Reinforcing Accountability at the Interpersonal Level in Healthcare Delivery Settings: A Case of Mwananyamala Hospital, Tanzania

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Abstract
Accountability in public healthcare involves more than whether practitioners comply with professional standards; it also depends on the organisational and interpersonal mechanisms through which concerns are raised, considered and acted upon. This study examined communication behaviour, interpersonal trust and accountability practices at Mwananyamala Hospital, Tanzania. A mixed-methods design combined a structured survey of 120 patients with semi-structured interviews with 10 healthcare providers and six focus group discussions, each involving eight participants in the HIV care and treatment context. The survey assessed 30 communication-related items using a seven-point scale, while the qualitative component explored practitioners' experiences and institutional conditions affecting communication and accountability. The reported association between communication behaviour and interpersonal trust was positive but weak ($r = .15$, 95% CI [-.03, .32], $p = .102$), and therefore does not support a claim that communication predicts trust in this sample. Descriptively, the highest-rated communication domain was practitioners' demonstration of care (87.6%), while use of visual aids had the lowest percentage score (65.7%). Qualitative findings highlighted patient feedback, complaint handling, teamwork, psychological safety and institutional support as relevant accountability mechanisms. The study therefore treats interpersonal trust as a relational outcome associated with communication rather than as a proxy measure of accountability. The findings suggest that strengthening accountability at the interpersonal level requires responsive communication and responsibility in provider-patient encounters, supported by institutional arrangements that enable feedback, learning and response to concerns.

Keywords: *Accountability; Interpersonal accountability; Communication behaviour; Public health; Interpersonal trust; Patient feedback*

INTRODUCTION

Accountability is a central requirement of safe and responsive healthcare because it establishes expectations for professional conduct, provides mechanisms for reviewing performance, and creates opportunities to address failures. In healthcare, however, accountability is not a single attribute of an individual practitioner. It operates through relationships among practitioners, patients, managers, professional bodies and regulatory institutions. Brinkerhoff (2004) consequently treats accountability as involving answerability and the possibility of consequences, while Emanuel and Emanuel (1996) locate it within the wider organisation of responsibilities in health care. At the interpersonal level, this is reflected in everyday interactions where practitioners explain, listen and respond to concerns.

Communication is particularly relevant because many aspects of clinical practice are not directly observable to patients. Patients can, however, observe whether practitioners listen, explain treatment, protect confidentiality, invite questions and respond respectfully. These behaviours may shape patients' perceptions of reliability and trustworthiness, even though they do not by themselves establish whether a practitioner has complied with clinical, legal or organisational standards. Research on doctor-patient communication similarly shows that communication can influence trust, satisfaction and treatment-related behaviour (Ha & Longnecker, 2010; Street et al., 2009).

This distinction is important for the present study. Interpersonal trust is treated here as a relational outcome that may be associated with communication behaviour, not as a validated proxy for accountability. Accountability is examined more broadly through observable communication practices, patient feedback and complaint mechanisms, professional responsibility, teamwork, institutional support and regulatory arrangements. This approach responds to the multidimensional character of healthcare accountability and avoids treating trust, communication and accountability as interchangeable constructs, while recognising interpersonal interaction as an important arena in which accountability is experienced.

The study focuses on Mwananyamala Hospital, a public health facility operating within the pressures associated with high service demand, constrained resources and a diverse patient population. The case provides an opportunity to examine how communication is experienced by patients

and practitioners and how institutional arrangements can reinforce or constrain accountable practice. The study sought to examine (i) communication behaviours observed by patients; (ii) the relationship between communication behaviour and interpersonal trust; (iii) practitioners' experiences of communication challenges; and (iv) mechanisms through which interpersonal interaction, feedback, teamwork and institutional arrangements may reinforce accountability.

THEORETICAL FRAMEWORK AND PREVIOUS STUDIES

Accountability in medical settings has ethical, legal, professional and institutional dimensions. Ethical approaches emphasise duties and professional obligations, while consequentialist perspectives focus on the effects of decisions on patient welfare (Rowe & Calnan, 2006; Molyneux et al., 2012). Legal and regulatory arrangements establish minimum standards and provide procedures for responding to failures (Leinster, 2011). At the organisational level, accountability is reinforced through quality-improvement systems, reporting arrangements, teamwork and professional oversight (Preston et al., 2016), which provide the setting for interpersonal accountability.

Patient-centred approaches add a relational dimension. Shared decision-making, informed consent and respectful communication can create conditions in which patients participate more actively in care (Rathert & Rathert, 2021). Communication therefore occupies an important position within the conceptual model used in this study: communication behaviours are observable practices; interpersonal trust is a relational perception that may arise partly from those practices; and accountability encompasses the broader mechanisms through which practitioners and institutions answer for their actions. These elements become particularly visible during direct healthcare encounters.

Previous research supports an association between communication and trust but does not justify equating the constructs. Ha and Longnecker (2010) review evidence linking doctor-patient communication with trust, while Dawson-Rose et al. (2016) emphasise trust and relationship-building in HIV care. O'Daniel and Rosenstein (2008) further show that communication within healthcare teams is relevant to patient safety. The present study extends this literature by considering communication alongside feedback and institutional mechanisms within a Tanzanian public-hospital setting, with attention to interpersonal accountability in healthcare delivery.

Patient participation is also relevant to accountability. Rathert et al. (2012) show how consumer perspectives can inform patient-safety improvement, while Edmondson (1999) demonstrates the importance of psychological safety for learning and speaking up in organisations. These perspectives suggest that accountability is strengthened where patients can communicate concerns and practitioners can raise problems without fear of inappropriate retaliation. The conceptual relationship is therefore not linear: communication may contribute to trust; feedback may inform corrective action; and interpersonal responses, organisational culture and regulation shape whether accountability can be sustained.

METHODS

Study design and setting

The study used a mixed-methods case-study design. Quantitative data were obtained through a structured questionnaire administered to 120 patients at Mwananyamala Hospital. Qualitative data comprised semi-structured interviews with 10 healthcare providers and six focus group discussions, each with eight participants, conducted in the HIV care and treatment context. Institutional information on feedback and accountability arrangements was also considered in interpreting the findings. The combination was intended to place measured patterns alongside participants' explanations of communication and organisational conditions, including everyday interactions relevant to accountability.

Participants and sampling

The quantitative component comprised 120 completed patient questionnaires. The source manuscript describes the survey approach as stratified sampling, but it does not preserve the stratum-specific allocation or the number of eligible patients approached. The response rate therefore cannot be calculated from the reported study records and is not presented as a numerical percentage. The qualitative component comprised 10 healthcare-provider interviews and 48 participants in six focus groups. The earlier manuscript's reference to 20 key informants was inconsistent with the methods actually reported; it has been removed rather than treating the unsupported figure as a separate participant group.

Instruments and measures

The questionnaire contained 30 items addressing communication behaviour and related perceptions. Responses were recorded on a seven-point Likert-type scale, with 1 representing inappropriate behaviour and 7 representing appropriate behaviour. The reported percentage scores

describe the distribution of responses for individual communication domains, while mean scores indicate the average rating on the seven-point scale. Interpersonal trust was examined as a separate relational construct and was not treated as a direct measure of interpersonal accountability. The available manuscript reports a Pearson correlation coefficient between the communication-behaviour and interpersonal-trust measures, but it does not provide item-level reliability coefficients or the original scale-development information. Accordingly, no claim of validated psychometric status is made in this revised manuscript.

Qualitative data and analysis

Semi-structured interviews explored providers' experiences of accountability, communication difficulties and institutional support. Focus groups addressed accountability in HIV care and treatment, where confidentiality, stigma, chronicity and sustained provider-patient relationships are particularly relevant. The original study records describe transcription and coding followed by thematic analysis. In the revised analysis, qualitative evidence is used to explain and contextualise the quantitative patterns rather than to establish causal relationships, including interactions relevant to interpersonal accountability.

Quantitative analysis and integration

Descriptive statistics were used to summarise communication items. Pearson's correlation was used to examine the association between the communication-behaviour and interpersonal-trust measures. The previously reported table contained an internally inconsistent confidence interval and an unsupported significance notation. Recalculation from the reported $r = .15$ and $N = 120$ gives a two-tailed p-value of .102 and an approximate 95% confidence interval of -.03 to .32. The association is therefore described as weak and not statistically significant. No regression or predictive model is claimed because the manuscript does not contain the model specification or the underlying dataset required to support such an analysis.

Qualitative and quantitative findings were integrated at the interpretation stage. Survey patterns identified areas of relatively stronger and weaker communication, while interview and focus-group accounts were used to identify organisational and interpersonal circumstances that may help explain those patterns. The integration is therefore complementary rather than a claim that one strand statistically validates the other.

Ethical considerations

The supplied study manuscript does not report an ethics-approval number, approving committee or formal clearance reference. To avoid inventing information, this revision does not state an approval number that cannot be verified from the study record. The manuscript should be accompanied at submission by the applicable institutional ethical-clearance information if it is available in the authors' research records. Participant quotations are presented without names or other direct identifiers.

RESULTS

Communication behaviour and interpersonal trust

The descriptive results indicate generally favourable patient ratings across several communication behaviours. Demonstrating care recorded the highest reported percentage score (87.6%; mean = 5.76/7). Confidentiality and concern for patient comfort recorded 82.6%, with mean scores of 5.46 and 5.45, respectively. Clear prescription was rated at 77.6%, with a mean of 5.61. These figures describe patient perceptions of communication behaviour; they do not by themselves establish practitioner accountability or clinical effectiveness, but they indicate the interpersonal conditions through which care is experienced.

The association between the communication-behaviour measure and interpersonal trust was weak and positive (r = .15, 95% CI [-.03, .32], p = .102, N = 120). The estimate does not provide sufficient evidence of a statistically significant relationship in this sample. It is therefore more appropriate to interpret communication as one possible contributor to interpersonal trust than as a predictor of trust or as a measure of accountability. Nevertheless, communication is one practical avenue through which interpersonal accountability is expressed.

Table 1:
Pearson correlation between communication behaviour and interpersonal trust

Measure	N	r	95% CI	p-value
Communication behaviour ↔ interpersonal trust	120	.15	−.03 to .32	.102

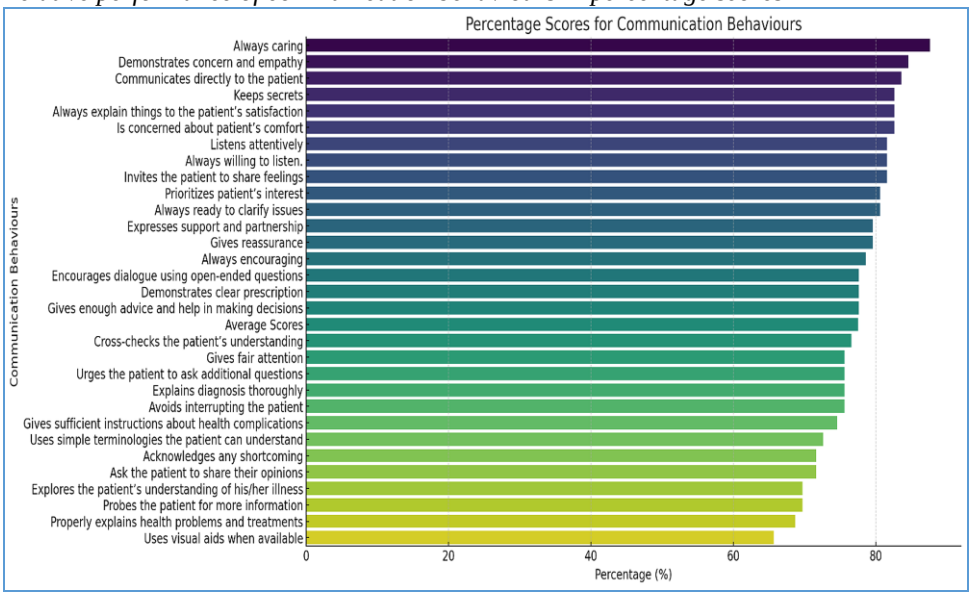
The recalculated result differs materially from the earlier presentation, which reported an implausible confidence interval [.13, .14] and a significance marker. The corrected statistics show why the present study should not use the language of prediction or statistical significance. The finding is nevertheless substantively relevant because it is consistent with the possibility that communication contributes to patients' perceptions of

trust, while leaving room for other determinants such as clinical experience, organisational reliability and previous encounters with the health system.

Relative performance of communication behaviours

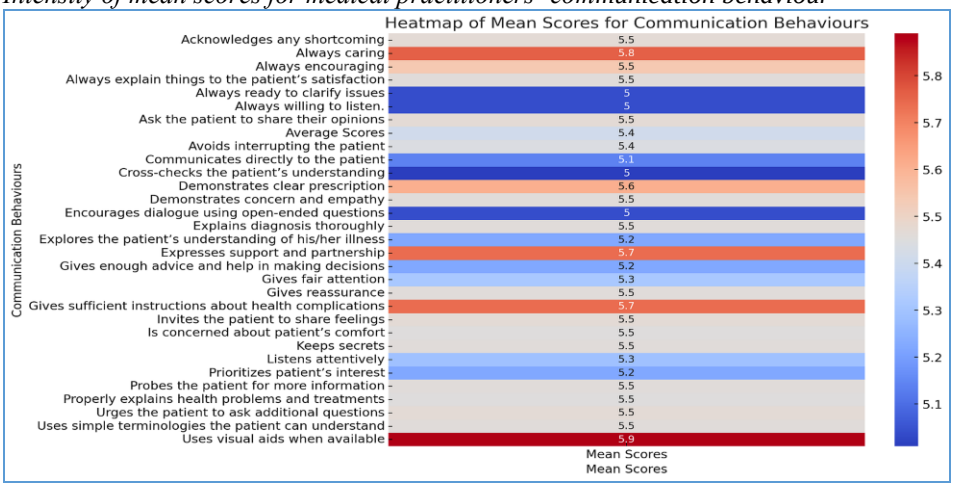
Among the reported communication behaviours, demonstrating care, direct communication, confidentiality and attention to patient comfort were relatively highly rated. Use of visual aids recorded the lowest percentage score (65.7%), although its reported mean was 5.89. This difference indicates that frequency and perceived quality were not necessarily aligned and may reflect differences in availability or routine use. Explaining health problems and treatment also recorded a relatively lower percentage score (68.7%), suggesting an area where communication could be strengthened.

Figure 1:
Relative performance of communication behaviours in percentage scores



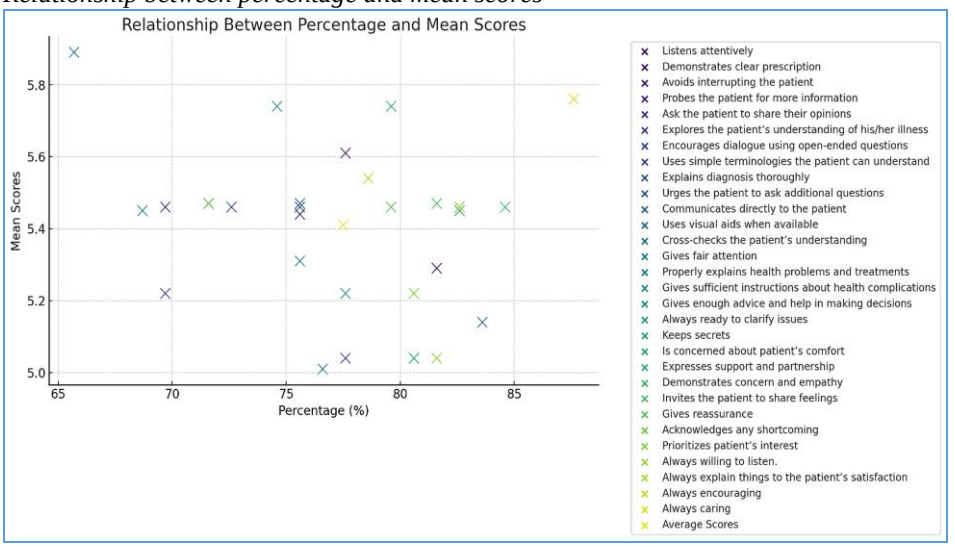
The figure summarises the percentage scores reported for the 30 communication elements.

Figure 2:
Intensity of mean scores for medical practitioners' communication behaviour



The figure displays the reported mean scores across communication behaviours.

Figure 3:
Relationship between percentage and mean scores



The figure illustrates the relationship between reported percentage and mean scores; it is descriptive and should not be interpreted as a causal plot.

Qualitative findings on communication and accountability

Provider accounts showed that communication was affected by the emotional demands of clinical work, particularly in interactions perceived

as difficult or highly stressful. Less experienced practitioners described greater difficulty managing challenging encounters. One provider stated that negative responses were more likely among staff who were not sufficiently firm or experienced to manage such situations. Another participant described differences in patient engagement, noting that some patients asked questions confidently while others were frustrated or reluctant to participate. Such encounters show that interpersonal accountability involves both provider responses and patient participation.

The interviews also highlighted patient vulnerability. Participants reported that some patients withheld information because of fear, embarrassment or concern about possible consequences. This finding should not be interpreted as evidence that mental illness caused problematic behaviour. The available qualitative material supports a more cautious interpretation: fear, vulnerability, frustration and difficult circumstances could affect communication, while practitioners' responses could either reduce or intensify communication barriers.

These accounts point to a reciprocal dimension of communication. Practitioners operate within institutional conditions that may include workload pressures and limited support, while patients may approach care with concerns that make disclosure difficult. Accountability consequently depends not only on individual communication skills but also on interpersonal responses and institutional mechanisms for de-escalation, supervision, teamwork and learning.

Patient feedback and complaint handling

The qualitative and documentary evidence identifies patient feedback as an important mechanism through which service users can communicate concerns. At the Mwananyamala CTC clinic, the study reports the availability of a complaint logbook and the discussion of complaints during staff briefings. Waiting time was among the concerns reported in the logbook. Such mechanisms can connect patient experience with organisational review and provide information for corrective action, while giving patients an avenue for raising concerns.

The original manuscript reported that 78% of practitioners affirmed that feedback improved service delivery. Because the supplied manuscript does not include the underlying frequency table from which this percentage was calculated, the figure is not presented as independently verified in the revised results. Instead, the qualitative evidence is used to

demonstrate the presence and perceived usefulness of feedback mechanisms. This distinction avoids presenting a descriptive percentage as evidence of demonstrated effectiveness.

Institutional mechanisms

The findings also point to institutional conditions that shape practitioner accountability. Teamwork across professional roles was described in the CTC setting, including collaboration between psychologists and physicians. Such collaboration may help practitioners understand patient concerns and adapt communication to individual circumstances. Organisational culture is similarly relevant: psychological safety can make it easier for staff to raise concerns, ask for assistance and learn from mistakes (Edmondson, 1999), thereby supporting interpersonal accountability.

Regulatory and professional frameworks provide another layer of accountability by establishing standards and procedures. The study references Tanzanian policies and guidelines on HIV and AIDS, psychosocial support and related areas (Ministry of Health, 2017; Ministry of Health, Community Development, Gender, Elderly and Children, 2021; Ministry of Health and Social Welfare, 2001, 2008, 2015). These arrangements form part of the institutional environment within which practitioner-level accountability is exercised.

DISCUSSION

The findings support a distinction between communication, trust and accountability. Patients reported relatively favourable experiences of several communication behaviours, and the statistical association between communication behaviour and interpersonal trust was positive but weak and not statistically significant. This result is more appropriately read as descriptive evidence of a possible relationship than as evidence that communication predicts trust. It also reinforces the conceptual point that trust cannot stand in for accountability: a patient may trust a practitioner while an organisational accountability mechanism remains weak, just as a formal accountability system may exist even where interpersonal trust is limited. Interpersonal communication nevertheless remains an important arena for accountable practice.

The qualitative findings help explain why communication should be situated within institutional conditions. Practitioners described difficult encounters, vulnerability and the need for support, while the case

evidence highlighted complaint handling, teamwork and regulatory standards. This is consistent with the broader literature, which treats accountability as a system of answerability rather than a property of individual behaviour alone (Brinkerhoff, 2004; Emanuel & Emanuel, 1996). Interpersonal accountability links this broader system to actual healthcare encounters.

Patient feedback appears particularly relevant because it creates an avenue through which service users can make experiences visible to the institution. The value of such systems lies not simply in collecting complaints but in reviewing patterns, responding to concerns and documenting corrective action. In this sense, feedback can reinforce accountability without being treated as proof that service quality has improved. The distinction is important: the present study documents feedback mechanisms and participants' perceptions of their usefulness, but it does not provide longitudinal outcome data that would permit a causal assessment of their effects.

The findings concerning practitioners' experiences also caution against locating communication problems exclusively in patients or practitioners. Stressful encounters may affect providers' communication, while fear or vulnerability may limit patients' willingness to disclose information. Effective accountability therefore requires organisational support for de-escalation, supervision, teamwork and safe reporting. Such measures are compatible with the patient-safety literature on communication and learning cultures (O'Daniel & Rosenstein, 2008; Edmondson, 1999).

LIMITATIONS

This is a single-facility case study, and the findings should not be generalised statistically to all public health facilities in Tanzania. The quantitative analysis is based on 120 respondents and a reported correlation rather than a multivariable model; consequently, causal and predictive interpretations are not warranted. The qualitative findings provide contextual explanation but should likewise be understood as case-based evidence rather than nationally representative estimates.

CONCLUSION AND RECOMMENDATIONS

The Mwananyamala case indicates that communication is an important part of accountable healthcare practice, but it should not be treated as synonymous with accountability or as a sufficient explanation of interpersonal trust. The survey evidence shows generally favourable

ratings for several communication behaviours, while the corrected correlation analysis indicates only a weak, non-significant association between communication behaviour and interpersonal trust. The qualitative evidence adds that feedback, teamwork, psychological safety and institutional support are relevant to the conditions under which accountable communication can occur. These findings place interpersonal interaction at the centre of how accountability is experienced in routine care.

Four practical areas emerge from the case. First, hospitals can strengthen routine patient-feedback mechanisms by ensuring that complaints are recorded, reviewed and linked to documented responses. Second, communication and de-escalation skills can be incorporated into continuing professional development, with particular attention to staff who are new to demanding clinical environments. Third, facilities can strengthen multidisciplinary support and opportunities for staff to discuss difficult encounters and service-quality concerns. Fourth, whistleblowing and complaint systems should provide clear procedures for reporting and follow-up, together with safeguards against inappropriate retaliation. Across these areas, practitioners should be encouraged to respond to concerns respectfully at the point of interaction. These recommendations are propositions arising from the case rather than claims that the interventions have been causally demonstrated to work nationally.

Future research should test the relationship between communication, trust and accountability using validated scales, larger multi-facility samples and multivariable models. Longitudinal designs would also be useful for assessing whether improvements in feedback systems or communication training are followed by measurable changes in patient experience, complaints, adherence or other service-quality outcomes, including outcomes associated with interpersonal accountability.

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The Moderating Role of SME Owner Age in the Relationship between Technological Compatibility and SME Performance in Tanzania

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Abstract
This quantitative study aimed to determine the moderating influence of SME owner age on the relationship between technological compatibility and SME performance in Tanzania covering Dar es Salaam, Dodoma, Arusha, Mwanza, and Zanzibar regions. An explanatory research design was used, and systematic random sampling was employed to select the sample. The researcher collected primary data by using questionnaires through a survey strategy. A sample of 204 respondents was used for primary data analysis, using the structural equation modeling (CB-SEM) technique through AMOS version 23. Results indicated a positive effect of technological compatibility on SME performance ($\beta = 0.30$, $p < 0.05$), confirming that technological compatibility positively influences SME performance and, thus, is considered an important factor in SME performance in terms of technological adoption and usage. Furthermore, the findings of an indirect relationship, suggesting that the link between technological compatibility and SME performance is moderated by SME owner age ($\beta = 0.97$, $p < 0.05$), indicating that the effect of compatibility on performance differs across SME owner age groups. This study made a significant contribution by expanding innovation adoption research through the assessment SME owner age as a moderating variable, improving the explanatory power of the model of technological compatibility and SME performance. Practically, SMEs should consider the SME demographic profiles in addition to technological compatibility when implementing existing and new technologies resulting to improve sales growth, service delivery, customer satisfaction and ultimately enhance overall SME performance.

Keywords: *SME performance, Technological compatibility, Innovation Diffusion Theory, Demographic factors.*