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ORIGINAL RESEARCH

Community members´ perspective on social accountability in the health system: a cross- sectional study from Tanzania

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ABSTRACT

Introduction: Social accountability initiatives are considered a way to address inefficiencies and improve overall health system performance. Tanzania has introduced Health Facility Governing Committees (HFGCs) to improve social accountability of the health system. However, information on how communities perceive these committees is lacking. This study aimed to assess the prevalence and social determinants of the HFGCs accountability from the community perspective in Tanzania.

Methods: The research employed a cross-sectional survey design in two Tanzanian districts (Handeni and Mbarali) selected for their contrasting health performance. Data collection took place from July to October 2022, involving 1184 households in 31 villages/mitaa. The study measured social accountability through a set of six questions, focusing on community support, sensitization, feedback, trust, engagement, and overall accountability of HFGCs. Socio-demographic data such as sex, age, education, occupation, type of health facility and district were also collected and analyzed using linear regression to identify factors influencing perceptions of accountability.

Results: The findings revealed a low prevalence of social accountability as measured by the variables of community awareness and engagement with the HFGCs. Only a small percentage of respondents felt adequately informed or involved in the activities of these committees. Social determinants such as higher education levels and certain occupations, such as business and retirement and those living in Handeni district, correlated positively with a better perception of social accountability.

Conclusion: The study highlights significant challenges in the operational effectiveness of HFGCs in Tanzania, with a notable disconnect between these bodies and the communities they serve. Despite the theoretical framework for social accountability, actual community engagement remains low, impacting the overall efficacy of health governance at the local level. Future research should focus on improving community awareness and participation in these committees to improve their functionality and accountability, thereby aligning with national health objectives and local needs.

Keywords: social accountability, health systems, rural, community

Abstract in Español at the end of the article

INTRODUCTION

Social accountability refers to mechanisms that engage and involve citizens in policy processes to ensure that their views are taken into account and to hold public officials accountable for delivering responsive services [1,2]. Social accountability has recently emerged as an important mechanism for strengthening community engagement and local-level infrastructure, providing a vital link between community stakeholders and public service entities [1,3,4]. Ensuring accountability at the local and sub-national levels is therefore considered crucial to achieving the ethical imperative of the Sustainable Development Goals' to "leave no one behind" [5].

In the context of health systems, social accountability refers to the obligation of the system to recognize and respond to people's needs and demands [6]. As such, social accountability initiatives are seen as a way to address inefficiencies and as a contributing factor to strengthen overall health system performance in line with the Sustainable Development Goals´ aim of universal health coverage [5,7,8].

Tanzania represents a case where social accountability mechanisms were introduced into the health system immediately after its independence. After an economic decline in the 1970s and 1980s when the government struggled to finance public services, a health sector reform starting in the 1990s aimed, among others, to increase community participation in the decision-making process of the different health facilities [9]. For that purpose, the Health Facility Governing Committees (HFGCs) were established to decentralize decision-making authority and develop a more efficient, accessible and sustainable healthcare system [6,10,11]. Eight to eleven members (depending on the health facility level) form the HFGC, consisting of both elected members, such as service users and private providers, and non-elected members, such as the facility in-charge and representatives from the ward development committee and village leaders [10].

The responsibilities of the members of the HFGCs include planning, budgeting, implementing, and monitoring service delivery at the facilities [12]. The HFGCs have two key functions concerning social accountability: to ensure the proper functioning of the facilities by holding providers accountable to community needs and to act as a platform for the service providers to reach out to the community [6].

While the role of HFGCs is seen as crucial in promoting social accountability, previous research has found that the functionality of HFGCs in Tanzania varies [10,13,14]. For example, Kesale et al [15] found that HFGCs were active in terms of gathering the community, discussing community concerns and engaging in planning and budgeting processes, but they had insufficient capacity to mobilize resources, a lack of management capacity among their members and poor communication between the committees and other boards within the health system. As a result, a lack of social accountability might lead to less responsive, efficient, and equitable healthcare services [16]. Social determinants, such as education and health literacy, economic conditions, health system infrastructure, governance, community network and access to information have been shown to impact the accountability and HFGCs ability to fulfil their mandate, creating a context-specific implementation and outcome [16,17]. While most existing research has focused on the functionality and performance of HFGCs, less is known about how the community perceives the social accountability of the committees. This study aimed to assess the prevalence and social determinants of the HFGCs accountability from the community perspective in Tanzania.

METHODS

Study context

The Tanzanian public health system is pyramidal, with health services provided through a hierarchical referral system at three levels (primary, secondary and tertiary), most of which are provided by the government. Primary healthcare facilities include dispensaries, health centers and district hospitals. Dispensaries and health centers are the first point of contact where most of the illnesses are treated. While dispensaries provide mainly outpatient care, health centers provide both outpatient and inpatient care. Patients requiring a higher level of care are referred to district hospitals. Regional Referral Hospitals (RRHs) are found at the secondary level and specialized, national hospitals are found at the tertiary level, higher in the referral system [18,19].

Facilities at all levels of the health system should have HFGCs (hospital, health center and dispensary committees) and Council Health Services Board (CHSB) at the district level to facilitate community participation [10]. The composition and function of the committees and boards are shown in the Supplementary material.

Study design

This study included data from a cross-sectional survey conducted between July and October 2022 in the districts of Handeni and Mbarali (Figure 1). The study districts were purposively selected based on the district's performance in the 2018 Star Rating Assessment conducted by the Ministry of Health. In the assessment, Handeni scored low, while Mbarali high [14]. Handeni is one of 11 districts in the Tanga region located in North-East Tanzania and the district had a total population of 384,353 in 2022 [20]. Livestock farming, hunting and gathering, fishing, forestry and subsistence farming are the main economic activities in the district [21]. One hospital, one health center and five dispensaries were selected from the district. The study was conducted in Handeni Town Council, a semi-urban location (Figure 2a). Mbarali mainly a rural district, is one of the seven districts of the Mbeya Region in the southern part of Tanzania. The district had a population of 446,336 in 2022 [20]. The main economic activities of the district include

agriculture, fishing and business. The district has one hospital, five health centers and thirty-four dispensaries (Figure 2b).

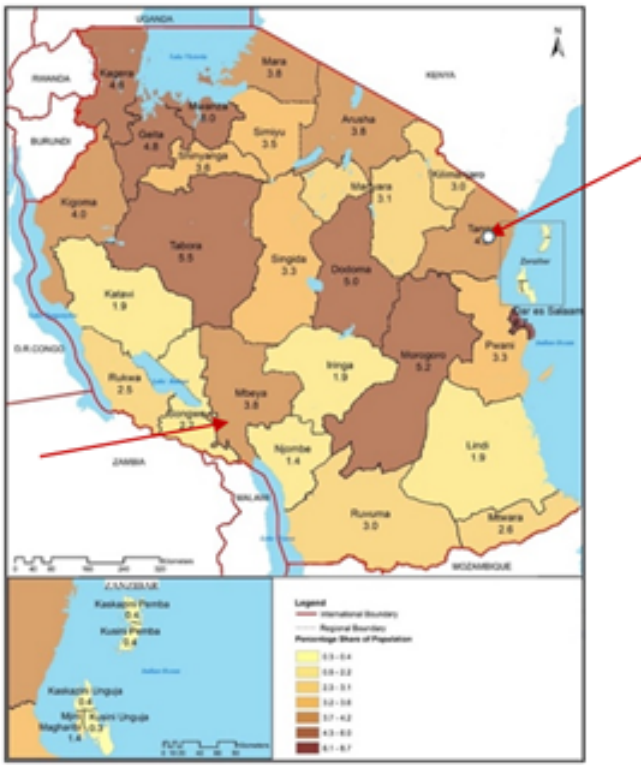

Figure 1. Map of Tanzania and regions. Arrows point to the study selected regions [20].

Data collection

Two district hospitals, three health centers and nine dispensaries were included based on geographical accessibility in both districts. A list of villages in the case of Mbarali and neighborhoods (mitaa) in the case of Handeni in the catchment area of these facilities was then compiled, resulting in a total of 31 villages/mitaa, 15 (48.4%) from Handeni and 16 (51.6%) from Mbarali.

The sample size was calculated based on a power of 80%, a significance level of 5%, a prevalence of the different outcomes of 50% and a non-response of 10%, giving a total of 1184 households. The number of households in each village/mitaa was estimated based on the population of each village/mitaa. The starting point for inclusion in each village/mitaa was determined with help of the local government leaders and every tenth household was selected until the desired sample size for the corresponding village/mitaa was reached. All selected households participated in the survey. A team of trained research assistants administered the questionnaire to the selected household head (man or woman), whoever was available and interested in participating.

Outcome

Six questions representing different aspects of social accountability were included as outcomes for this study. The questions were developed by the research team after reviewing the literature and considering the aim of the study: i) Do you think the community supports activities of the health facility governing committee? ii) Do you think the community is sensitized about activities of the health facility governing committee? iii) Have you ever received any feedback on the activities of the health facility governing committee?; iv) Do you have trust in the members of the health facility governing committee/board?; v) Do the health facility governing committee members collect views from the community regarding delivery of health care services at your health facility?; vi) Do you think members of the health facility governing committee are accountable to the community? Participants had to answer "Yes", "No" or "I don't know", with "No" and "I don´t know" responses being combined in the analysis as "I don´t know" responses were interpreted as a lack of knowledge and awareness.

Independent variables

The questionnaire collected additional information on demographic, socioeconomic and health system factors. Sex, divided into men and women, and age, further categorized into four groups (21-30, 31-40, 41-50 and 51-60 years) were included as demographic variables. Two variables: education, divided into none, primary, secondary and tertiary, and occupation, categorized as farmer/pastoralist, business, other and retired, were used as socioeconomic variables. Finally, the type of facility closer to the village/mitaa (dispensary, health center and district hospital) and the type of performing district (Handeni, low and Mbarali, high) were used as health system variables.

Statistical analysis

All statistics were calculated using the software R version 2023.06.2+561. Firstly, the frequency and percentage of the independent variables and the different outcomes were calculated. The answers to the six different questions of social accountability were used to create a continuous index. Answering "No" was given the value of 0 and "Yes" the value of 1, creating an interval ranging from 0 to 6. Using that score as the dependent variable, a linear regression analysis was performed. Firstly, the sociodemographic variables were used as separate independent variables and secondly those variables which were statistically significant in the univariate model were added to the multivariable linear regression analysis. The variance inflation factor (VIF) was used to examine the collinearity between the independent variables in the linear regression models. Since the VIF was below 1.9 for all variables, all variables were included in the model.

Ethics

This study received ethical approval from the National Ethical Review Committee in Tanzania – National Institute for Medical Research (NIMR/HQ/R.8a/Vol.IX/3928). The President´s Office Regional Administration and Local Government and

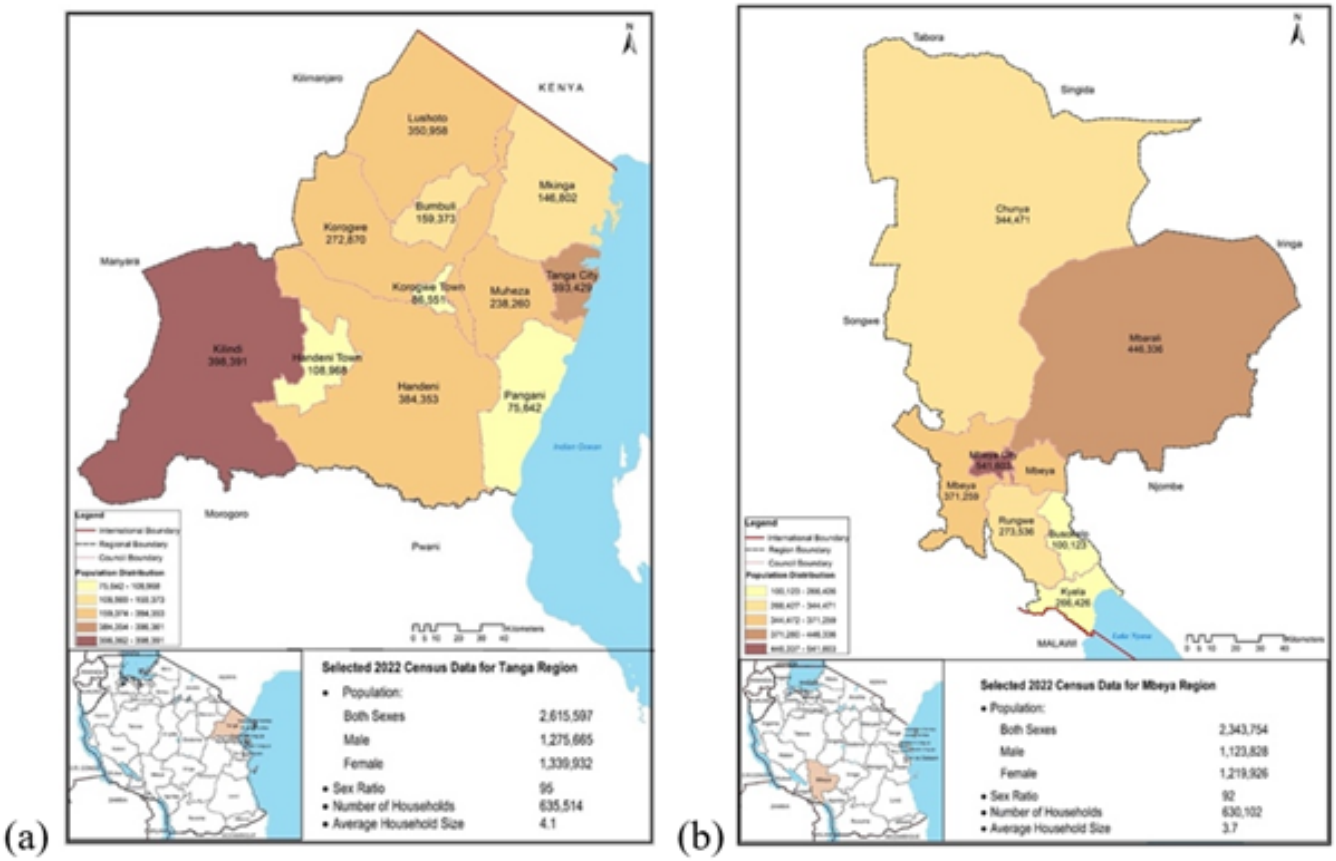

Figure 2. Map of the Tanga region and Handeni district (a), and the Mbeya region and Mbarali district (b). Both maps include data on population, sex ratio, number of households and average household size [20].

relevant regional and district authorities permitted to conduct the study in their health facility catchment area.

All participants were informed of their rights and risks of participating in the study. Verbal consent was obtained from community participants, and written consent from healthcare workers and policymakers. Verbal consent was preferred because, based on previous experience, it was considered more culturally appropriate for engaging with participants. However, the verbal consent process still met ethical standards by ensuring that participants were fully informed about the study and voluntarily agreed to participate. Privacy and confidentiality were ensured as participants´ personal details were not linked to the information provided. The dataset used for this study does not contain any sensitive personal data.

RESULTS

Characteristics of participants

The total sample size included 1184 participants. Table 1 shows the distribution of the characteristics of the study population. There was a higher participation of women than men but relatively equal participation across age groups, with slightly higher participation in the 51-60 age group (31.5%). Almost two-thirds of the participants referred to having completed primary education and the majority were engaged in agriculture or pastoralism as occupation (71.5 %). Most of the participants reported that the nearest health care facility was a dispensary (40.1%).

Accountability

A low prevalence regarding all dimensions of social accountability was observed, with positive answers ranging from 4% on the question about receiving feedback from the HFGC to 20.2% who thought that the community supported the activities of the HFGCs (Table 2).

The linear regression analysis showed in the crude model that social determinants such as education, occupation and the type of district were associated with an increased prevalence of social accountability. When adjusted, the three variables remained statistically significant. Those with medium (β=0.34; 95% CI: 0.05-0.62) and high education (β=0.74; 95% CI: 0.27-1.21) and those with other (β=0.31; 95% CI: 0.01-0.62) and retired (β=0.76; 95% CI: 0.27-1.24) as occupation had a higher score in the social accountability index compared to their reference groups. Finally, those living in Mbarali scored less than those from Handeni (Table 3).

Table 1. Frequency and percentages of sociodemographic characteristics among the study participants.

Characteristics	N=1184 n (%)
Sex	
Men	375 (31.6)
Women	811 (68.4)
Age (years)	
20-30	230 (19.4)
31-40	291 (24.5)
41-50	291 (24.5)
>50	374 (31.5)
Education	
None	185 (15.6)
Primary	781 (65.9)
Secondary	179 (15.1)
Tertiary	41 (3.5)
Occupation	
Farmer/Pastoralist	848 (71.5)
Business	217 (18.3)
Other	90 (7.6)
Retired	31 (2.6)
Type of facility	
Dispensary	476 (40.1)
Health center	414 (34.9)
District hospital	296 (25.0)
District	
Handeni	522 (43.8)
Mbarali	622 (56.2)

DISCUSSION

This study aimed to assess the prevalence and social determinants of the HFGCs accountability from the community perspective in Tanzania. The results showed an overall low awareness and knowledge regarding all six aspects of social accountability among the community members, with higher education, business and retired occupations and those living in Handeni showing higher levels of social accountability.

Prevalence of social accountability

Low community knowledge and awareness of the HFGCs is consistent with other studies investigating social accountability in health facilities in Tanzania [14]. Effective communication between the HFGCs and the community has previously been identified as crucial in promoting social accountability [22,23]. However, the situation seems not to have improved over time. This observed low prevalence reflects a persistent deficient communication and information sharing between the HFGCs and the community, illustrated for instance, where HFGCs are not invited to the community or where a community representative is inactive on the committee. Naher et al [1] have described how a more bottom-up system could lead to more formal mechanisms through which the community can voice its concerns and increase collaboration to strengthen social accountability.

Table 2. Frequency and percentage of the different dimensions of social accountability.

Characteristics	N=1184n (%)
Knowledge on community support	
Yes	240 (20.2%)
No	946 (79.8%)
Sensitized community regarding the HFGCs[1]	
Yes	91 (7.7%)
No	1,095 (92.3%)
Feedback received from the HFGCs	
Yes	40 (3.4%)
No	1,146 (96.6%)
Trust in members of the HFGCs	
Yes	182 (15.4%)
No	1,004 (84.7%)
Views collected from the HFGCs	
Yes	96 (8.1%)
No	1,090 (91.9%)
Accountable HFGC-members	
Yes	173 (14.6%)
No	1,013 (85.4%)

[1] HFGC: Health Facility Governing Committee

Kesale et al found that HFGCs that adopted fiscal decentralization through the 2018 Direct Health Facility Financing (DHFF) experienced high levels of functionality [12]. However, while HFGCs may have become stronger in some areas, this does not mean that this goes hand in hand with social accountability.

A recent review of the impact of decentralization on the functioning of HFGCs internationally found that the devolution of powers and functions to HFGCs at the primary health care facility level did not guarantee effective functioning of HFGCs or increased community participation at the facility level [15].

Factors associated with social accountability

The results highlighted certain occupations (retired and business) and high education as relevant social determinants that increase knowledge of the social accountability of HFGCs. One explanation for this could be the increased need for health services among retired people [24], which leads to closer contact with the health system and therefore better knowledge of how it works. Also, having business as occupation could have a positive impact on social accountability, as the flexibility to manage their own time more freely could provide them with an opportunity to get involved in the local community and HFGCs; a desire to express power and influence in their local community could also explain their potentially higher involvement. Although it was expected that those with higher education could have a

better understanding of how the health system works and therefore score higher, it was surprising that Handeni, a poor performing district, reported a higher level in terms of perceived social accountability. While further research is needed to elucidate the specific reasons, it is well-known that factors related to health system performance are complex and multidimensional [23], and therefore it is difficult to draw conclusions from this study about the importance of perceived social accountability for the health systems performance.

Table 3. Mean, standard deviation, crude and adjusted linear regression models with their 95% confidence intervals (95% CI) assessing the relationship between sociodemographic variables and social accountability.

	Mean (sd)	Univariable model Coefficient (95% CI)	Multivariable model Coefficient (95% CI)
Sex			
Men	0.8 (1.5)	Ref.	
Women	0.6 (1.3)	-0.16 (-0.32 to 0.00)	
Age (years)			
20-30	0.6 (1.2)	Ref.	
31-40	0.6 (1.2)	-0.05 (-0.28 to 0.19)	
41-50	0.8 (1.4)	0.15 (-0.08 to 0.39)	
51-60	0.7 (1.5)	0.12 (-0.11 to 0.34)	
Education			
None	0.5 (1.1)	Ref.	Ref.
Primary	0.7 (1.3)	0.20 (-0.01 to 0.42)	0.22 (0.00 to 0.44)
Secondary	0.8 (1.5)	0.37 (0.09 to 0.64)	0.34 (0.05 to 0.62)
Tertiary	1.4 (1.7)	0.94 (0.49 to 1.40)	0.74 (0.27 to 1.21)
Occupation			
Farmer/Pastoralist	0.6 (1.3)	Ref.	Ref.
Business	0.7 (1.2)	0.09 (-0.11 to 0.29)	-0.01 (-0.21 to 0.20)
Other	1.1 (1.8)	0.46 (0.17 to 0.75)	0.31 (0.01 to 0.62)
Retired	1.5 (2.1)	0.93 (0.45 to 1.41)	0.76 (0.27 to 1.24)
Type of Facility			
Dispensary	0.7 (1.3)	Ref.	
Health center	0.8 (1.4)	0.08 (-0.10 to 0.26)	
District hospital	0.6 (1.3)	-0.05 (-0.24 to 0.15)	
District			
Handeni	0.8 (1.4)	Ref.	Ref.
Mbarali	0.6 (1.3)	-0.18 (-0.33 to -0.03)	-0.16 (-0.31, -0.00)

Strengths and limitations of the study

The large sample of participants in the community survey and the high response rate (100%) strengthen the validity of the study and reduced the possibility for selection bias. However, some limitations should be noted. First, the two districts included were purposively selected based on their performance in the Star Rating Assessment and may not be representative of the rest of the rural districts in the country. Second, the questionnaire was not designed to explore social determinants of social accountability, which limits the scope of the potential factors included. In addition, as there is no standard way of measuring social accountability, the validity of our survey and its comparability with other studies can be questioned. We also acknowledge the arbitrary criteria used by the researchers to define the prevalence of knowledge and awareness below 20% as low. Given the self-reported nature of the surveys, both recall and response bias could be operating. For example, participants may be more likely to recall negative than positive events, or some might have given a positive answer to please the interviewers. To reduce such biases, the questionnaire was piloted, and the data collectors underwent a thorough training in communication and data gathering techniques. However, it is not possible to assess the extent of this and those biases could have been present.

Conclusion

This study assessed the community members´ perceptions of social accountability of HFGCs in two rural districts of Tanzania. The results revealed a widespread deficit covering several aspects of social accountability. Those with higher education and those who were retired or engaged in business were associated with higher levels of social accountability. Further research is needed on community perspectives on social accountability in the health systems and on interventions that can increase their knowledge and awareness to strengthen community participation.

DECLARATIONS

Publication Consent

Not applicable.

Competing interests

No potential conflict of interest was reported by the authors.

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Author contributions

SM was responsible for the initial conceptualization of the research idea, and together with HK played a pivotal role in the collection of the primary data. ES conducted the analysis and drafted a first version of the manuscript. MSS, AKH, HK and SM provided critical input during the revision process significantly improved the clarity and coherence of the final document. Each author has read and approved the final manuscript.

Data availability

Data are available from Dar es Salaam University (contact via the correspondent author) for researchers who meet the criteria for access to confidential data.

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La perspectiva de la comunidad sobre la responsabilidad social en el sistema de salud: un estudio transversal de Tanzania

RESUMEN

Introducción: Las iniciativas de responsabilidad social son una estrategia para abordar las ineficiencias y mejorar el desempeño del sistema de salud. Tanzania ha implementado los Comités de Gobierno de los Centros Sanitarios (CGCS) para reforzar esta responsabilidad social. No obstante, falta información sobre la percepción comunitaria de estos Comités. Este estudio buscó evaluar la prevalencia y los factores sociales que influyen en la responsabilidad de los CGCS desde la perspectiva comunitaria en Tanzania.

Métodos: La investigación utilizó una encuesta transversal en dos distritos tanzanos (Handeni y Mbarali) seleccionados por sus diferencias de rendimiento. La recopilación de datos se llevó a cabo entre julio y octubre de 2022, abarcando 1,184 hogares de 31 aldeas/vecindarios. El estudio midió la responsabilidad social a través de seis preguntas que abordan el apoyo comunitario, la sensibilización, la retroalimentación, la confianza, el compromiso y la responsabilidad general de los CGCS. Además, se recogieron datos sociodemográficos (sexo, edad, educación, ocupación, tipo de centro de salud y distrito) que se analizaron mediante regresión lineal para identificar los factores que influyen en la percepción de responsabilidad.

Resultados: Los resultados mostraron una baja prevalencia de responsabilidad social, particularmente en las variables de concienciación y compromiso de la comunidad hacia los CGCS. Solo un pequeño porcentaje de los encuestados se sentía adecuadamente informado o involucrado en las actividades de estos Comités. Factores como un mayor nivel educativo, determinadas ocupaciones (tener un negocio o estar jubilado) y vivir en el distrito de Handeni se correlacionaron positivamente con una percepción más favorable de la responsabilidad social.

Conclusiones: El estudio resalta importantes desafíos en la eficacia operativa de los CGCS en Tanzania, mostrando una desconexión entre estos comités y las comunidades que atienden. A pesar del marco teórico de responsabilidad social, la participación comunitaria sigue siendo limitada, lo que afecta la eficacia de la gobernanza sanitaria a nivel local. Futuros estudios deberían enfocarse en fortalecer la sensibilización y participación comunitaria en estos comités, alineándose con los objetivos de salud nacionales y necesidades locales.

Palabras clave: responsabilidad social, sistemas de salud, rural, comunidad

REFERENCES

[1] Naher N, Balabanova D, Hutchinson E, Marten R, Hoque R, Tune SNBK, et al. Do social accountability approaches work? A review of the literature from selected low- and middle-income countries in the WHO South-East Asia region. Health Policy Plan. 2020 Nov 9;35(Suppl 1):i76–96.

[2] Danhoundo G, Nasiri K, Wiktorowicz ME. Improving social accountability processes in the health sector in sub-Saharan Africa: a systematic review. BMC Public Health. 2018 Apr 13;18:497.

[3] Molyneux S, Atela M, Angwenyi V, Goodman C. Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. Health Policy Plan. 2012 Oct;27(7):541–54.

[4] Dwicaksono A, Fox AM. Does decentralization improve health system performance and outcomes in low and middle income countries? A systematic review of evidence from quantitative studies. Milbank Q. 2018 Jun;96(2):323–68.

[5] World Health Organization, Organisation for Economic Co-operation and Development, International Bank for Reconstruction and Development. Delivering quality health services: a global imperative for universal health coverage [Internet]. Geneva: World Health Organization; 2018 [cited 2023 Nov 10]. 93 p. Available from: https://iris.who.int/handle/10665/272465.

[6] Kesale AM, Mahonge C, Muhanga M. The quest for accountability of Health Facility Governing Committees implementing Direct Health Facility Financing in Tanzania: A supply-side experience. Mordaunt DA, editor. PLoS One. 2022 Apr 28;17(4):e0267708.

[7] Boydell V, McMullen H, Cordero J, Steyn P, Kiare J. Studying social accountability in the context of health system strengthening: innovations and considerations for future work. Health Res Policy Syst. 2019 Mar 29;17(1):34.

[8] Joshi A. Legal Empowerment and Social Accountability: Complementary Strategies Toward Rights-based Development in Health? World Dev. 2017 Nov;99:160–72.

[9] Sirili N, Kiwara A, Gasto F, Goicolea I, Hurtig AK. Training and deployment of medical doctors in Tanzania post-1990s health sector reforms: assessing the achievements. Hum Resour Health. 2017 Dec;15(1):27.

[10] Maluka SO, Bukagile G. Community participation in the decentralised district health systems in Tanzania: why do some health committees perform better than others? Int J Health Plann Manage. 2016 Apr;31(2):E86–104.

[11] George AS, Mehra V, Scott K, Sriram V. Community participation in health systems research: A systematic review assessing the state of research, the nature of interventions involved and the features of engagement with communities. PLoS One. 2015 Oct 23;10(10):e0141091.

[12] Kesale A, Mahonge C, Muhanga M. The Functionality of Health Facility Governing Committees and Their Associated Factors in Selected Primary Health Facilities Implementing Direct Health Facility Financing in Tanzania [Internet]. In Review; 2022 Jan [cited 2023 Oct 18]. Available from: https://www.researchsquare.com/article/rs-1092885/v1.

[13] Maluka SO. Strengthening fairness, transparency and accountability in health care priority setting at district level in Tanzania. Glob Health Action. 2011;4.

[14] Kinyenje ES, Yahya TA, Hokororo JC, Eliakimu ES, Mohamed MA, Degeh MM, et al. Social accountability in primary health care facilities in Tanzania: Results from Star Rating Assessment. Augusto O, editor. PLoS One. 2022 Jul 25;17(7):e0268405.

[15] Kesale AM, Mahonge C, Muhanga M. Effects of decentralization on the functionality of health facility governing committees in lower and middle-income countries: a systematic literature review. Glob Health Action. 15(1):2074662.

[16] Kraft JM, Paina L, Boydell V, Elnakib S, Sihotang A, Bailey A, et al. Social Accountability Reporting for Research (SAR4Research): checklist to strengthen reporting on studies on social accountability in the literature. Int J Equity Health. 2022 Aug 30;21(1):121.

[17] Marston C, McGowan CR, Boydell V, Steyn P. Methods to measure effects of social accountability interventions in reproductive, maternal, newborn, child, and adolescent health programs: systematic review and critique. J Health Popul Nutr. 2020 Dec 7;39(1):13.

[18] Maluka S, Kamuzora P, San Sebastiån M, Byskov J, Olsen ØE, Shayo E, et al. Decentralized health care priority-setting in Tanzania: evaluating against the accountability for reasonableness framework. Soc Sci Med. 2010 Aug;71(4):751–9.

[19] Mukasa O, Masanja H, DeSavigny D, Schellenberg J. A cohort study of survival following discharge from hospital in rural Tanzanian children using linked data of admissions with community-based demographic surveillance. Emerg Themes Epidemiol. 2021 Dec;18(1):4.

[20] Tanzania National Bureau of Statistics and President's Office - Finance and Planning, Presidents' Office - Finance and Planning Office of the Chief Government Statistician Zanzibar. The 2022 Population and Housing Census: Administrative Units Population Distribution Report. 2022 [cited 2023 Oct 5]. Administrative_units_Population_Distribution_Report_Tanzania_volume1a.pdf. Available from: https://www.nbs.go.tz/nbs/takwimu/Census2022/Administrative_units_Population_Distribution_Report_Tanzania_volume1a.pdf.

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[22] Kesale A, Mahonge C, Muhanga M. The determinants of the performance of health facility governing committees (HFGC) in selected primary health facilities in Tanzania. Tanzania J Community Develop. 2021 Nov 18;1:53–66.

[23] Oyeyemi AI, Gberevbie DE, Ibietan J. Citizens participation and primary healthcare policy implementation in Ogun State, Nigeria: An empirical and systems enquiry. Humanit Soc Sci Lett. 2021;9(1):50–7.

[24] Ageing and health [Internet]. [cited 2023 Dec 6]. Available from: https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.