, where they have chance to demand and support health services delivery at their locality. Moreover, there are those with least understanding, who share equal perception of social accountability with other choices. Understanding and participation in groups offers an opportunity for gaining knowledge and skills of executing mutual responsibilities. Indeed individuals' participation in community activities and demand response unlock potentials for social support and shared responsibilities among community members.

Those who perceived and understood it differently from the set choices were only 3%. Concurrent to the findings, civil servants and influential people viewed it as "an act of managing subordinate, dispensing rights and listening from citizens as well as citizens participation and being responsible in community development" in reiterating the same. An influential person in the study area pointed out that "*citizens should be responsible and service providers dispense services without being demanded*". In this way everyone will be doing their responsibilities without force and both the community members and professionals will have mutual relationship. Critical understanding in the findings is that the 43% of respondents' perceptions and understanding align with scholarly material, which acknowledges social accountability. Therefore, it is scientifically proven that the level of perception and understanding among the citizens is below 50% in the study area of which there is a need for interventions.

Contribution of Social Accountability to Health Service Delivery

The contribution of social accountability was meant to determine service users' understanding of the role-played by social accountability in improving health service delivery in health facilities at Chamwino District.

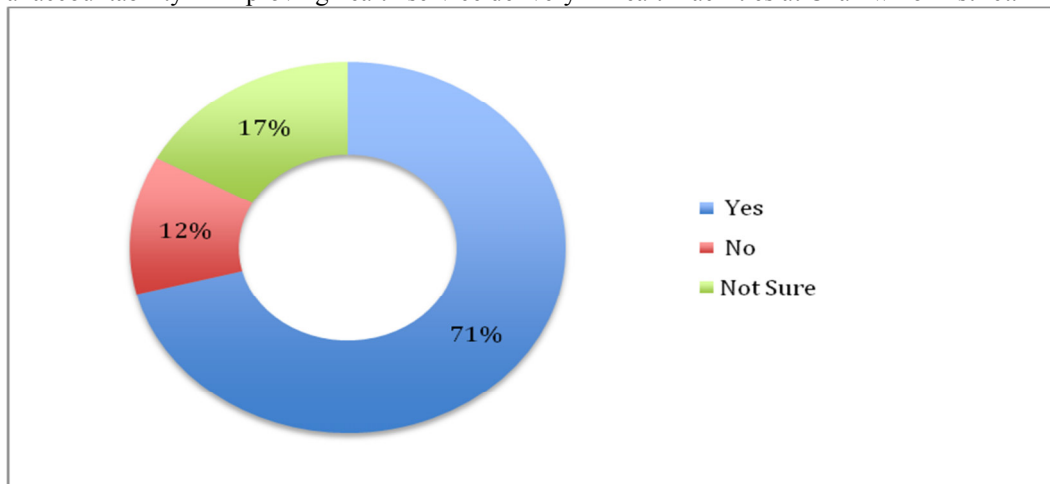


Figure 2: Contribution of Social Accountability to Health Service Delivery

Social accountability plays a vital role in shaping the level of health service delivery in the study area. 71% of respondents were in the view that this is an important aspect in making sure that actors in health service delivery are responsible to the community that they are serving. These findings indicate that people at community level plays their power and influence in determining health delivery. As observed in the study area, decisions on how citizens can take part in making sure that accountability are adhered. For instance, in an attempt to improve health service delivery environment, it was decided during village meetings that, everyone should take part in making sure that surroundings of the village dispensary are not only clean and safe for patients and anyone who visits the area but also required basic health services including drugs, laboratories, and responsible medical personnel are available.

The citizens' practice, their power and influence in determining the level of health service delivery at their own settings; making every actor in health service deliverance accountable and responsible. Moreover, one can still ask a question, "if the big picture suggests that there is an influencing link of social accountability to public health service delivery, then what could be the practice in Chamwino District?"

There is an existing relationship in the role played by social accountability and public health delivery in Chamwino District. Majority of respondents 71% are in the view that social accountability have something to do

with public health services delivery. The ability to contribute to health service delivery was ranked at 12% by the respondents. This might be due to the fact that in the point of view of lived experiences of citizens while participating in different roles in their localities, the notion on how and where they learned is of importance. However, if one consider people’s participation and monitoring participation, it is also necessary to look onto the context of their participation and a sense of belonging. A sense of belonging goes together with struggle in different ways, for the position of competent contributor (Shotter, 1993). Much of competencies to negotiate, to participate in collaborative decision making, and gaining of self confidence are learned through everyday participation in groups, committees that transcends individuals and groups (Cakmakli, 2015). In this article we are also arguing that monitoring accountability are learned through participating in different entities and constellations where rights and responsibilities are negotiated where the feelings of belonging and identity emerges.

Health Service Users’ Participation on the Social Accountability in Public Health Service Delivery

Health service users’ participation is one of the important issues that this article addresses. This is particularly looking on what does the respondents think about their fellow community members on participation in social accountability. The responses are indicated on Figure 3.

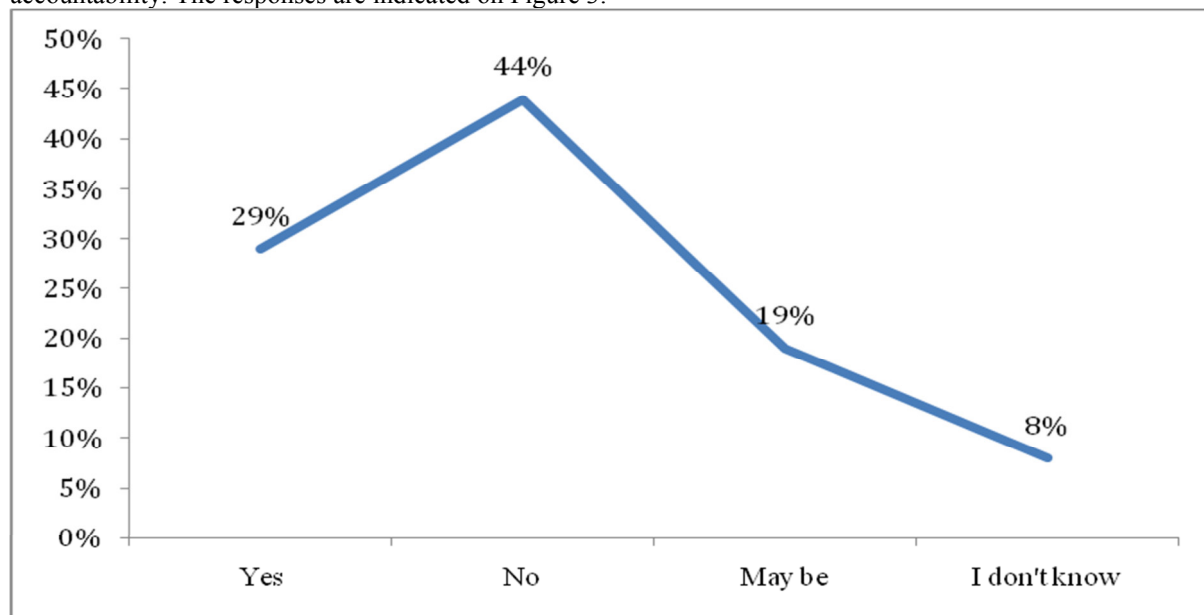


Figure 3: Citizens' Participation in Social Accountability

Participation in Social Accountability as argued by COADY, 2014 is contextual and a learning process.

Factors Influencing Social Accountability to Health Service Users in Chamwino District

Looking at the identified problem in this study, it was also designed to capture collective awareness of the factors influencing social accountability to health service users. The analysis shows that out of all respondents interviewed 79% were aware of factors influencing social accountability while 21% were not aware of the limiting factors in Chamwino District. This implies that people at the community level are aware that there are barriers to social accountability in their localities. The argument conforms to that of Ahmad (2008) that increased donor-led efforts to converge good governance agendas and neo-liberal economics tend to overlook politics that is central to the struggles for social accountability.

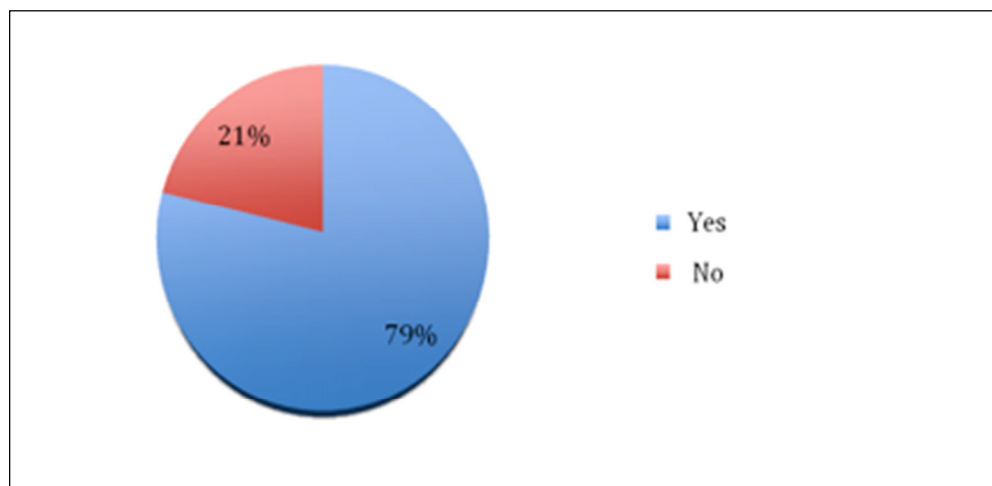


Figure 4: Awareness of Factors Influencing Social Accountability

Moreover, in interview with civil servants and influential people, the same came to picture as well. One of the influential persons, who was interviewed narrated that

“... There are two key factors that influence demand of accountability, first is the general poverty where people can't afford health services hence they are afraid to demand accountability because they will definitely need to negotiate; and second is lack of awareness and education. If these two are worked out, they could positively influence the rise of social accountability”

From this quotation we argue that awareness is the major influencing factor in social accountability and hence lack of it to majority of members of the community might lead to minimal social accountability among members. As such, there is a need to well address the issue at Chamwino district, which could lead into boosting the provision of public health services in the district.

CONCLUSION

The analysis presented in this study indicates evidence that social accountability is the vehicle towards improved public health service delivery in Chamwino District. Moreover, on the course of examining the contribution of social accountability in health sector at Chamwino District social accountability directly determines the level of public health service delivery.

The critical relationship on the level of service delivery may significantly affect attendance in public service facilities. Hence, it is recommended that stakeholders should work collaboratively to determine public health service delivery, which from the study; social accountability has the majority confidence of the respondents. Arguably, however, people at the community level need more sensitization to understand importance and potentials of social accountability. This is because some have views that are barriers to social accountability in their localities hence hinder their participation, and in reality much of the barriers are more of lack of awareness than anything else.

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