LEARNING BRIEF

Accelerating Improved Quality of Care in Healthcare Facilities: Through an Accountability Lens

USAID Health and Hygiene Activity

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INTRODUCTION

The USAID Health and Hygiene Activity (HHA), implemented by DevWorks International, supported the Government of Nepal in improving quality of health service delivery and hygiene across 181 healthcare faciliites in mountainous and hilly remote areas of Karnali and Lumbini provinces. From 2016-2024, HHA supported healthcare facilities in rural and urban areas of Dolpa, Salyan, Jajarkot, Rukum West, Rukum East, Dailekh and Surkhet. This learning brief captures HHA's experience in increasing the accountability of key stakeholders to improve the quality of service delivery at healthcare facilities through improvements in access to water, sanitation and hygiene (WASH) facilities; electrification and healthcare waste management assets; overall infection prevention and control practices and client counseling; and awareness among health workers and community members on the importance of good hygiene practices.

Three forms of accountability are highlighted in this learning brief—**social, performance, and financial accountability**—addressing both effective approaches to improve accountability and challenges HHA faced in carrying out the specific mechanisms to strengthen accountability. While this learning brief separates out the different forms of accountability to provide a more in-depth analysis, in reality, a holistic approach to strengthening systems-level WASH in healthcare requires that the different forms of accountability mechanisms interact with and build upon one another to achieve and sustain quality health care services. Determining the right mix of accountability mechanisms makes for more effective and efficient interventions.

Figure 1: Accountability aspects to strengthen systems-level WASH

BACKGROUND

A brief overview of Nepal's recent political history is critical to understanding the context in which HHA implemented various accountability mechanisms. After a long history of centralized government, in 2017, Nepal adopted a decentralized federal model transforming more than 3,900 municipalities and villages in 77 districts into 753 new rural and urban municipalities. This transition aimed to shift power to local governments and with that, greater responsibility at local level to bring quality service delivery to communities. This also required Nepal to restructure its government system, redefine personnel roles and responsibilities, and redraw **lines of accountability**.

At the federal level, following the major restructuring towards the end of 2018, the governance mechanisms between the three tiers of government (federal, provincial, and local) are still not fully sorted out. While the government has finalized the organograms for the state, provincial and local body structures, the country awaits a national Act that will define the means of coordination between the different levels of government. At the healthcare facility level, health facility operation and management committees (HFOMCs) and water users and sanitation committees (WUSCs) have also restructured.

Seven years after the onset of federalism, there remains confusion on roles and responsibilities at different levels of government; lack of awareness of reforms in policies, regulations, and lines of accountability within lower tiers of government; and a need for further institutionalization of accountability mechanisms. While many previous district-level functions have been delegated to the local-level, local government staff are not fully aware of these functions and procedures, and much of the health system decision-making is still centralized. As a historical legacy and often due to social and cultural norms, governments and healthcare providers may also not be responsive to citizen demands. Conversely, citizens, particularly the most marginalized, may not recognize that they have the right to hold healthcare providers or government officials accountable.[1]

Despite these challenges, there has been important recent progress at the municipality level with "improved health infrastructure and service capacity, increased resources (health budgets, staffing and supplies) and improved real-time data reporting from health facilities"[2] —providing some of the preconditions required for accountability mechanisms to be effective.

> Accountability is defined as an "obligation to demonstrate work has been conducted in compliance with agreed rules and standards or to report fairly and accurately on performance results vis-a-vis mandated roles and/or plans. (OECD/DAC).

In terms of vertical lines of accountability, each individual or entity within the system has a particular role and responsibility and is accountable to some other individual or entity with an unequal level of power and/or influence. Factors such as **transparency** (open understanding among actors on objectives and how the lines of accountability relate to each other), **representation participation** (inclusion of critical voices), **oversight** (monitoring and supervision to measure progress in attaining objectives), **responsiveness** (consequences for not following through with required actions) and presence of **incentives** (for creating intrinsic/extrinsic motivation to achieve objectives) have been found to be necessary preconditions to determine the effectiveness of the lines of accountability.[3] From a practical standpoint, certain conditions or inputs—such as availability of cleaning products or awareness of proper protocols—also need to be present for accountability mechanisms to function. Horizontal lines of accountability involve checks between institutions with equal levels of authority, such as between government ministries, and also require some of the underlying factors mentioned above to be present to be effective.

Figure 2 below illustrates the current mixture of roles and responsibilities of key actors at different administrative tiers where lines of accountability—**vertically upward and downward, and horizontally**—are needed to ensure that the healthcare system in Nepal comes together to promote WASH in healthcare facilities.

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[1] Social Accountability and Social and Behavior Change. Health Systems Strengthening: Practice Spotlight. https://www.usaid.gov/sites/default/files/2023-09/LHSS/Practice_Spotlight_Brief/Social_Accountability_SBC.
[2] 2024, Wasti, et. al. Overcoming the challenges facing Nepal's health system during federalism: an analysis of health system building blocks. https://health-policy-systems.biomedcentral.com/articles/10.1186/.
[3] Achieving Our Best: Strengthening Performance Accountability in Immunization Programs. MOMENTUM: Routine Immunization Transformation and Equity. https://usaidmomentum.org/resource/achieving-our-best-strengthening-performance-accountability-in-immunization-programs/.

Figure 2: Government Roles and Responsibilities by Tiers

LEVELS OF HEALTH SERVICE DELIVERY	MAIN ROLES AND RESPONSIBILITIES	KEY ACTORS
FEDERAL	Create federal policies, guidelines and protocols for planning, executing, regulating, and operating and maintaining WASH ; develop and execute a National Management Information System (N-WASH) to collect data on water supply and sanitation from communities and institutions; implement water quality testing	Ministry of Water Supply (Department of Water Supply and Sewage Management - DWSSM)
	Review of existing policies, guidelines, protocols, standards, and policy frameworks to support improved conditions in healthcare facilities; prepare national health reports with data collected from all healthcare facilities; provide national expertise and knowledge; monitor consistent application of standards at all levels; produce training and information, education and communication materials	Ministry of Health and Population
PROVINCIAL	Plan and execute WASH infrastructures; support collection of N-WASH data	Provincial Ministry/Water Supply & Sanitation Divisional Offices
	Develop policies, protocols and guidelines; conduct monitoring, supervision, organization, dissemination of information, and trainings related to updated environmental health; provide expertise and resources for assessment and planning at local level	Provincial Ministry of Public Affairs (Health Directorate) - reports to Ministry of Water Supply
LOCAL	Plan and provide basic, small-scale water supply and sanitation services within community and institutional settings; support operation and maintenance of respective WASH systems; enhance public awareness for sustainability of WASH facilities; collect and update data in the N-WASH on-line portal for monitoring and costing of WASH programs	Civil Engineer/N-WASH focal person (reports to Provincial Water Supply & Sanitation) Water Users and Sanitation Committees (works under the Ministry of Water Supply/DWSSM)
	Ensure quality of health service in accordance to Minimum Service Standards; conduct monitoring, supervision, organization, dissemination of up-to-date information, and trainings related to environmental health; provide expertise and resources for assessment and planning at healthcare facility-level	Health Coordinator (reports to provincial government – Health Directorate)
PUBLIC HEALTH CARE FACILITIES	Maintain water, sanitation and hygiene facilities; adopt good hygiene behaviors; counsel clients on good hygiene behaviors	HFOMCs, WUSCs, all healthcare facility staff, Female Community Health Volunteers

Source: *Adapted from National Standards for WASH in Healthcare Facilities of Nepal (2018) from the Nepal Ministry of Health and Population & Nepal Water Supply, Sanitation and Hygiene Sector Development Plan (2016-2030), Ministry of Water Supply and Sanitation.*

The next few sections highlight the various interventions HHA used to strengthen stakeholders' accountability towards developing and maintaining improved WASH in healthcare facilities.

HHA'S APPROACH AND EXPERIENCE

Social Accountability

At its core, **social accountability** involves the active role of citizens in holding government and service providers accountable—related to their conduct, performance, and management of resources—in this case, to provide improved, equitable health service delivery that is responsive to their needs.[4] HHA utilized **four social accountability mechanisms** to give community members a platform to advocate for services and provide feedback so as to hold health systems actors accountable for providing overall quality health service delivery and to address particular individual healthcare needs. These included: 1) dialogues; 2) regular health facility operation and management committee (HFOMC) meetings, 3) client exit surveys, and 4) provider behavior change communication monitoring checklists.

1. Dialogues (to strengthen downward accountability): Prior to construction of WASH and solar power systems, HHA facilitated a series of participatory three-stage dialogues over the course of three to five months at each targeted healthcare facility. Partiipants included representatives from municipalities, HFOMCs/WUSCs, and healthcare facility staff. Per government mandate, a female teacher representative, a local trade union representative, and a female community health volunteer must be members of HFOMCs, and a female and a Dalit/Janjati representative must be members of WUSCs. The dialogues covered topics related to: designing infrastructure improvement plans, including on gender and disability-friendly toilets; determining municipalities and HFOMCs' financial, non-financial and technical contributions; and agreeing to roles and responsibilities regarding management and implementation of construction activities and operations and maintenance of these systems for improved adoption of infection prevention and control protocols.

Other community voices were also brought in to confirm or demonstrate that there were no conflicts related to the healthcare facility drawing water from community water source supplies or private land, a critical step where water sources are not yet registered with the municipalities.

Challenges: Including the voices of representative community members during participatory dialogues requires effective facilitation skills to ensure that those in higher or elite positions of power (i.e., ward chairperson vs. women and Dalit/Janjati members) do not dominate discussions and decisions. If a lack of trust exists between the government and communities, or government does not feel accountable to the community, then community motivation to participate in such forums is weakened. The presence of community representatives does not automatically mean that their voices are heard or that their views represent all of the community.

The overall participatory dialogue process was designed to develop a sense of trust and ownership among participating stakeholders. After coming to an agreement on the terms and conditions of constructing/rehabilitating small scale infrastructures, the respective HFOMC/WUSC and respective municipality signed a tripartite implementation agreement with HHA. In total, HHA conducted 240 first dialogues to determine which HCFs to move forward with infrastructure construction/rehabilitation support, 188 second dialogues to develop WASH infrastructure improvement plans for selected HCFs, and 181 third dialogues to develop the final designs and determine estimated costs and cost-share contributions. Some municipalities did not continue on to the second or the third dialogues if they did not meet the requirements from the preceeding dialogue based

[4] Social Accountability and Social and Behavior Change. Health Systems Strengthening: Practice Spotlight. https://www.usaid.gov/sites/default/files/2023-09/LHSS/Practice_Spotlight_Brief/Social_Accountability_SBC.

on HHA's selection criteria. Municipalities and HFOMCs followed through in providing both financial and non-financial support to construction/ rehabilitation activities as agreed upon during dialogue sessions.

Follow up surveys highlight that communities felt overall positive about the presence of WASH facilities at the healthcare and were more likely to seek healthcare services as a result.

2. Regular Health Facility Operation and Management Committee meetings (to strengthen upward and downward accountability): When HHA began implementation, a number of HFOMCs had to be either formed or reactivated as a result of the government transition to federalism.[5] Certain members of the HFOMCs represent the newly formed ward office, including the HFOMC chairperson. HHA supported 180 HFOMCs in fulfilling their responsibility to ensure the operation and maintenance of WASH, solar and healthcare waste management infrastructures, and to implement infection prevention and control and provider behavior change communication protocols. HHA facilitated regular quarterly HFOMC meetings where gaps were identified during self-assessments and action plans to address these gaps either developed or updated. Service readiness scores related to infection prevention and control improved where HHA provided consistent follow up coaching and mentoring to HFOMCs on a regular basis. With increased awareness of their roles and responsibilities, HFOMC members demonstrated **collective social accountability and intrinsic motivation** in providing better health service delivery to community members.

Chaalenges: HFOMC members are elected representatives and new members have to be reoriented on their roles and responsibilities. Leadership trainings may also be necessary to empower socially disadvantaged members of the committee to actively participate in discussions and decision making during meetings. Also, many donor projects are trying to support HFOMCs - acknowledging that they are the local governance body at healthcare faciity-level - giving rise to potentially conflicting demands on the HFOMC members. Good coordination among implementing partners is necessary to avoid duplication and to leverage resources to support HFOMCs.

In order to close the loop on accountability, after receiving training, HFOMC members representing women and socially marginalized groups—the female community health volunteer, the female teacher representative from the school in the ward,[6] the female representative from the ward office, and the local trade union representative – are responsible for gathering feedback on community demands and reporting back to the HFOMC at these meetings. However, these HFOMC members lacked mechanisms to gather and convey feedback on community demands.

Other members of the HFOMC—ward chair and Health Facility In-charge – are responsible for reporting to their respective municipalities the status of their HCFs and what resources or technical support are needed to make improvements. HHA observed that HFOMCs secured support from municipalities at times, with either financial or in-kind materials, to improve conditions at healthcare faciliites.

3. Client Exit Surveys (to strengthen downward accountability): HHA supported HFOMCs/HCF staff to conduct client exit surveys to monitor clients' feedback on quality health service

[5] Since 2021, most Health Facility Quality Improvement Committees (HFQICs) have dissolved, and their roles and responsibilities have been transferred to HFOMCs. HFOMCs are now responsible for quality assurance in health facilities as highlighted in the Ministry of Health and Population's Minimum Service Standard (MSS) tool 2076/77 BS. Prior to 2021, HHA had been working to increase the capacity of primarily HFQICs.

[6] Not all HFOMCs have a female teacher representative from a school.

provision during their visits seeking healthcare. Patients voiced their satisfaction or grievances through these surveys. The survey included questions about perceived cleanliness of premises, access to water and toilets, behavior of health workers towards them, and level of satisfaction of services rendered. A survey conducted in May 2024 found that of 72 patients from 46 randomly sampled HHA-supported HCFs, 28% of patients were from marginalized communities (Dalits and Janjatis). Of those from marginalized communities, 20% expressed full satisfaction with the services and facilities provided by their healthcare facilities, while 80% expressed satisfaction. Out of 40 female clients, 23% were fully satisfied, 75% were satisfied and three percent were not satisfied with the services provided by the healthcare facility they visited. As a social accountability tool, HCFs/HFOMCs benefit from these client exit surveys in understanding how they can improve on the services of their healthcare facilities.

Challenge: Within Nepal, administering client exit surveys is not common practice and there is no standard template what questions healthcare facility staff should ask clients. While the HHA team supported the HFOMCs/HCFs in administering client exit surveys based on a template HHA developed, it was not an activity HFOMCs/HCFs seemed to independently want to uptake themselves, let alone analyze findings to act upon. In HHA's experience, client exit surveys proved not to be as effective a social accountability tool simply due to the added administrative burden put on HFOMCs/HCFs to fill out the forms.

4. Provider Behavior Change Communication (PBCC) Monitoring Checklist (to strengthen downward accountability): HHA's PBCC approach was a one-on-one interaction between providers and patients at healthcare facilities. The approach built healthcare provider's capacity and motivation to communicate behavior change benefits to clients around five targeted WASH behaviors: 1) hygienic use of toilets, 2) handwashing with soap and water at critical times, 3) safe disposal of child feces, 4) personal and/or menstrual hygiene management, and 5) safe handling and treatment of drinking water. Healthcare providers were also expected to: deliver medical care in clean attire; properly wash their hands with soap and water and/or use hand sanitizer before and after the examination of a client; and provide counseling on WASH issues effectively. HHA developed a National Health Education Information and Communication Center-approved PBCC facilitator's training guidebook and handbook manual and trained 558 (254 male, 304 female) Health Facility In-charges, nursing staff, and health coordinators from municipalities on PBCC.

As part of regular self-assessments, HFOMC members with HHA support utilized a PBCC monitoring checklist and observed this one-on-one interaction of providers and patients at the healthcare facilities.

A survey conducted while administering the PBCC monitoring checklist in May 2024 of 46 healthcare providers found that while the majority of the healthcare providers surveyed (98%) delivered medical care in clean attire, only 87% of healthcare providers properly washed hands with soap and water and/or used hand sanitizers before and after examining patients. Data from the PBCC monitoring checklist provided useful information to the HFOMCs/healthcare providers on whether they were being accountable to patients in providing quality services.

Challenges: Healthcare providers may have difficulty following through with PBCC practices given high case loads and not enough time to explain the five key WASH messages to patients. Patients with lower education might also require more time to understand these oral messages, or patients might be unwilling to stay longer at an appointment to listen to the healthcare provider speak about these behaviors. These could all impact the results of the PBCC observers' monitoring checklist.

Performance Accountability

Performance accountability involves an actor or entity with the power vested to require certain performance-based outcomes or targets and to hold another actor or entity accountable. Two performance accountability mechanisms are highlighted here: 1) supervisory monitoring visits and 2) self-assessments.

1.Supervisory monitoring visits (to strengthen upward accountability):

Elected officials from the municipalities (mayors, vice-mayors, chairs, vice-chairs) conducted joint monitoring visits with municipality staff (health coordinators, engineers, Chief Administrative Officers) to HHA-supported healthcare facilities during construction. They received updates on the status of improvement works, observed the quality of construction, and provided feedback on gaps and needs to ensure timely completion of construction during these visits. The HHA team observed that healthcare facility staff were frequently motivated to perform better after municipality site visits as they felt the performance of their work was valued.

Challenge: Municipalities face their own financial and logistical constraints in making frequent joint monitoring visits to healthcare facilities. HHA's current recommendation is for the municipalities to make joint monitoring visits four times a year. Yet, since the transition to federalism, more healthcare faciliites have come under the jurisdiction of municipalities with some healthcare facilities in very remote areas of the hills/mountainous regions. Healthcare faciliites in the Dolpa region are impassable during certain times of the year due to adverse weather conditions.

Health Coordinators from the municipalities also conducted separate visits specifically to monitor infection prevention and control and PBCC activities during regular HFOMC meetings. These field visits informed municipalities' annual planning processes providing the evidence to justify planning and allocating funds to address gaps identified at healthcare facilities in the following financial cycle. Such periodic visits were also observed to motivate healthcare facility staff to continue to improve on the performance of their service readiness. The government mandates that HFOMCs meet at least quarterly, so ideally, municipality representatives should budget and plan to conduct site visits to healthcare facilities quarterly as well.

2. Self-assessments (to strengthen upward and downward accountability): To assess the performance of healthcare facilities, HHA facilitated HFOMCs in conducting self-assessments using an adapted version of the government's Service Readiness (SR)-05 form for infection prevention and control, and healthcare waste management, and later aligned with relevant indicators within the 2019 Minimum Service Standard for healthcare facilities. HHA coached and mentored HFOMC members to reflect on the data from their SR-05 scores during HFOMC regular review meetings, and to develop action plans with clear timelines to address gaps and needs. HFOMC members assessed progress in improving their scores in subsequent meetings in an iterative process. Health Facility In-charges were then expected to report the scores to municipalities during their planning meetings and to request resources accordingly.

Challenge: If healthcare facilities do not have the necessary budget to procure inputs to carry out operation and maintenance of WASH infrastructure (e.g. passive chlorination replacement cartridges), or to implement infection prevention and control protocols (e.g. personal protective equipment and soap), they will not score well on their self-assessments and cannot be held to weak performance accountability.

Financial Accountability

Financial accountability involves transparent tracking and reporting how finances are used to ensure they are spent efficiently. HHA conducted public audits as a means **to strengthen downward**

accountability. Upon completion of HHA-supported WASH and/or solar infrastructure works, municipalities, HFOMCs, WUSCs and HCF staff arranged public audits for community members - local leaders, teachers, Female Community Health Volunteers and community members, including women and persons with disabilities - informing them of the time, date and venue of the events. The public audits informed the public that the budget allocated from the municipalities and other resources actually went towards their intended purposes, ensuring financial transparency and accountability of the WASH construction works. Skilled laborers spoke about the construction process and participants toured the completed construction works. HFOMCs/HCFs recorded and documented the discussions with participants during question and answer sessions. Media attended and published the public audits on social media or in printed form. Such publications informed community members on how the government utilized public funds and allocated resources towards WASH and solar power installation in healthcare facilities. In total, with HHA support, municipalities and HFOMCs conducted public audits in 180 targeted healthcare facilities. In interviews, municipalities mentioned that public audits are important to strengthen trust between the government and communities.

Challenge: Public audits may unintentionally exclude women and socially marginalized groups from the process. Deliberate steps to involve these historically excluded groups through facilitating discussions to include their voice would make public audits a more effective accountability tool.

LESSONS LEARNED

As national guidelines continue to be developed during Nepal's federal system transition, additional resources are needed to orient health workers on updated protocols. Either due to lack of or changes in national guidelines midway through the Activity, HHA encountered obstacles while rolling out interventions and the self-assessment accountability mechanism. For instance, in 2022, the Ministry of Health changed its guidelines on the use of cleaning agents for general cleaning, disinfecting medical instrument, as well as handwashing protocols. HHA updated its training manuals accordingly, retrained HFOMCs/health workers on these updated recommendations, and followed through to monitor their performance. While updates to guidelines are necessary based on the latest evidence, additional resources are required to reorient health workers so they can be held accountable for correctly and consistently following these new protocols.

Ensuring stakeholders understand their roles and responsibilities is critical to the effective roll out of accountability mechanisms. HHA strengthened 180 HFOMCs and supported the formation/revitalization of 37 out of 100 WUSCs. Orienting members on their roles and responsibilities was a critical step towards building their capacity to support and monitor Village Maintenance Workers in the operation and maintenance of WASH facilities, and health workers in practicing consistent and correct infection prevention and control protocols. Likewise, HHA's whole-site orientations clarified confusion on who within the healthcare facilities was responsible for maintaining WASH facilities and cleaning—basically, all health workers!

Understanding the context and addressing the preconditions (as feasible) are needed to effectively implement accountability mechanisms. For instance, environmental cleaners cannot be expected to perform well if they do not have the personal protective equipment and supplies to carry out their roles and responsibilities. Understanding the lack of motivation or incentives (both intrinsic and extrinsic) of actors to be held accountable also needs to be considered. For instance, maintaining the functionality of water supply systems seemed to be of higher priority than toilets and handwashing systems. HHA also encountered challenges in identifying appropriate stakeholders/staff to coordinate with given the frequent transfer of health workers as a result of the government's relocation program.

Use of financial accountability mechanisms has had mixed results. HHA did not support the utilization of **financial incentives** (a form of upward accountability mechanism) as a potential

motivator to improve performance accountability. Studies on the use of financial incentives have mixed results. One study highlights that increased job motivation potentially correlated with more financial incentives delivered.[7] However, other studies highlight that financial independence, professional development opportunities, sufficient staffing levels, feeling valued and supported, feeling a sense of responsibility to provide a community service, and functional infrastructures at the healthcare facility also motivated workers to perform well; financial incentives alone were found not to be as effective in motivating actors to perform better.[8]

Good leadership and management[9] are critical to ensuring effectiveness of accountability mechanisms. In HHA's high performing healthcare facilities, Heath Facility In-charges play an instrumental role in both advocating to municipalities on behalf of HCFs' resource needs, and in supervising healthcare facility staff. Well-managed healthcare facilities were also ones where the Health Facility In-charges have taken the lead in convening the HFOMCs regularly and the HFOMCs systematically address issues as they arise through action planning and holding persons responsible.

Determining the right combination of accountability mechanisms to implement to achieve sustainable WASH in healthcare facilities requires systems thinking both in terms of upward and downward accountability, and even horizontally. In order to achieve quality health service delivery, various accountability mechanisms are needed, from federal to local level, to hold the system together. Although not addressed in this learning brief, even horizontal accountability where different ministries coordinate with each other is necessary. The accountability mechanisms HHA utilized and highlighted in this learning brief—addressing social, performance and financial accountability—focused primarily on interventions at the sub-national level from municipality down to community level to support WASH in healthcare facilities. Future programming aiming to expand interventions to ensure lines of accountability from all three tiers of government will need to reevaluate the right mix of accountability levers and mechanisms to support the Nepal government in implementing the Roadmap on WASH in healthcare facilities' strategy currently being developed.

CONCLUSION

Many of the accountability mechanisms HHA implemented are scalable to other healthcare facilities also seeking to construct/rehabilitate WASH facilities and to improve on their service readiness. Whereas a focus on accountability has gained much attention in recent years in the health sector, the dialogue on accountability within the WASH in healthcare facilities sub-sector is not as robust. The hope is that this learning brief will contribute to learnings and discussions on accountability in WASH in healthcare facility settings.

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Author: Marjorie Huang with contributions from Bal Bahadur Thapa and Prakash Pant

[7] Achieving Our Best: Strengthening Performance Accountability in Immunization Programs. MOMENTUM: Routine Immunization Transformation and Equity. https://usaidmomentum.org/resource/achieving-our-best-strengthening-performance-accountability-in-immunization-programs/.
[8] Ibid
[9] Social Accountability and Social and Behavior Change. Health Systems Strengthening: Practice Spotlight. https://www.usaid.gov/sites/default/files/2023-09/LHSS/Practice_Spotlight_Brief/Social_Accountability_SBC.