Analysis of Accountability for WASH services Sustainability within Health System in Liberia

Photo credit: Sophie Bruneau, 04.2016, Monrovia.

REPORT

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Acronyms

BCC	Behavior Change Communication
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CH	County Hospital
CHDC	Community Health Development Committee
CHDD	County Hospital Department Director
CSO	Civil Society Organization
DEOH	Division of Environmental and Occupational Health
EHT	Environmental Health Technician
EPA	Environmental Protection Agency
EVD	Ebola Virus Disease
gCHVs	general Community Health Volunteers
GoL	Government of Liberia
HC	Health Care
HF	Health Facilities
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
IPC	Infection Prevention and Control
LWSC	Liberia Water Supply and Sewerage Corporation
MCC	Monrovia City Cooperation
MD	Medical Director
MDG	Millennium Development Goal
MIA	Ministry of Internal Affairs
MLME	Ministry of Lands, Mines and Energy
MoE	Ministry of Education
MoF	Ministry of Finance
MOH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MPW	Ministry of Public Work
NGO	Non-Governmental Organization
PBF	Performance-Based Financing
PHC 1	Primary Health Care Clinics Level 1
PHC 2	Primary Health Care Clinics Level 2
SDG	Sustainable Development Goals
TTMs	Trained Traditional Midwives
UNICEF	United Nations International Children Emergency Fund
WASH	Water, Sanitation and Hygiene.
WHO	World Health Organization

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I. Country context

A. Health System

1. General context and demographic/economic data

Liberia has suffered from almost two decades of civil conflict which devastated its health system. The post-conflict recovery period was encouraging with progresses made in major development indicators. In addition, the National Health and Social Welfare Policy and Plan (2011-2021) and its implementation produced some positive results in terms of childhood mortality reduction and improvement of maternal health indicators.
There are currently operational and financial challenges that need to be addressed for the health system to become resilient to shocks and improve population health status.

Table 1: Demographic data in Liberia

Key Data	Value
Surface area	111,379 km2[1]
Total population	4,294 thousand inhabitants[2]
Population under 15	43%[3]
Fertility rate	4.8[4]
Annual Population growth rate	2.1%[5]
Literacy rate	63,5% for male, 37.2% for female
Life expectancy	62[6]
HDI rank	177e rank out of 187 countries[7]

Table 2: Economic data in Liberia

Key Data	Value
Gross National Income	380$ per inhabitant[8]
Growth Rate	+0.7%[9]
Governmental budget allocated to health	6%.
Total expenditures on health per capita	98$ per inhabitant[10]
Total expenditures on health as % of PIB	10.0%[11]
Population below the poverty line.	63.8%[12]

2. Organization of the health system

Health service delivery in Liberia is organized into primary, secondary and tertiary levels.

- At primary level: there are Primary Health Care Clinics Level 1 (PHC 1) for populations below 3,500, and Primary Health Care Clinics Level 2 (PHC 2) for populations above 3,500; which are located within a 5 km radius.
  Community health services like health promotion activities, immunization and health awareness on hygiene are provided by community health volunteers including the Trained Traditional Midwives (TTMs) and general Community Health Volunteers (gCHVs).

[1] Ministry of Health, Liberia Health System Assessment Report, 2015.
[2,3,4] WHO, Liberia: Statistical Profile. 2013. http://www.who.int/gho/countries/lbr.pdf?ua=1.
[5] 2008 Census, Liberia Health System Assessment Report, MoH 2015.
[6] WHO, Liberia: Statistical Profile. 2012. http://www.who.int/gho/countries/lbr.pdf?ua=1.
[7] UNDP, 2014. http://hdr.undp.org/en/composite/HDI.
[8] World Bank. 2015. http://data.worldbank.org/country/liberia
[9] World Bank. 2014. http://data.worldbank.org/country/liberia
[10,11] WHO. 2014. Liberia Country Profile. http://www.who.int/countries/lbr/en/
12World Bank. 2007. http://data.worldbank.org/country/liberia

- At secondary level: there are County Hospitals located in the capital city of each county. Each of Liberia's 15 counties has a County Hospital that provides secondary health access and receives referrals from the community and District Health Systems. The County Hospital is expected to provide general surgery, pediatrics, general medicine, obstetrics and gynecologic services (including Comprehensive Emergency Obstetric and Newborn Care, or CEmONC). It should have 100 or more beds with an intensive care unit, a laboratory, and basic radiology services, and an outpatient facility for the provision of primary healthcare. Each County Hospital is expected to be open 24 hours every day.
- At tertiary level: There are 2 types: the Regional Hospitals and the National Referral Hospital, John F. Kennedy Medical Center. Regional Hospitals serve a catchment area of three to five counties and receive referrals from County Hospitals. Each Regional Hospital is expected to have a bed capacity of 100 or more. Regional Hospitals provide additional specialized services and are expected to be open 24 hours every day.

In 2006, the MoH decentralized administrative and management functions to the county level.

3. Health profile

By 2010, Liberia was one of the few Sub-Saharan African nations to have achieved the Millennium Development Goal target of reducing child mortality by at least two-thirds from the 1990 baseline. Health indicators were improving until the emergence of the Ebola Virus Disease (EVD) epidemic, which has caused an unprecedented impact of the health system due to extended exposure, infection and mortality particularly among healthcare workers, leading to a critical shortage of skilled health professionals. This crisis has undermined progress and preexisting efforts to reduce maternal mortality and address the growing burden of communicable and non-communicable diseases.

Table 3: Estimates of mortality indicators in Liberia

Key mortality rate	**1990**[13]	**2012**[13]	**MDG -2015 Targets**[14]
Children under 5 (per 1,000 living birth)	248	75	64
Infantile (per 1,000 living birth)	165	56	39
Maternal (per 100,000 living birth)	994 (2007)	1,072	145

Malaria remains the most frequent cause of health facility visits across Liberia and it's the leading cause of morbidity and mortality for most age groups. Liberia currently has one of the world's highest burdens of tuberculosis and a generalized HIV epidemic, with a prevalence of 1.9%[15].
Most important diseases in Liberia are preventable diseases, such as malaria, HIV, diarrhea, onchocerciasis and schistosomiasis, among others.

B. Health system and WASH sector

1. Organization of the WASH sector

The National Water Resources and Sanitation Board is responsible for providing oversight on WASH sector policy, strategy, planning, technical support, coordination, M&E, Human Resources, capacity building, decentralization, programs, financing, NGO support, management information systems, donor coordination and the enforcement of standards, regulations and by-laws through its oversight of the Water Supply and Sanitation Commission (WSSC).
WASH sector is fragmented between different government institutions, which play a key role as followed:

- Ministry of Lands, Mines and Energy (MoLME): Leads policy formulation.

[13] http://www.unicef.org/infobycountry/liberia_statistics.html
[14] African Health Observatory, WHO.
[15] 2013 Demographic and Health Survey.

- Ministry of Public Works (MoPW) – Leads the process of development of the second Poverty Reduction Strategy (PRSII) for the WASH sector and the WASH sector coordination at National level.
- Liberia Water Supply and Sewerage Corporation (LWSC) – Responsible for service delivery in urban areas and provides technical support to the WASH sector.
- Ministry of Health and Social Welfare (MoHSW) - Responsible for Health Promotion, Environmental and Occupational Health, Hygiene Education and development of Sanitation facilities.
- Ministry of Education (MoE) - The Division of School Health in the ministry is responsible for School Health and Hygiene in the country's schools.
- Environmental Protection Agency (EPA) - Responsible for Environment protection with a specific responsibilities of protecting the right to a clean and healthy environment.
- Ministry of Planning & Economic Affairs (MoPEA) - Undertake economic studies for planning and economic policy to foster, promote, and develop the Liberian economy.
- Ministry of Finance (MoF): Mandated to collect revenue; engage in loan arrangement, disburse Government funds, and service the National Debt.

Others institutions implement or support the implementation of the sector's policies and programmes such as:

- National and International NGOs (NGOs/INGOs): engage in the delivery of hardware and software activities, principally for the most vulnerable.
- Private sector: present but not well-developed.

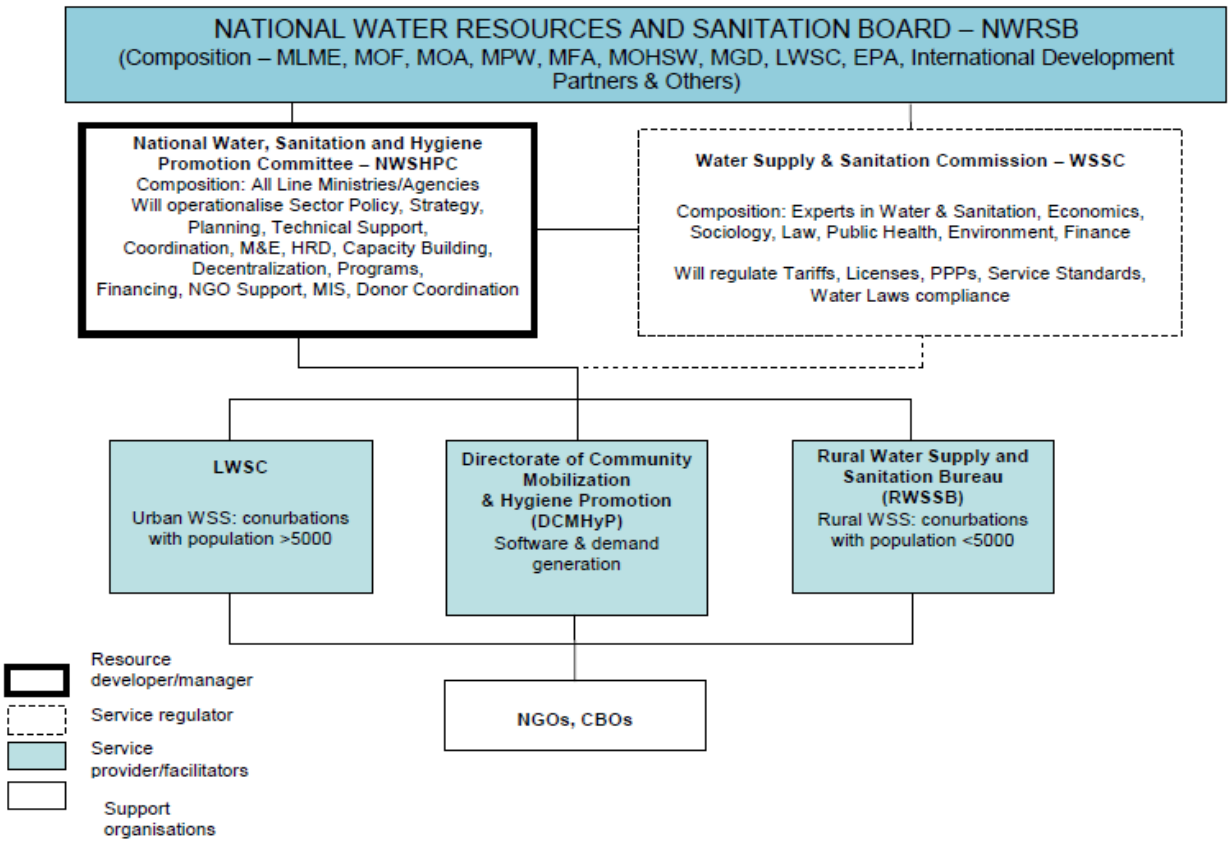

Fig 1: Institutional framework for Water and Sanitation sector[16].

2. WASH data in health facilities

- WASH Data in health facilities at global level

[16] MoHSW, Water supply, Sanitation and Hygiene (WASH) sector strategic plan for Liberia, 2012-2017.

A WHO/UNICEF report on Water, sanitation and hygiene in health care facilities (2015) highlighted that in 54 low and middle income countries, counting 66,101 facilities, 38% of health care facilities do not own an improved water source (the access to safe water is even lower in Africa, with 42% of them being without water access at health facilities), 19% do not own improved sanitation and 35% do not have water and soap for handwashing[17]. These coverage rates decrease by half when continuity and security in the provision are considered. At global level, sepsis is responsible for 15% of maternal and neonatal mortality; tetanus for 2% of neonatal mortality.
At regional level, the review of Emergency Obstetric and Neonatal Care (EmONC) Needs Assessment in 7 countries of West and Central Africa, conducted since 2010, counting 4,087 maternities with 1,265,980 assisted deliveries, show that only 65% own water access in delivery rooms and 18% in the post-partum room. It is important to note that no country in the region of West and Central Africa reached the MDG 5 (Improvement of Maternal Health).

- WASH Data in health facilities in Liberia

In 2015 a WHO IPC/WASH assessment highlighted that only 26% of health care facilities met minimum standards for water quantity supplied and only 51% had any form of bulk water storage. Between January and October 2015, a WHO assessment of WASH activities in 63 health care facilities in 8 counties was conducted. Findings underlined challenges in healthcare waste management (segregation of waste, handling, treatment and final disposal) as well as challenges in water treatment and quality testing, lack of ash pits and placenta pits, lack of protective fencing in waste management areas, poor environmental management and energy use.
A national, comprehensive 'WASH package' training of trainers was developed by the Ministry of Health, WHO and UNICEF to address these needs. The WASH package outlines minimum requirements for Water, Sanitation and Hygiene in healthcare facilities as part of the program for Early Recovery and Resilience Building from Ebola Virus Disease Outbreak in Liberia. The training covers the WASH FIT methodology, a risk-based approach to improving WASH services by facilities themselves. The aim is that all healthcare facilities should have implemented WASH FIT by the end of the investment plan (2015-2021) which aims to build a resilient healthcare system in Liberia.

II. Strengthening WASH in health facilities

A. Global strategy

In 2015, based on the results of a WHO and UNICEF assessment on the status of WASH in health care facilities in low-and middle-income countries, highlighting a significant proportion of facilities without any services, WHO, UNICEF and partners committed at a global level to address the situation with the aim of achieving universal WASH access in all health facilities. A five change objectives have been developed[18].

Table 4: Change objectives, WASH in health care facilities, Global Action Plan. 2015

CO 1	WASH in health care facilities is prioritized as a necessary input to achieving all global and national health goals especially as those linked to Universal Health Coverage. Key decision makers and thought leaders champion WASH in health care facilities.
CO 2	All countries have national standards and policies on WASH in health care facilities and dedicated budgets to improving and maintaining services.
CO 3	Global and national monitoring efforts include harmonizing core and extended indicators to measure WASH in health care facilities.

[17] UNICEF, WHO. Water, sanitation and hygiene in health care facilities – Status in low-and middle-income countries and way forward. WHO, 2015.
[18] WHO, UNICEF. Water, Sanitation and Hygiene (WASH) in Health care facilities, Global Action Plan. 2015.

CO 4	The existing evidence base is reviewed and strengthened to catalyze advocacy messages and improve implementation of WASH in health care facilities.
CO 5	Health care facility staff, management and patients advocate for and champion improved WASH services. Risk-based facility plans are implemented and support continuous WASH improvements, training and practices of health care staff.

Table 5: Global Action Plan Task Teams and Activities, WASH in health care facilities, Global Action Plan. 2015

ADVOCACY LEADERSHIP AND ACTION		**MONITORING**	**EVIDENCE AND OPERATIONAL RESEARCH**	**POLICY, STANDARDS AND FACILITY IMPROVEMENTS**
Change Objective 1	Change Objective 2	Change Objective 3	Change Objective 4	Change Objective 5
Aim: To advocate for global and national action to improve WASH in health care facilities and support the leaders dedicated to this effort.		**Aim: To develop, test and revise core and extended indicators to track WASH in health care facilities.**	**Aim: To draw on and extend the evidence base to support increased investments, quality improvements and advocacy efforts.**	**Aim: To develop a suite of field-tested tools, training and reference materials for a variety of facilities and settings.**
Activities: Document national case studies including processes and change mechanisms for improving WASH in health care facilities.		Activities: Core and extended indicators incorporated into all relevant WASH and health monitoring and accountability mechanisms.	Activities: Develop priority operational research agenda and seek opportunities to address the evidence gaps.	Activities: Support regular training and competency assessments for all health care facility staff including cleaners and health care workers.

These important objectives will only be achieved if WASH and health sectors work in close collaboration in an effective manner.

B. Liberia situation and challenges

Based on the 2010 Basic Package Health Service accreditation report, findings highlighted that 48 facilities (13%) do not have access to safe water and 162 facilities (43%) do not have a functional incinerator[19]. Main challenges related to infrastructure are linked to a poor availability of standards and policies for the provision of WASH and health services, associated to a lack of budget allocation and skilled human resources for maintenance and modelling, which is a critical concern for the pre-war and old built health facilities. There are also disparities in the status and the investment of health facilities linked to the governance. Based on this presented situation and challenges, the ambition was to facilitate discussions among key WASH and health actors within the health system to get deeper understanding and links on concerns to develop consensus around solutions aiming at strengthening WASH services in health facility.

III. Bottleneck analysis conducted in Liberia

[19] MoH. Liberia Health Assessment Report. 2015.

A. Rationale

At global level, the recent revised WHO guidelines on postnatal care for the mother and newborn recommends their hospital discharge at least 24 hours after birth, a critical time for infectious risks and other complications. Quality postnatal care is now a requirement, which implies permanent access to sufficient quantities of safe water, sanitation facilities, and effective system of medical waste disposal as well as access and use of adequate disinfection products, to ensure and maintain optimal hygienic conditions in health facilities. However, in low and middle income countries, including Liberia, WASH services in health facilities are almost absent. Risks related to inability to provide quality health care have been well documented and threaten the patient lives. Globally, about 1,400 children die every day from preventable diarrhea[20]; 9 out of 10 diarrhea cases are linked to insufficient water, sanitation and hygiene[21]. The burden of infections is particularly high for newborns. The sepsis and other serious infections can be fatal with a risk associated with sepsis estimated at 34 times higher in low-resource settings[22].

To achieve a sustainable management of WASH services in health facilities, political authorities in Liberia and health systems must take responsibility for their actions. At the national level, it involves the different actors (Ministries, agencies, corporation, organization) and at the county level, the County Heath Teams (CHTs). Good management involves constructive cooperation between the different sectors where the result is efficient use of resources, responsive use of power and effective and sustainable service provision. In the framework of the implementation of WASH in health interventions, the Division of Environmental Health will conduct training, supportive supervision and monitoring of the project in collaboration with county health teams, which was an opportunity to work with the different partners on accountability and substainability. The focus on accountability is an essential complement stakeholders' integration of sustainability. Tackling sustainability issues in WASH in health facilities requires a holistic approach, focusing on governance and particularly on strategies to increase accountability as a way to improve access and service quality. Building strong accountability mechanisms help in clarifying the obligations of actors involved in the provision of WASH services in health facilities and enhance the efficient use of public funds to improved quality of healthcare for all. Improving accountability for WASH service in health facilities therefore requires the recognition by all stakeholders of the principles of transparency, participatory management, assessment and consideration of users' feedback (patients and communities) on the quality of WASH services in health care facilities. These elements are crucial to provide actors legitimacy and efficiency and essential for the establishment efficient and sustainable WASH services in health care facilities.

B. Approach /method

The analysis on the accountability for the sustainability of WASH services within the health system was conducted in Liberia through a workshop guided by the Division of Environmental and Occupational Health (DEOH), part of Ministry of Health, with the participation of governmental and non-governmental actors involved in health and/or WASH and representatives of the three key levels that were target of the analysis (state, health facilities and communities).

i. Initial phase

To optimize the workshop effectiveness, an initial phase was scheduled to develop the methodology and associated accountability tools that were adapted to the context of WASH in health facilities in Liberia. For this preparation exercise, two key document were used:

- *The reference document Accountability in WASH, Explaining the Concept*[23], which is an introduction of accountability in WASH addressed to water practitioners with a toolbox of concepts to help identify which accountability factors affect the sustainability of water and

[20] Liu L, Oza S, Hogan D, Perin J, Rudan I et al (2014) Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis, The Lancet, 1 October.
[21] World Health Organization (2008) Safe Water, Better Health: Costs, benefits and sustainability of interventions to protect and promote health.
[22] Oza et al., 2015.
[23] UNICEF, Water Governance Facility, SIWI, UNDP. Accountability in WASH, explaining the concept. 2015.

sanitation service delivery and match this diagnosis to different solutions and options for action. It include four parts:

- **Water Governance, Wash and Sustainability** that explains the importance of governance and accountability to achieve sustainable water and sanitation services.
- **Wash and Accountability** that describes the different dimensions of accountability in the WASH sector and how actions can strengthen accountability in public service delivery.
- **Accountability relations in WASH services** that provides an analysis of the main weaknesses in accountability of water and sanitation services, with the aim of helping WASH practitioners understand the context of accountability in their work.
- **Working with Accountability** that explores the role of External Support Agencies in the promotion of Accountability in WASH services; it gives some insights on how to integrate accountability mechanisms in WASH interventions.

- *The reference guide for programming*[24], which provide structured and concise information to help programming support to accountability-related actions and contains guidance on existing mechanisms promoting accountability. It is organized into three main levels of intervention and eight potential objectives. Under each objective, Action Sheets illustrates the main aspects of these actions. The three levels of intervention and related objectives are:
    - **RESPONSBILITY**: Setting the scene – defining the roles and enabling cooperation in service delivery. A precondition for accountability is that those in positions of authority (governments and service providers) have clearly defined duties and performance standards, enabling their behavior to be assessed transparently and objectively. At the same time, users need to know their rights and obligations. Moreover, effective coordination mechanisms between different responsible parties need to be put in place. Under this level three different objectives can be pursued:
        - Objective 1: Enhance policy coherence.
        - Objective 2: Clearly define responsibilities between stakeholders.
        - Objective 3: Put coordination mechanisms in place.

    - **ANSWERABILITY**: A new quality of relationships – informing, consulting and including stakeholders in all stages of service delivery. A second level of intervention requires that timely, and accurate information is made available about several aspects of service provision, such as the current status of services, the performance of service providers, the decisions about financial allocations, etc. Information and the spaces for interaction between users and service providers and government need to be created, where decisions can be explained, questioned and/or justified. Under this level we present three main objectives:
        - Objective 4: Enhance the flow of information and use of consumer feedback.
        - Objective 5: Improve consumers' access to information.
        - Objective 6: Create spaces for stakeholder participation.

    - **ENFORCEABILITY**: Exercising oversight - monitoring performance, supporting compliance and enforcement. A third level of intervention is aimed at putting mechanisms in place that monitor the degree to which public officials, service providers and institutions comply with established standards, impose sanctions on officials and companies who do not comply, and ensure that appropriate corrective and remedial action is taken when required. Under this level we present two main objectives:
        - Objective 7: Support the establishment or functioning of a regulatory function.
        - Objective 8: Strengthen external and internal control mechanisms.

[24] UNICEF, Water Governance Facility, SIWI, UNDP. Accountability in WASH, a reference guide for programming. 2015.

Several introductive external meetings took place with the actors in WASH and health (Annex A) as well as internal meetings with UNICEF health and WASH staff members to present the team in charge of supporting the overall analysis process and explain the methodology. A field visit was then conducted in Margibi County Hospital on April 7, 2016, which gave the opportunity to discuss with part of the County Health Team and to obtain preliminary information on the relationships and interactions between the three main levels (state, health facilities and communities) in the specific context of Liberia. In collaboration with the DEOH team, the list of participants and 10 axes of discussion were validated (cf. Table 5), corresponding to 10 action sheets, and reflecting the three pillars of accountability: Responsibility, Answerability and Enforcement.

Table 6: Orientations for discussion selected with the DEOH team in Liberia

Primary accountability objectives	Levels of Intervention	Objectives	Action Sheets
RESPONSIBILITY	**Setting the scene:** **Defining the roles and enabling cooperation for WASH service delivery in health facilities**	Objective 1: Enhance policy coherence	1A Definition/revision of sectoral policies
		Objective 2: Clearly define allocation of responsibilities between stakeholders (patients, health staff, communities)	2A Instruments to clarify roles and responsibilities of communities and health facilities 2B Instruments to clarify the delegation between governments and health facilities
		Objective 3: Put coordination mechanisms in place	3A Supporting intersectoral WASH and Health coordination and reviews
ANSWERABILITY	**A new quality of relationships:** **Informing, consulting and including stakeholders**	Objective 4: Enhance the flow of information and use of patients/community feedback	4B Citizen report cards 4C Community scorecards
		Objective 5: Improve communities' access to information	5B Disclosure of information by the government and health facilities
		Objective 6: Create spaces for stakeholder participation and influence	6A Public expenditure tracking surveys 6B Participatory budgeting
ENFORCEABILITY	**Exercising oversight:** **monitoring performance, supporting enforcement and compliance**	Objective 7: Support the establishment or functioning of a regulatory function	
		Objective 8: Strengthen external and internal control mechanisms	8B Institutional mechanisms for monitoring and control

For each action sheet/selected orientations, three to four key axis have been defined to encourage group discussions during the workshop (cf. Annex C).

ii. Workshop

Aim of the workshop:

Obtain a common vision from discussions hold between key government partners involved in the areas of WASH and health to identify accountability bottlenecks for WASH services in the health system, define priority actions to provide improved accountability for sustainable WASH services in the health system.

Objectives of the workshop:

The objectives of the workshop was to facilitate discussions and debates between WASH and health partners from national and decentralized levels on their views, perceptions and perspectives of accountability components for WASH in health facilities in the health system:

- Define roles and promote cooperation to strengthen and clarify the scope of responsibility, answerability and enforceability, essential conditions for the exercise of accountability
- Identify bottlenecks and theirs causes.
- Formulate possible actions to remove obstacles and their conditions for success.
- Agree on the priorities in the short, medium and long terms.

Expected results

- A priority action plan to enhance ownership of WASH in health facilities in the health system.
- Active participation of all stakeholders (central, health facilities and community levels) to go further in the discussion.
- A recognition of the importance/cohesion of following principles: transparency, participatory management, assessment and consideration of patients/communities and health staff feedbacks on the quality of WASH service in health facilities.

The workshop for the analysis for accountability for WASH services sustainability in health system was conducted through working group sessions followed by plenary sessions to further the discussions. In each group, the 3 targets (state, health facilities and community) were represented to conduct the discussion based on the different actor perspectives, except for the group 1 that gather national level actors and WHO as their discussion topics were concerning the policies, which require expertise and specific awareness on this component.

During the first day, participants focused on the identification of bottlenecks that limit the development and sustainability of WASH services in health facilities, and their direct and underlying causes, based on accurate examples and arguments. The second day, participants developed activities to mitigate or remove the effects of bottlenecks and identified the conditions for success, for which their feasibility was estimated. Each group had a supporting matrix to help capturing key conclusions per group.

The steps followed during the workshop are presented in the figure below.

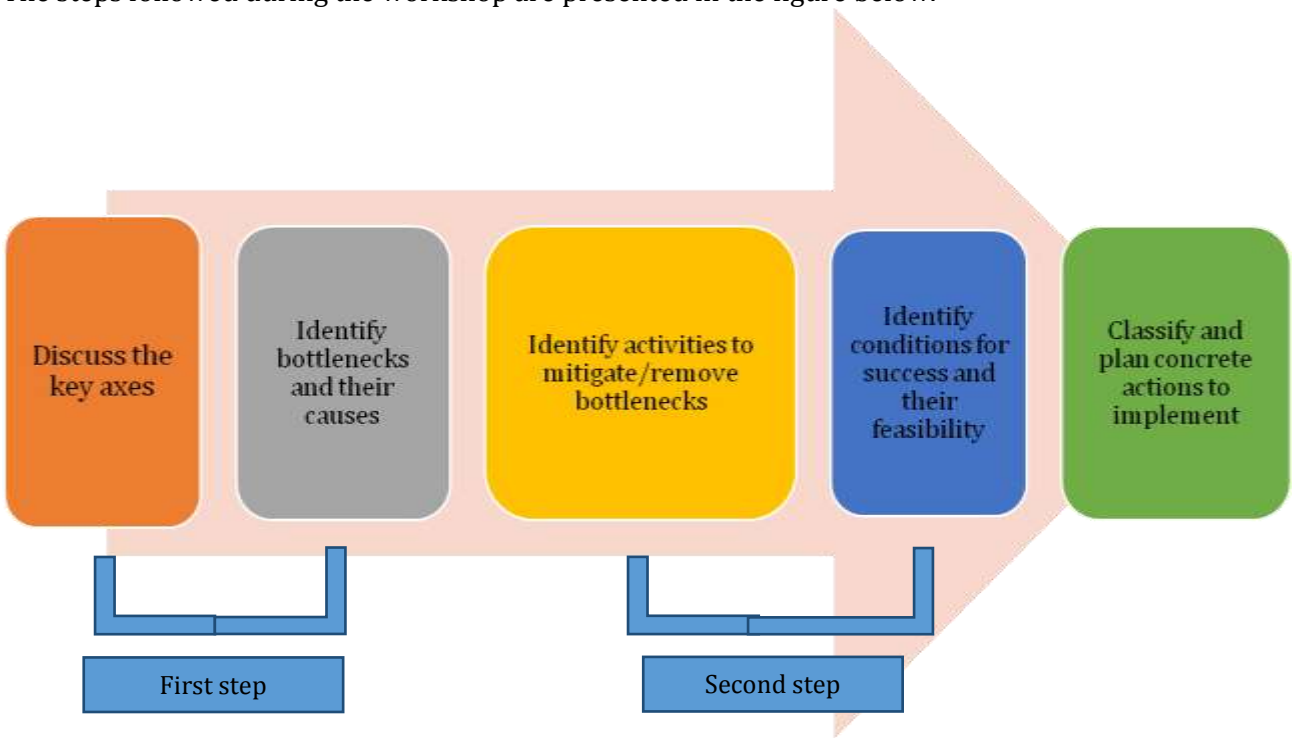

Figure 2: Work steps to conduct the Analysis on Accountability.

C. Findings

The 2-day workshop on the analysis for accountability for WASH services sustainability in health system was held on April 13-14, 2016 (cf Annex C: Workshop agenda) and brought together thirty participants (cf. Annex D: List of participants). The workshop started with an introduction on WASH in health facilities at global level and in Liberia. The presentations highlighted the importance of WASH in health facilities for health and security, disease prevention and treatment, health staff motivation and performance, health care focused on community, health care cost and performance. At global level, WASH access in health facilities remains limited but the global ambition is supported by the Sustainable Development Goals (SDG).

The presentation of WASH in Liberia detailed the strategy and program implementation for the WASH and Environmental Health Package in Healthcare Facilities.

The first working groups aimed to identify bottlenecks and their causes, then after their validation by the participants, the second working group took place to develop solutions to remove or mitigate identified bottlenecks with their conditions for success assessed according to the feasibly criteria; color codification used as following:

- Condition for success achievable on short term (1st year).
- Condition for success achievable on middle term (2nd year).
- Condition for success achievable on long term (3rd year)

1. DEFINITION / REVISION OF SECTORIAL POLICIES

Bottlenecks	Direct and underlying causes	Solutions/strategies	Condition for success	
Monitoring of the Strategies/Guidelines (no WASH in health policy), coordination among various stakeholders, inadequate manpower.	Inadequate and/or lack of awareness and funding support for WASH in health.	MoH to establish meetings and lead partners on monitoring and coordination of WASH in HF strategies	MoH to improve logistics and others supports to WASH in health facilities, MOH to ensure WASHFIT monitoring tool is implemented.	1 yr
		MoH to lead in WASH in health facilities awareness campaign through social media, posters, community meetings and engagements.	To establish good relationship with health promotion communication divisions in the MoH to support WASH in health facilities awareness creation; continue capacity building of MoH and communities.	3 yrs
		MoH/GoL to establish a clearly defined budget line for WASH in HCF.	MoH to fund and identify sources of funding to start the implementation of WASH in health facilities activities.	2 yrs
Operational strategies not implemented.	Lack of funding, lack of/or inadequate manpower whereas clear role and responsibilities are defined; lack of distribution and dissemination of strategies (WASH and Environmental Health package developed for health facilities).	Allocate adequate funding for WASH in HF.	MoH to fund and identify sources of funding to continue the implementation of WASH in health facilities activities.	3 yrs
		Develop manpower and minimize WASH in HF staff attrition.	Motivation for WASH staff through recognition, training, and other incentives.	3 yrs
		Improve the mechanism of distribution and dissemination of operational strategies to CHT and to health facility level.	Monitoring and observing behavior change for the distribution and dissemination of keys WASH in health documents.	3 yrs
Lack of distribution of documents and dissemination of information, continued training support.	Mechanisms are not in place, database does not exist.	Improve the distribution and dissemination mechanism to CHT and to the facility level.		3 yrs
		Ensure that WASH in health information is available through establishment of database records. Capacity building of wash staff.	Trained data managers and provide data tools.	3 yrs
Lack of decentralization of stakeholder's platform needed for resource mobilization.	Lack of total involvement and sustainability of different partners.	Involve all CHT and stakeholders to plan long term WASH in HF activities.	Planning together through meetings and workshops.	3 yrs
		Mobilize financial resource from stakeholders for WASH in HF activities.	Establishment of sustainable resource mobilization platform.	3 yrs

2. SUPPORTING INTERSECTORAL WASH & HEALTH COORDINATION AND REVIEWS

Bottlenecks	Direct and underlying causes	Solutions/strategies	Condition for success	
Low profiled, competition with curative and others services.	No budget allocation for WASH in health, relying on external support.	Integrate WASH in HF in the mainstream of HC service delivery.	Lobbying and funding; key staff establishment, develop self-funding projects through the involvement of communities and stakeholders.	3 yrs
		Allocate adequate budget for WASH in health facilities	Appropriate allocation of budget for the health facilities	3 yrs
		Encourage sustainability of WASH in HF.		3 yrs
Lack of WASH in HF information dissemination at county and health facilities levels.	Inadequate means to execute and promote public awareness, inadequate channels used.	Disseminate information at county level is compulsory.	County Health Team to disseminate the information	1 yr
		Ensure that the communities are informed through the right channels (meetings and training).	Hold meetings and training.	1 yr
Inadequate funds allocated for WASH at HF level due to asymmetry (lumpsum) between the budget needed and the funding allocation from the central level.	No specific budget line for WASH in health, relying on external support.	Adequate funds to be made available to support WASH in HF and transparency to be practiced.	Auditing, monitoring of WASH expenditure conducted.	3 yrs

3. INSTRUMENTS TO CLARIFY ROLE AND RESPONSIBILITIES OF COMMUNITIES AND HEALTH FACILITIES

Bottlenecks	Direct and underlying causes	Solutions/strategies	Condition for success	
Lack of accountability from the involved parties in WASH in HF with a lack of possibility for patient/ community to assess the performance of health facility leading to abuse/misuse of WASH services provided.	Fear of check and balances amongst parties, inability of the stakeholders to integrate the parties on the formulation of policies/formal agreement, lack of information of the roles and responsibility, lack of patient/community orientations in the health facilities.	Organize a stakeholder conference at the county level with central level involvement to strengthen accountability.	Information to all stakeholders, central level endorsement, minimum budgetary allocation available for the organization of the conference.	1 yr
		Formulate though a formal partnership agreement amongst parties (Community, Health facility and County health authority) the role and responsibilities of each parts.	Legal arm of the central level along with stakeholders of the conference.	1 yr
		Cascade agreements to District and individual facilities.	Draft of the agreement to local level and feedbacks, technical review, printing, publishing and distribution of the agreement to stakeholders.	2 yrs
Absence/limited WASH educational posters/materials, awareness and training in the communities and health facilities, with health talk and community outreach which often do not focus on WASH services in HF.	Low budgetary allocation for WASH activities in health facilities, WASH component being neglected and associated to a lack of resources.	Print IEC/BCC materials on WASH in HF and organize distribution at the communities and facilities levels.	Availability of resources (logistic, human and financial)	1 yr
		Include WASH in HF in Health talk and Community outreach programs.	Health facility taking ownership of their catchment areas along with the County Health Team.	1 yr
		Conduct specific training on WASH in HF at County, District and community health facilities.	Training content (targeting health facilities, representative of other sectors including the community) is available	2 yrs
Curative is prioritized over preventive services by health administrator/leaders.	Lack/minimum availability and accessibility to preventive data to highlight the benefits of prevention over curative services.	Review or conduct nationwide assessment of WASH in health facility and its impacts on the quality of care.	Monitoring & Evaluation Officer to work with DEOH/EHT; communicate with partners to share data available.	1 yr
		Publish and distribute results of the WASH in HF assessment at all levels.	Logistical support for distribution and sharing of results.	1 yr
		Integrate key relevant WASH in health indicators in the HMIS.	Advocacy to the health Management Evaluation Monitoring and Research (HMEMR) - HMIS; availability of WASH in HF indicators.	2 yrs
		Build research capacities to analyze the impact of WASH in health on quality of care in HF.	Budget allocation for research capacity building from CHT/MOH in collaboration with partners.	1 yr

4. INSTRUMENTSTO CLARIFYTHE DELEGATION BETWEEN GOVERNMENT AND HEALTH FACILITIES

Bottlenecks	Direct and underlying causes	Solutions/strategies	Condition for success	
No defined target and inability to measure deliverables of WASH services in HF.	Policy makers/health facilities and communities have not made available clearly define standards at the peripheral level.	Formulate clear standards with defined targets for WASH services in HF at the peripheral level.	Meetings/ symposium by stakeholders/DEOH/MOH/Partners.	1 yr
		Print and distribute agreed standards and targets for WASH services in HF to all facilities.	Logistic support available (Fliers, posters…)	1 yr
		Define scheme to reward compliance and sanction non-compliance.	Allocation of incentives for staffs and health facilities	1 yr
Lack of coordination and cooperation as well as information sharing associated to poor performance leading to morbidity/mortality.	Ignoring the importance of community integration in WASH service in health facilities.	Conduct WASH in HF coordination meetings, share information amongst actors.	Available resources for coordination meetings.	1 yr
Communities lack information, thus unable to assess WASH services performance at health care facility.	Fear of accountability to community, low budgetary allocation.	Involve all actors in budgetary formulation for WASH services in HF at the local level.	Increase in budget committee members by OFM (Office of Financial Management)/MOH.	2 yrs
		Integrate WASH in HF in the PBF.	Availability of indicator criteria, advocacy for PBF.	2 yrs
		Increase GOL/MOH allocation with specific budget lines for WASH.	Specific budget lines by MFPD/MOH-OFM, private facilities and partners (Ministry of Finance Planning & Development)	2 yrs

5. CITIZEN REPORT CARDS & COMMUNITY SCORECARDS

Bottlenecks	Direct and underlying causes	Solutions/strategies	Condition for success	
Patients/communities are not feedbacking to the Community Health Development Committee (CHDC) and Hospital Boards about their experiences and HF management teams are not doing enough to ensure utilization of existing tools (Bulletin Boards, Suggesting boxes, IEC, BCC Materials).	Patients/communities do not know about the committees because it is not popularized, health facilities management are not informed about patients/communities concerns because they do not receive feedbacks from committees; inadequate awareness and high illiteracy.	Create awareness through focus group discussion, town hall meetings, radio programs etc. on the CHDC and Hospital boards about their purpose of existence, Terms of Reference (TOR) and method through which patients/communities can sent feedbacks (suggestion box etc.) on WASH in HF.	Planning and budgeting, developing training and pre testing materials; availability of TORs.	1 yr
		Conduct Training for CHDC, Hospital Boards and health center management teams and insert in staff job description a part for getting patients/communities feedbacks on WASH services in HF.	Planning and budgeting, developing training and pre testing materials; availability of TORs	1 yr
		Include in the daily patient health education through different languages the aim at giving/getting feedbacks from patients/communities on WASH services in HF.	Need for dedicated people (GCHVs, CHDC and user) who speaks the various languages in health center operation areas with the will to provide voluntary translation service.	3 yrs
Low participation of stakeholders at meetings and poor sharing of WASH in HF information, limited options to get feedbacks from patients/communities.	Logistic challenges hinder patient/community representatives to attend meetings, implemented approach to gather feedbacks are not community driven.	Create advocacy directed at representatives' members of the Board and committee to influence them attending meetings and giving/receiving feedbacks from patients/communities.	Planning and budgeting, capacity amongst media and civil society.	1 yr
		Support integration of WASH in health in community health services activities.	Strengthening community health program to support WASH in health facilities	2 yrs
		Develop feedback gathering tools (Suggestion Box, check list, questioner etc.), tailored to WASH services in HF.	Expertise and budget availability.	3 yrs
Poor communication chain/channel and availability of tools on WASH in health not well tailored to community.	One of the communication channel used is the mail without follow-up, language barrier.	Establish multiple channels of communication (print, electronic and social media, focus group discussions etc.) and increase follow-up.	Availability of internet and connectivity, communication cards, access to the media.	3 yrs
		Develop feedback gathering tools (Suggestion Box, check list, questioner etc.) on WASH services in HF tailored to different patients/community's needs.	Expertise and budget availability.	1 yr
There is no design strategy on community evaluation on WASH service in HF.	No recognition of the added value of patients/communities evaluation and no request by patients/communities to be	Develop strategies, approaches and tools tailor to patients/community's needs and national context.	Expertise and budget availability.	3 yrs
		Create awareness and advocacy among patients/communities to influence their demand	Planning and budgeting, capacity amongst media and civil society.	1 yr

	involved.	for their participation and evaluation of health services aim at improving WASH in health.		
		Create advocacy and awareness to health facilities managers and policy makers about the potential benefit to be generated from evaluation of WASH in health by patients/communities.	Planning and budgeting, capacity amongst media and civil society.	1 yr

6. PUBLIC EXPENDITURE TRACKING SURVEYS

Bottlenecks	**Direct and underlying causes**	**Solutions/strategies**	**Condition for success**	
Health service funds are centralized, no clear dichotomy between clinical and WASH.	Insufficient budget clarity between clinical and WASH components in health facilities; government does not have a defined budget for WASH in health care facilities; WASH is dependent on donor support.	Establish a defined budget line for WASH in health facilities at national and HF levels.	Engage with CHT and MOH to ensure that WASH in health facility budgets reflect the real needs of the health facilities and are appropriately allotted.	1 yr
		Advocate for government ownership for WASH in health facilities.	Engage the health board, legislators and other stakeholders to take ownership for WASH in health facilities.	2 yrs
		Advocate for budget allotment in the MoH national budget for WASH in HF.	Engage the legislator, executive and other stakeholders through the County Legislative Caucus.	2 yrs
Clinical interventions budget expenses supersedes WASH in health facilities, WASH is partner driven.	No specific budget allotment is made for WASH; WASH is though as an NGO affairs; priorities oriented more toward curative than preventive.	Establish a defined budget line for WASH at national and HF levels.	Engage with CHT and MOH to ensure that WASH budgets reflect the real needs of the health facilities and are appropriately allotted.	1 yr
		Advocate for government ownership for WASH in HF.	Engage the health board, legislators and other stakeholders to take ownership for WASH in HF.	2 yrs
		Engage national government and health care administrators to value preventive services including WASH.	Increase human resources and logistics support; capacity building of WASH staff	2 yrs
Information is not shared to the bottom to avert accountability to beneficiaries.	Little information known about WASH and its impact on health at central and local levels.	Make available financial information to all stakeholders at all times.	Share financial report, financial updates during board meeting and coordination meeting.	1 yr
There are no policy document to reinforce accountability in WASH in HF.	No value recognized to provide access of spending data to public.	Engage government to develop an accountability policy including WASH in HCF.	Identify a team, develop term of reference, organize a consultative conference, develop and validate accountability policy.	2 yrs

7. PARTICIPATORY BUDGETING

Bottlenecks	Direct and underlying causes	Solutions/strategies	Condition for success	
WASH is not given due priority, so no exclusive budget for WASH	Limited knowledge about the impact of WASH in health care service delivery.	Share WASH in HF information with national and local stakeholders.	Organizing meeting/trainings, use of printed support, electronics medias…	1 yr
Priorities identified by communities are not taken in consideration as WASH is more preventive while health care system is more curative.	Health facilities do not want to be answerable by communities.	Advocate for more resources for prevention.	Engage legislators, executive, donors and traditional leaders to support WASH at national and local levels.	3 yrs
No effort is been expended to getting community more involved in participatory budgeting process in HF.	Health facilities do not want to be answerable by the communities.	Introduce participatory budgeting process involving grassroots stakeholders.	Engage stakeholders and include their inputs.	2 yrs
The culture of budget transparency and accountability to beneficiaries is a new scenario and yet to be followed.	Communities do not have access to WASH in health information and the added value of their opinion is not recognized.	Create and share information on accountability for WASH.	Organization of training, awareness, meetings.	1 yr

8. DISCLOSURE OF INFORMATION BY THE GOVERNEMENT AND HEALTH FACILITIES

Bottlenecks	Direct and underlying causes	Solutions/strategies	Condition for success	
Lack of political will and lack of adequate information.	Limited public awareness, limited human resources capacity at health facility level.	Intensify public awareness (media, town crier, town hall meetings, etc.) on WASH in health.	Budgetary allotment.	1 yr
		Train and deploy EHT at all health facility.	Provide scholarship opportunity for EHT, prioritize motivation for EHT workers (attractive salary, housing facility etc.)	3 yrs
Lack of available resources to introduce tools at community level, existing tools are not community friendly.	Inexistence of WASH in health budget line and absence of community involvement in planning and implementation processes.	Provide a budget line for WASH in health in the GoL MoH budgetary allocation		2 yrs
		Involve communities and county health team in developing tools.	Messages translated in various dialects.	1 yrs

Disclosure information are not adapted to build local capacity to influence decision-makers.	Inadequate resources available, lack of competency amongst staff.	Provide adequate resources (human, material, financial) to build local capacity.	Availability of appropriate logistics and financials means; staff training.	2 yrs
Literacy level at the clan/district/community level and lack of awareness to engage public officials.	Poor community entry.	Improve community entry.	Follow of guidelines and norms for community entry.	1 yr
		Create awareness by engaging local and public authorities.	Organize town hall meetings, WASH conference.	1 yr

9. INSTITUTIONAL MECHANISMS FOR MONITORING AND CONTROL

Bottlenecks	**Direct and underlying causes**	**Solutions/strategies**	**Condition for success**	
Lack of trained WASH specific human resources, no infrastructure at public institutions, IPC approaches has overwhelmed WASH in health approaches.	No slot for EHT at health facility in the Essential Package of Health Services, poor motivation for EHTs, most of health facilities do not conform to current WASH standards, lack of WASH capacity.	Provision of EHT slot at every health facility.	Provision of EHT slot at every health facility.	3 yrs
		Improve motivation.	Review for better salary, scholarship, housing, etc.	1 yr
		Regulatory body be set up to ensure that current WASH in health capacity guideline be adhere to.	Adherence to current standards, sensitization.	1 yr
No mechanism to publish information that promotes WASH in health activities; conflict of interest.	Lack of appropriate strategy to disseminate WASH information to the public; limited Public Relation Staff.	Create appropriate strategies/methods to disseminate WASH in health information.	Town hall meetings, use of local media.	1 yr
		Integration of WASH in health facility in health promotion activities at all levels.	Capacity building of all staff.	2 yrs
Lack of implementation and poor decentralization for institutional mechanism of control.	Limited resources for WASH in health implementation, poor ability of the communities to demand improved services.	Increase WASH in Health resources for implementation.	Construction & rehabilitation of WASH facilities, training and deployment of EHT staff.	2 yrs
		Sensitizing the public on the access of WASH services at all health facilities.	Community engagement for communication on the use of WASH facilities.	1 yr
Lack of ownership by local authorities at the county level and problem linked to health workers attitude towards patients/communities.	Lack of motivation, inadequate remuneration.	Increase sensitization to local authorities regarding WASH in health.	Engagement through meetings.	1 yr
		Improve/increase motivation (salaries/others).	Increase budget line.	1 yr

IV. Limitations of the approach

- The exercise was conducted at national level with the participation from some of the decentralized levels. The results cannot have the ambition to be representative of the overall country, however it provide a perspective of the mains challenges and possible solutions through the selection of based on representation of the three group (central, health facilities and communities),.
- Qualitative methodology was used, based on the experience, expertise, knowledge of thirty participants from the 3 different targeted levels, on the health system, WASH and health components. As the choice was to choose a single qualitative method, it may create a bias.
- Time constraints may have limited the exchanges. With additional time, some discussions could have gone further, with additional details and analysis. However, key relevant participants especially from the Ministries and the health facilities may not have been able to attend the whole workshop it was scheduled for more days.

Two key aspects for the success of this approach could be highlighted: the involvement of UNICEF/MoH team in this exercise as an integrated part of ongoing WASH in health program and a well arranged preparation phase.

V. Conclusions and way forward

This workshop enabled key actors and partners, from national and decentralized levels, to reflect on the theme of WASH services in health facilities in the context of Liberia. Some accountability barriers were identified by reaching consensus and then feasible actions were developed to remove or mitigate these obstacles. This first step provided a road map for the improvement of accountability for the sustainability of WASH services in the health system. These orientations could be integrated and guide future interventions and programming in the perspective of improving the sustainability of WASH services in health facilities.

Some key points to highlight:

- Low priority given to preventive health components (including WASH in health facilities) versus curative ones, which could be explained by the lack of available data, evidence concerning the impact of preventive activities on patients and communities. Consequently, the funds allocated by the central level to some health facilities was presented as often not representing the budget needed that was transmitted by the health facilities. This results on the prioritization on curative activities, which limits the implementation of sustainable WASH services in health facilities. Conducting assessments and local research on WASH in health would create in-country evidence-based information that could support advocacy. At central level, this could encourage government ownership of WASH in health and facilitate the creation of a specific WASH in health facilities budget line, contributing to a more balanced distribution of funds between curative and preventive components. At health facility level, capacity building for WASH in health would be required to guarantee the quality and accountability of WASH services in health facilities. In addition to the increase of health staff competency, a WASH in health representation at County level would be needed. It would be essential as well that the EH Coordinators prioritize WASH in Health and intensify advocacy for more funding. At community level, sensitization and training would contribute in sharing existing information and encourage community engagement to improve WASH in health facilities.
- The mechanism of interaction with the communities around WASH in health services seems to be limited in Liberia. According to the participants, some reasons include fear/reluctance from health staff and/or lack of recognition of the community views. The opinions of patients / communities in terms of needs, priorities and feedbacks would need to be better integrated to improve WASH services in health facilities.

- At health facilities, there is a need to integrate and increase WASH activities. Though the EVD outbreak has highlighted the crucial role of WASH services, WASH in health needs to be strengthened at all levels of the health system.
- To improve the monitoring of WASH service in health facilities, it was recommended that WASH in health data be integrated within the HMIS and the PBF frameworks.

Way forwards:
This exercise was conducted in the purpose to trigger actions. The agreed road map elaborated in consensus with the participants, constitute a basis of priority actions to consider and could support advocacy on some key underlined concerns.

This document could be used as a basis to go further with the costing of the activities, the definition of schedule, monitoring and evaluation plan. It can be a framework for actors who may want to conduct a similar exercise at different sub-national level in order to better understand key accountability challenges and integrate them in their interventions.

To ensure a close follow-up and engagement of the involved partners on the discussed topics, it would be recommended to conduct the similar exercise after 2-3 years to assess the progresses in tackling the identified bottlenecks and to adjust the priorities, new obstacles and adapted solutions.

ANNEX A: List of external meetings conducted for the initial preparation phase

Date	Persons met	Position Institution
April 5	Mr Adbul Hafiz Koroma.	National Coordinator of the WASH sector, Ministry of Public Work
April 6	Mr John Linga and his team	Environmental Health Assistant Minister, Ministry of Health and Social Welfare
April 6	Dr Francis Ndivo	WASH / Environmental Health Leader, World Health Organization (WHO).
April 7	Wataku Kortimai	WASH Coordinator, MoH

ANNEX B: Discussion axes defined per action sheet/selected orientations

ACTION SHEET 1A: DEFINITION / REVISION OF SECTORIAL POLICIES

1. Existence of national WASH in health facilities policy or strategy.
2. Clarity of guidance and orientations ensuring WASH in health operationalization, coherence and synergy between actors.
3. Availability of evidence on the current state of WASH in health policy implementation, which informs policy improvement debate.
4. Presence of multisectoral platforms between stakeholders involved in the management and provision of WASH services in health facilities.

ACTION SHEET 3A: SUPPORTING INTERSECTORAL WASH & HEALTH COORDINATIONAND REVIEWS

1. Integration of WASH in health facilities component in the annual health review process.
2. Public accessibility of the annual WASH in health facilities review results.
3. Involvement of civil society, private sector and donors in coordination mechanisms and plans for improved WASH in health facilities.
4. Existence of closer linkage between WASH in health facilities planning process and health system budgeting cycle.

ACTION SHEET 2A: INSTRUMENTS TO CLARIFY ROLE AND RESPONSIBILITIES OF COMMUNITIES AND HEALTH FACILITIES

1. Existence of formal agreements between users (patients, health staff, and community) and health facilities about the management and quality of service (needs analysis, budget tracking, monitoring and evaluation of performance).
2. Level of user (patients, health staff, community) information on their rights and terms of the WASH service in health facilities.
3. The dissemination of WASH service information by health facilities ensures higher willingness to pay from patients / communities.

ACTION SHEET 2B: INSTRUMENTS TO CLARIFY THE DELEGATION BETWEEN GOVERNMENT AND HEALTH FACILITIES

1. Existence of clear standards with defined targets against which WASH in health performance can be monitored.
2. Level of information of health care facility and communities on roles and responsibilities of each actors involved in the provision WASH services in health facilities.
3. Accessibility by communities to information on WASH in health facilities performance.
4. Health facilities benefit from quality of care improvement in relation to better WASH in health performance.

ACTION SHEET 4B: CITIZEN/COMMUNITY REPORT CARDS

1. Existence of feedback mechanism which measures users (patients, communities) access to and satisfaction with WASH in health services.
2. Integration of needs and concerns of users (patients, communities) on WASH in health facilities by policymakers and health facilities managers.
3. Dissemination of results from citizen/communities cards (user needs and concerns) facilitate linkages among actors involved in WASH in health.

4. Dissemination of results from communities encourage the Development of Joint Action Plans and facilitate linkages among actors involved in WASH in health.
5. Users (patients, communities) evaluation process including WASH in health facilities improve engagement in WASH in health issues and strengthen trust in health system over time.

ACTION SHEET 5B: DISCLOSURE OF INFORMATION BY THE GOVERNEMENT AND HEALTH FACILITIES

1. Existence of mechanism for formal public disclosure of information on WASH services in health facilities.
2. Formal public disclosure of information of governmental policy and public service missions empower community with tools at its disposal for action (positive or complaints).
3. Formal public disclosure of information enhance capacity of local organizations to influence effectiveness, credibility and trust in decision-making for better WASH in health facilities.
4. Community access to public disclose information enhanced engagement and participation in accountability mechanisms for sustainable WASH services in health facilities.

ACTION SHEET 6A: PUBLIC EXPENDITURE TRACKING SURVEYS

1. Existence of Public Expenditure Tracking Survey (PETS) in health system including WASH in health facilities component.
2. PETS' results identify areas where budget asymmetries exist for WASH services in health facilities.
3. Conducting regular PETS encourage communities to demand more transparency and results from the policy makers.
4. Access to public spending data contribute to strengthen the ability of stakeholders involved in WASH services delivery in health facilities to engage government on issues of public spending.

ACTION SHEET 6B: PARTICIPATORY BUDGETING

1. Existence of a participatory budget process in health system including the WASH in health facilities component.
2. Integration in public budgets of WASH in health facilities priorities identified with communities through participatory budget process.
3. Conducting regular participatory budget processes encourage communities to demand more transparency and results from health services providers.
4. Strengthening public literacy (training) and awareness of budget issues enables communities´ involvement in budget process to improve WASH in health facilities.

ACTION SHEET 8B: INSTITUTIONAL MECHANISMS FOR MONITORING AND CONTROL

1. Existence of institutional mechanisms for monitoring and control of health system including WASH in health facility component.
2. Institutional mechanisms for monitoring and control of health system publish the main obstacles related to WASH in health including administrative and judicial decisions.
3. Institutional mechanisms for monitoring and control of health system strengthen observance of and adherence to right to safe and clean drinking water and sanitation.
4. Institutional mechanisms for monitoring and control of health system strengthen community trust and credibility toward health facilities management systems.

ANNEXE C: Workshop agenda – Analysis for Accountability for WASH Services Sustainability in Health System

Day 1: April 13, 2016

Time	Sessions	Moderators /Participants
9.00 – 9.10 am	Welcome & Workshop objectives.	MoH
9.10 – 9.20 am	Introduction of the participants.	Participants
9.20 – 9.45 am	Situation of WASH in health facilities, (Global & Liberia).	Fabrice Fotso, UNICEF MoH
9.45 – 10.00 am	Working groups organization.	Sophie Bruneau, UNICEF Consultant
10.00 – 10.45 am	First Step: Identification of bottlenecks of accountability and their causes (part I).	Participants
10.45 – 11.00 am	Coffee-Break	
11.00 – 12.45 am	First Step: Identification of bottlenecks of accountability and their causes (part II)	Participants
13.00 – 14.00 pm	Lunch Break	
14.00 – 15.30 pm	Restitution of works of the 3 groups in plenary session and discussions (15 minutes/presentation, 15 minutes discussions / group) - (part A).	Participants
15.30 – 15:45 pm	Coffee-Break	
15.45 – 17.00 pm	Restitution of works of the 2 groups in plenary session and discussions - (part B).	Participants

Day 2: April 14, 2016

Time	Sessions	Moderators / Participants
9.00 – 9.15 am	Summary of the first day of work	Sophie Bruneau, UNICEF Consultant
9.15 – 9.30 am	Working groups organization.	Sophie Bruneau, UNICEF Consultant
9.30 – 10.30 am	* Identification of activities to remove or attenuate the bottlenecks and their conditions for success. * Evaluation of the conditions for success on short, middle and long run (part I).	Participants
10.30 – 10.45 am	Coffee-Break	
10.45 – 12.00 pm	* Identification of activities to remove or attenuate the bottlenecks and their conditions for success. * Evaluation of the conditions for success on short, middle and long run (part II).	Participants
12.00 – 13.00 pm	Restitution of works of 5 groups in plenary session and discussions (20 minutes / groups).	
13.00 – 14.00 pm	Lunch Break	
14.00 – 16.15 pm	Restitution of works of 5 groups in plenary session and discussions (20 minutes / groups).	Participants
16.15 – 16.30 pm	Coffee-Break	
16.30 – 17.00 pm	Conclusion, closing of the workshop.	MoH

ANNEXE D: List of Participants – Workshop on the analysis for accountability for WASH services sustainability in health in Liberia (Margibi)

N	Name	Institution / organization	Position
1	Dehwehn O. Yeabah	DEOH / MOH	Director
2	Wataku Kortimai	MOH	WASH Coordinator
3	Dr Samson K. Arzoaquoi	MOH	Assistant Minister – Preventive Services
4	E. Jeffersen Dahnlo	DEOH / MOH	Coordinator
5	Amos F. Gborie	DEOH/MOH	Assistant Director
6	James V. Juman	Bong CHT	EHT Coordinator
7	Tamba Boima	MOH CHSD – Community Health Service Division	Director
8	Dekontee O. Saytarkon	MOH	Supervisor
9	Edward G. Wingbah	Environment Protection Agency (EPA)	Assistant Manager/County Coordination
10	Edward S. Paye	Ministry Lands, Mines & Energy (MLNE)	Hydro – Chemist
11	Sylvester A. Sanyon	Ministry Public Work (MPW)	WASH Coordinator
12	Layber M. Flomo	Ministry Public Work (MPW)	Social Worker
13	Abraham BY.J Garnoz	Monrovia City Cooperation (MCC)	Director General Service Programme
14	Joseph J Korhene	Margibi County Health Team (MACHT)	CHDD
15	E. Menkar Nuah	Bassa County Health Team –(BACHT)-MOH	EH Coordinator
16	Leenu K. Tarpeh	Montserrado CHT (MCHT)	WASH Coordinator
17	Momo J. Kamasa	Montserrado CHT (MCHT)	EHTs Coordinator
18	C. Paul Nyanzee	Nimba County Health Team (NCHT)	CHDD
19	Dao Kamara	CHDL – Gibi District	CHDC Chairman
20	Jimmie Slobor	Bomi County Health Team (BCHT)	EH Coordinator
21	Henry Larway	Margibi County Health Team - MACHT	EH Coordinator
22	Kalamon Klullie	County Health Team (CHT)	Medical Director
23	Kumblytee L. Johnson	CHRH Margibi – CH Rennie Hospital	Medical Director
24	Dr Lavela B. Kortimdi	GWH Hospital- Nimba	Medical Director
25	Dr Willimatta	Liberian Government Hospital Bomi	Medical Director
26	Dr Kalamon Wullie	Phebe Hospital	Medical Director
27	Ezelciel J. Mallay	County Health Team (CHT)	EHT
28	Prince D. Kreplah	Liberia CSO WASH Network	Chairman
29	Robertetta Rose	Consortium	Advocacy & Communication Coordinator
30	Dr Francis Ndivo	World Health Organization (WHO)	WASH / Environmental Health Leader
31	Raymond B. Musa	ACCEL- Academic Consortium Combatting Ebola in Liberia	WASH Specialist
32	James S. Kendor	ACCEL	WASH Manager
33	Fabrice Fotso	UNICEF	WASH Specialist
34	Bruneau Sophie	UNICEF	WASH in health Consultant
35	Philip M. Pawa	UNICEF	WASH Officer
36	James Massaqui	UNICEF	WASH