FACT SHEET

Analysis for Accountability for WASH services Sustainability in Health in Liberia

Overview

The analysis in Liberia is part of a project targeting 3 countries, including DRC and Mali. The goal of this project is to improve access and sustainability of WASH services in health facilities throughout the strengthening of accountability and management of WASH services in health facilities in the health system of 3 targeted countries.

General description

In Liberia, this analysis was conducted at the County Hospital in Margibi though a 2-day workshop (April 13 and 14, 2016) under the leadership of the Division of Environmental and Occupation Health with the support of UNICEF and the participation of thirty actors.

- Aim of the workshop: Obtain a common vision from discussion between stakeholders to improve accountability for sustainable WASH services in the health system.
- Objectives: Define roles and promote cooperation, identify bottlenecks and theirs causes, formulate possible actions to remove obstacles and their conditions for success on short, medium and long terms.
- Targeted audience: Governmental and non-governmental actors involved in health and/or WASH and representing the three levels (state, health facilities and communities).
  At the workshop: Among governmental partners: the MoH represented by the Division of Environmental and Occupational Health, the Community Health Service Division, the County Health Teams from Margibi, Bassa, Montserrado, Nimba , Bomi, the Medical Directors from CH Rennie Hospital (Margibi), GWH Hospital (Nimba), Liberian Government Hospital (Bomi) and Phebe Hospital, the Liberia CSO WASH Network and the WASH Consortium; the Ministry of Environment Protection Agency (EPA), Ministry Lands, Mines & Energy (MLNE), Ministry Public Work (MPW) and Monrovia City Cooperation (MCC). Non-governmental partners: World Health Organization (WHO) and ACCEL (Academic Consortium Combatting Ebola in Liberia).
- Methodology: The workshop was organized through two main working group sessions followed by plenary sessions, based on different aspects of accountability, corresponding to 10 action sheets, validated in consensus with the DEOH.
- Expected results: A priority action plan to enhance ownership of WASH in health facilities in the health system, an active participation of all stakeholders and 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.

Table 1: Orientations of the discussions selected by the MoH 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.

Main results

Table 2: Bottlenecks and priority actions scheduled in time.
(Color code: blue-short term/1st year, purple-middle term/2 years, orange-long term/3 years).

DEFINITION / REVISION OF SECTORIAL POLICIES	
Bottleneck 1: Monitoring of the Strategies/Guidelines (no WASH in health policy), coordination among various stakeholders, inadequate manpower.	
1. MoH to establish meetings and lead partners on monitoring and coordination of WASH in HCF strategies.	1
2. MoH to lead in WASH in health facilities awareness campaign through social media, posters, community meetings and engagements.	3
3. MoH/GoL to establish a clearly defined budget line for WASH in HCF.	2
Bottleneck 2: Operational strategies not implemented.	
1. Allocate adequate funding for WASH in HF.	3
2. Develop manpower and minimize WASH in HF staff attrition.	3
3. Improve the mechanism of distribution and dissemination of operational strategies to County Health Team and to health facility level.	3
Bottleneck 3: Lack of distribution of documents and dissemination of information, continued training support.	
1. Improve the distribution and dissemination mechanism to CHT and to the facility level.	3
2. Ensure that WASH in health information is available through establishment of database records. Capacity building of wash staff.	3
Bottlenecks 4: Lack of stakeholder's platform at decentralized level (eg. District level) needed for resource mobilization.	
1. Involve all Country Health Teams and stakeholders at decentralized level (eg. District) to plan long term WASH in HF activities.	3
2. Mobilize financial resource from stakeholders at decentralized level (eg. District) for WASH in HF activities.	3

SUPPORTING INTERSECTORAL WASH & HEALTH COORDINATION AND REVIEWS	
Bottlenecks 1: Low profiled, competition with curative and others services.	
1. Integrate WASH in HF in the mainstream of health centre service delivery.	3
2. Allocate adequate budget for WASH in health facilities	3
3. Encourage sustainability of WASH in HF through advocacy for increased governmental allocation and diversification of external source of funding.	3
Bottlenecks 2: Lack of WASH in HF information dissemination at county and health facilities levels.	
1. Disseminate information at county level is compulsory.	1
2. Ensure that the communities are informed through the right channels (meetings and sensitization).	1
Bottlenecks 3: Inadequate funds allocated for WASH at HF level due to asymmetry (lumpsum) between the budget needed and the funding from the central level.	
1. Adequate funds to be made available to support WASH in HF and transparency to be strengthened.	3

INSTRUMENTS TO CLARIFY ROLE AND RESPONSIBILITIES OF COMMUNITIES AND HEALTH FACILITIES	
Bottleneck 1: 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 misuse of WASH services provided.	
1. Organize a stakeholder conference at the county level with central level involvement to strengthen accountability.	1
2. Formulate though a formal partnership agreement amongst parties (Community, Health facility and County health authority) the role and responsibilities of each parts.	1
3. Cascade agreements to District and individual facilities.	2
Bottleneck 2: 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.	
1. Print IEC/BCC materials on WASH in HF and organize distribution at the communities and facilities levels.	1
2. Include WASH in HF in Health talk and Community outreach programs.	1
3. Conduct training on WASH in HF including information on the rights and terms of the WASH service in health facilities at County, District and community health facilities	2
Bottleneck 3: Curative is prioritized over preventive services by health administrator/leaders.	
1. Review or conduct nationwide assessment of WASH in health facility and its impacts on the quality of care.	1
2. Publish and disseminate results of the WASH in HF assessment at all levels.	1
3. Integrate key core WASH in health indicators in the HMIS.	2
4. Build local operational research capacity within the MOH to evaluate the impact of WASH in health on quality of care in HF.	1

INSTRUMENTSTO CLARIFY THE DELEGATION BETWEEN GOVERNMENT AND HEALTH FACILITIES	
Bottleneck 1: No defined target and inability to measure deliverables of WASH services in HF.	
1. Formulate clear standards with defined targets for WASH services in HF at the peripheral level.	1
2. Print and distribute agreed standards and targets for WASH services in HF to all facilities.	1
3. Define scheme to reward compliance and sanction non-compliance.	1
Bottleneck 2: Lack of coordination and cooperation as well as information sharing associated to poor performance leading to morbidity/mortality.	
1. Conduct WASH in HF coordination meetings, share information amongst actors.	1
Bottleneck 3: Communities lack information, thus unable to assess WASH services performance at health care facility.	
1. Involve all actors in budgetary formulation for WASH services in HF at the local level.	2
2. Integrate WASH in HF in the PBF.	2
3. Increase GOL/MOH allocation with specific budget lines for WASH.	2

CITIZEN/COMMUNITY REPORT CARDS	
Bottleneck 1: Patients/communities are not feedbacking to the Community Health Development Committee (CHDC) and Hospital Boards about their experiences and health facility management teams are not doing enough to ensure utilization of existing tools (Bulletin Boards, Suggesting boxes, IEC, BCC Materials).	
1. 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.	1
2. 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.	1
3. Include in the daily patient health education through different languages the aim at giving/getting feedbacks from patients/communities on WASH services in HF.	3
Bottleneck 2: Low participation of stakeholders at meetings and poor sharing of WASH in HF information, limited options to get feedback from patients/communities.	
1. Create advocacy directed at representatives' members of the Board and committee to influence them attending meetings and giving/receiving feedbacks from patients/communities.	1
2. Support integration of WASH in health in community health services activities.	2
3. Develop feedback gathering tools (Suggestion Box, check list, questioner etc.), tailored to WASH services in HF.	3
Bottleneck 3: Poor communication chain/channel and availability of tools on WASH in health not well tailored to community.	
1. Establish multiple channels of communication (print, electronic and social media, focus group discussions etc.) and increase follow-up.	3
2. Develop feedback gathering tools (Suggestion Box, check list, questioner etc.) on WASH services in HF tailored to different patients/community's needs.	1
Bottleneck 4: There is no design strategy on community evaluation on WASH service in HF.	
1. Develop strategies, approaches and tools tailor to patients/community's needs and national context.	3
2. Create awareness and advocacy among patients/communities to influence their demand for their participation and evaluation of health services aim at improving WASH in health.	1
3. 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.	1

PUBLIC EXPENDITURE TRACKING SURVEYS	
Bottleneck 1: Health service funds are centralized, no clear dichotomy between clinical and WASH.	
1. Establish a defined budget line for WASH in health facilities at national and HF levels.	1
2. Advocate for government ownership/leadership for WASH in health facilities.	2
3. Advocate for budget allotment in the national budget for WASH.	3
Bottleneck 2: Clinical interventions budget expenses supersedes WASH in health facilities, WASH is partner driven.	
1. Establish a defined budget line for WASH at national and HF levels.	1
2. Advocate for government ownership for WASH in HF.	2
3. Engage national government and health care administrators to value preventive services including WASH.	2
Bottleneck 3: Information is not shared to the bottom to avert accountability to beneficiaries.	
1. Make available financial information to all stakeholders at all times.	1
Bottleneck 4: There are no policy document to reinforce accountability in WASH in HF.	
Proposed activities	
1. Engage government to develop an accountability policy including WASH in HCF.	2

PARTICIPATORY BUDGETING	
Bottleneck 1: WASH is not given due priority, so no exclusive budget for WASH	
1. Share WASH in HF information with national and local stakeholders.	1
Bottleneck 2: Priorities identified by communities are not taken in consideration as WASH is more preventive while health care system is more curative.	
1. Advocate for more resources for prevention.	3
Bottleneck 3: No effort is been expended to getting community more involved in participatory budgeting process in HF.	
1. Introduce participatory budgeting process involving grassroots stakeholders.	2
Bottleneck 4: The culture of budget transparency and accountability to beneficiaries is a new scenario and yet to be followed.	
1. Create and share information on accountability for WASH.	1

DISCLOSURE OF INFORMATION BY THE GOVERNEMENT AND HEALTH FACILITIES	
Bottleneck 1: Lack of political will and lack of adequate information.	
1. Intensify public awareness (media, town crier, town hall meetings, etc.) on WASH in health.	1
2. Train and deploy EHT at all health facility.	3
Bottleneck 2: Lack of available resources to introduce tools at the level of the community, existing tools are not community friendly.	
1. Provide a budget line for WASH in health.	1
2. Involve communities and county health team in developing tools.	1
Bottleneck 3: Disclosure information are not adapted to build local capacity to influence decision-makers	
1. Provide adequate resources (human, material, financial) to build local capacity.	2
Bottleneck 4: Literacy level at the clan/district/community level and lack of awareness to engage public officials.	
1. Improve community entry.	1
2. Create awareness by engaging local and public authorities.	1

INSTITUTIONAL MECHANISMS FOR MONITORING AND CONTROL	
Bottleneck 1: Lack of trained WASH specific human resource, no infrastructure at public institutions, IPC approaches has overwhelmed WASH in Health approaches.	
1. Provision of EHT slot at every health facility.	3
2. Improve motivation (scholarship, salary, housing, etc.)	1
3. Regulatory body be set up to ensure that current WASH in health capacity guideline be adhere to.	1
Bottleneck 2: No mechanism to publish information that promotes WASH in health activities; conflict of interest.	
1. Create appropriate strategies/methods to disseminate WASH in health information.	1
2. Integration of WASH in health facility in health promotion activities at all levels.	2
Bottleneck 3: Lack of implementation and poor decentralization for institutional mechanism of control.	
1. Increase WASH in Health resources for implementation.	2
2. Sensitizing the public on the access of WASH services at all health facilities.	1
Bottleneck 4: Lack of ownership by local authorities at the county level and problem linked to health worker attitude towards patients/communities.	
1. Increase sensitization to local authorities regarding WASH in health.	1
2. Improve/increase motivation (salaries/others).	1

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). Time constraints and qualitative used methodology, based on participant 'experience, expertise and knowledge may have created a bias.

Way forwards: 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. The repetition of a similar exercise is recommended after 2-3 years.