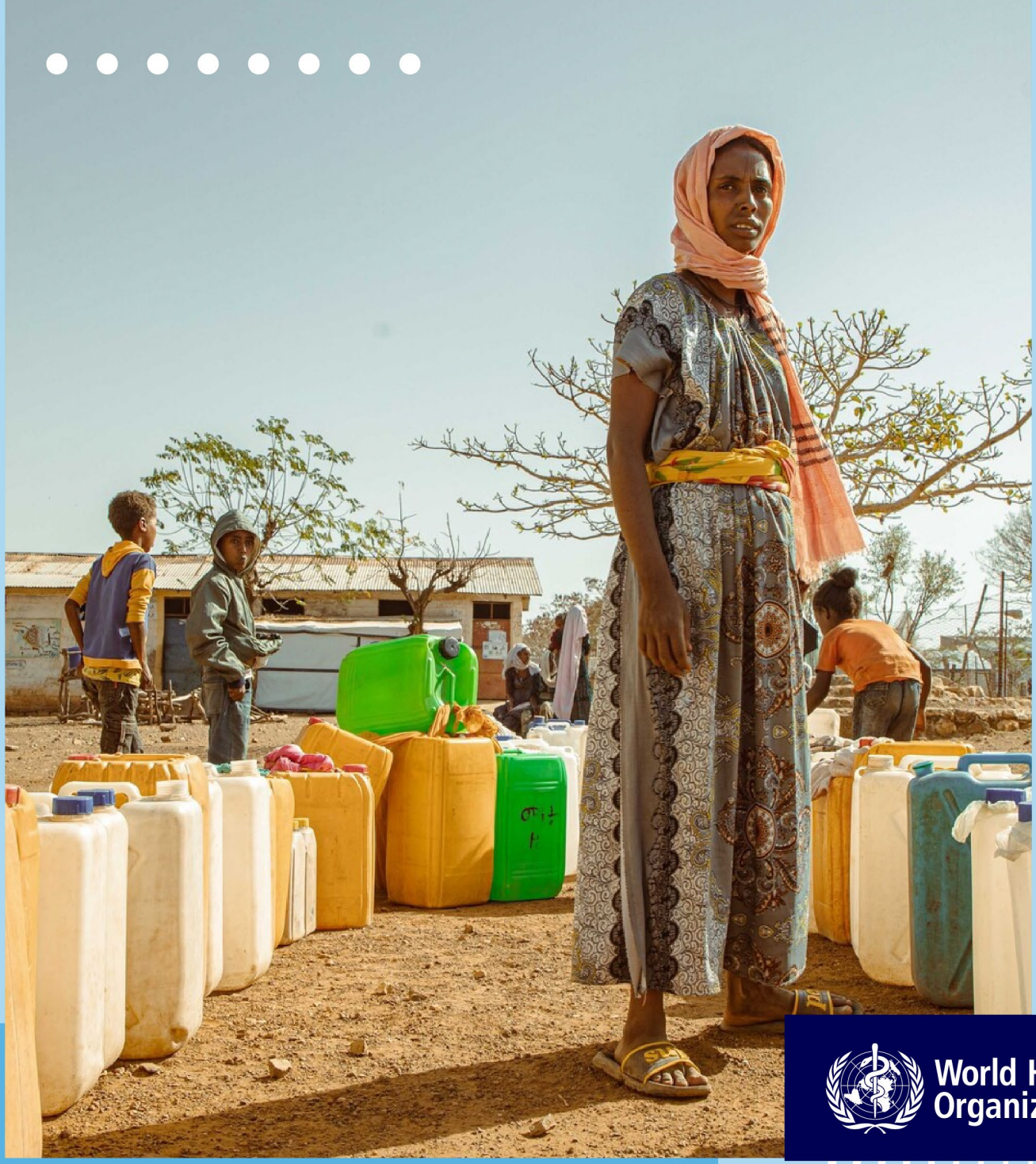

World Health Organization

Evaluation of WHO's contribution to Water, Sanitation, Hygiene (WASH) and Health: **The WHO Global WASH Strategy 2018-2025**

Contents

LIST OF TABLES

LIST OF FIGURES

LIST OF BOXES

Acknowledgements

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Acronyms

AFD	French Development Agency
AMR	antimicrobial resistance
DAC	Development Assistance Committee
DFAT	Department of Foreign Affairs and Trade, Australian Federal Government
ECH	environment, climate change and health
EHG	Euro Health Group
ERG	Evaluation Reference Group
EQ	evaluation question
FAO	Food and Agriculture Organization
GLAAS	UN Water Global Analysis and Assessment of Sanitation and Drinking-Water
GEDSI	gender equality, disability, and social inclusion
GPW	WHO General Programme of Work
GTFCC	Global Task Force on Cholera Control
HCF	health care facilities
HH4A	WHO/UNICEF Hand Hygiene for All Partnership
IPC	infection prevention and control
IWA	International Water Association
JMP	WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
KII	key informant interviews
Logframe	WHO Water, Sanitation and Hygiene Strategy 2018–2025 Results framework
NGO	nongovernmental organization
NTD	neglected tropical disease
OECD	Organisation for Economic Co-operation and Development
PIA	priority intervention area
RegNet	International Network of Drinking-water and Sanitation Regulators
SDG	Sustainable Development Goal
Strategy	WHO Water, Sanitation and Hygiene Strategy 2018–2025
SWA	Sanitation and Water for All
ToC	theory of change
ToR	terms of references
TrackFin	Tracking financing to sanitation, hygiene and drinking-water
UHC	universal health coverage
UN	United Nations
UNEP	United Nations Environment Programme
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WASH FIT	Water, Sanitation and Hygiene for Facilities Improvement Tool
WHA	World Health Assembly
WHO	World Health Organization
WSP	water safety plan
WSH	Water, Sanitation, Hygiene and Health (Unit at WHO headquarters)

Executive Summary

BACKGROUND

WHO has worked on water, sanitation and hygiene (WASH) issues for over 60 years. This area of work is enshrined in its constitution and World Health Assembly (WHA) resolutions, global conventions, initiatives and partnerships. The WHO WASH Strategy 2018–2025 was developed to articulate WHO's unique role on WASH, in response to global initiatives, including the 2030 Agenda for Sustainable Development and the UN's recognition of the human right to safe drinking water and sanitation, and the continuing high burden of WASH-related disease. Achieving targets towards Sustainable Development Goal (SDG) 6 by 2030 requires significant acceleration, particularly in access to safe drinking water, sanitation and hygiene. The Strategy contains a theory of change, along with a results framework and monitoring and evaluation framework identifying results to be achieved.

The WHO WASH Strategy aims to improve health through the safe management of water, sanitation and hygiene services. To do so, it focuses on priority areas and progressive improvements around safe drinking water, sanitation and wastewater management; WASH in health care facilities (HCF); monitoring of the WASH enabling environment and access; estimation of the disease burden from inadequate WASH; and the essential linkages between WASH and health programmes. These represent the most pressing challenges, with significant gaps in coverage, quality and access that directly impact health and well-being. The Strategy also seeks to address global challenges such as climate change and public health emergencies through resilient WASH services and system-strengthening.

To implement this strategy, WHO works through partnerships, notably with UNICEF, to promote equitable access to WASH services, support universal health coverage (UHC) and meet critical health and environmental goals, despite human and financial resource constraints. The Strategy recognizes that effective WASH programming depends on stakeholder engagement, political will and resource mobilization.

PURPOSE AND SCOPE

The evaluation had a dual purpose of accountability and learning, identifying good practices and opportunities for improvement. To this end, the evaluation assessed the **effectiveness** and **added value** of WHO's WASH Strategy for health and its interventions. This evaluation's findings and recommendations will inform the development of the new WHO strategy. The evaluation scope covered Strategy design, implementation and results achieved between 2018 and August 2024 in the Strategy priority intervention areas (PIA). The geographical scope was global.

METHODOLOGY

Combining summative and formative elements, this evaluation used a **theory-based, utilization-focused and gender, equity and social inclusion responsive evaluation** approach to address the criteria of relevance, effectiveness, efficiency, coherence and sustainability. The independent evaluation team conducted 174 key informant interviews (KII) with informants from focus group discussions (overall 48% female); an online survey with 213 respondents (30% response rate); and two country case studies (Ethiopia and the Philippines); and reviewed over 600 documents.

KEY FINDINGS – RELEVANCE

The Strategy is aligned to WHO's organizational mandate and the global 2030 Agenda for Sustainable Development. Its design and implementation respond to country needs and have adapted to changing global circumstances. Additionally, WHO plays a key role in setting the global WASH agenda.

The Strategy is highly relevant to global needs and critical to promote and protect health for all. WHO WASH normative guidance and tools are critical to responding to country needs. Yet the Strategy does not sufficiently

prioritize specific target geographies or populations, other than through specific support to countries based on annual workplans. Considering that priorities at country level are set through country and regional governance processes, accountability for the implementation strategy at the country level is limited. WHO has clearly been responsive to emerging issues and new commitments in its GPW14 (2025–2028), which gives renewed prominence to WASH and environmental health, with climate change as one of its six overall strategic objectives. This increased demand for climate resilient WASH interventions may need to be covered more extensively in the next WASH Strategy.

Yet Gender Equality, Disability, and Social Inclusion (GEDSI) remains insufficiently articulated.
The Strategy does not articulate its contribution to GEDSI principles explicitly, despite constructive efforts in integrating GEDSI in global monitoring and normative guidance and risk management tools and approaches. While stakeholders find that WHO generally addresses gender adequately, they feel that more could be done to address equity issues more systematically in its WASH efforts. For example, there is no assigned GEDSI focal point in the WHO Water Sanitation and Health (WSH) Unit at headquarters to drive the agenda forward.

EFFECTIVENESS

Despite challenges faced, WHO's WASH strategy is being implemented effectively and is achieving its objectives.
Results are generally on track, with most targets and milestones achieved. WHO is viewed as highly influential in setting the global WASH agenda. Despite modest in-house staffing and declining funding, WHO produces highly regarded normative guidance, publications and monitoring data that inform national and international health programmes and initiatives.

A key WHO contribution is adapting and contextualizing global guidance to ensure local relevance and uptake at country level. Yet the prioritization of WASH in country workplans has often been influenced by dialogue with national governments, particularly health ministries, which do not always prioritize WASH; the extent to which WASH is integrated into other WHO programmes therefore varies.

Climate resilience has progressed from an emerging to a mainstream issue and has been incorporated into much of the normative guidance. For partnership-based advocacy and other efforts, more guidance is needed at the country level. The results framework and associated monitoring processes need strengthening to track progress in Strategy implementation.

The COVID-19 pandemic played a dual role: it led to the creation of the WHO/UNICEF Hand Hygiene for All (HH4A) partnership, while also causing significant interruptions to government and development agency interventions due to lockdowns and resource reallocations. Conflicts and other emergencies have further disrupted routine government activities and external support in some countries.

EFFICIENCY

Over the past decade, the declining funding trends and increased levels of earmarking have challenged WHO's capacity to implement the Strategy.
Despite the significant number of countries and populations affected by high burden diseases attributable to unsafe drinking-water, sanitation and hygiene conditions and the recognized contribution of WHO, funding to implement the Strategy tends to be earmarked and short-term. The limited availability of predictable and flexible sources has constrained the provision of timely funding to priority interventions and countries. The UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) receives the most resources, in part because it provides catalytic funding to many countries towards GLAAS data survey collection. This is followed by cross-cutting activities and the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP).

However, WHO has optimized the use of available human and financial resources.
Strong cooperation levels within the WASH team have contributed to an efficient use of limited human and financial resources. While maintaining a tight focus on key mission areas, prioritizing integration of WASH with health programmes and responding to emerging challenges, WHO efficiently leverages partnerships with organizations like

UNICEF and using consultants to manage a growing workload.

Opportunities exist to further enhance coordination within WHO through joint resource mobilization, training, in-country visits and planning. Although efforts to improve collaboration across the Organization's three levels have shown positive results, there is a tendency to scale up activities in response to emerging needs rather than scaling down ineffective ones. There is also a need to align the WASH strategy more closely with financial reporting.

COHERENCE WITH THE GLOBAL WASH ARCHITECTURE

WHO clearly contributes to the SDG 6 Global Acceleration Framework and complements other initiatives coherently.

WHO has provided global leadership on WASH and health, fulfilling its role as a normative, standard-setting organization and playing a pivotal role in the SDG6 Global Acceleration Framework and related initiatives. WHO's mandate in WASH and health in the global WASH architecture is clear and unique and in line with the WHO constitution and related WHA resolutions. At global level, WHO's role is well recognized by and coherent with external WASH stakeholders. It is viewed as key in communicable diseases control – a role which could be leveraged further for disease prevention through safe WASH services.

Coordination and collaboration with external partners are strong at the global level but roles are less clear at the regional and country levels.

At the global level, WHO has developed a strong partnership with UNICEF, harnessing both agencies' strengths. It involves a wide range of key collaborators (academia, funding partners, UN agencies, NGOs, networks and multi-agency partnerships). Yet there is scope for more strategic engagement with the World Bank and for making more use of collaborating centres.

At the regional level, collaboration with partners varies, with a need for clearer role division between UNICEF and WHO. At the country level, WHO works closely with health ministries on WASH, but cross-sector support is limited by human resources and funding constraints and is not prioritized in country cooperation strategies. While UNICEF is a critical partner, collaboration and clarity of respective roles varies depending on the context. There are opportunities for WHO to enhance its role in WASH sector coordination and integration with health at the country level. Within WHO, the Organization's clear mandate in WASH and health is not fully appreciated and is less evident at regional and country levels.

SUSTAINABILITY

WHO WASH efforts to support an enabling environment for sustainable health gains have been stepped up.

Although advocacy, communication and training activities have intensified, timeliness and effectiveness could be improved further. New tools and approaches have also been implemented and key documents published. Internal advocacy and communication need to be reinforced across WHO. There has been a strong focus on training and capacity-building, especially in recent years, across various thematic areas and regions and using new approaches. There remains a strong demand for continued training, as indicated by informants and survey respondents.

Embedding WASH approaches and tools further in national strategies and systems and in partners' approaches will enhance sustainability.

WHO effectively tracks the integration of key WASH standards and guidance into national policies, although the actual achievement of targets at the country level is largely beyond the WSH unit's control, and there is some ambiguity about the boundaries of WHO's implementation role. The evaluation survey indicates good levels of knowledge and use of WSH global knowledge products among governments and partners. However, while in-country support is essential for contextualizing and implementing WHO WASH guidance, resources are often insufficient to provide this support in many contexts.

KEY CONCLUSIONS

Relevance

Access to safe WASH services is highly relevant to global needs and critical to promoting and protecting health, especially as global progress on WASH SDG targets and

indicators is falling behind. WHO's WASH interventions are highly relevant, well aligned to country needs and well regarded. WASH normative guidance and tools are invaluable outputs of the Strategy, critical to health outcomes and informing implementation at scale for other actors. WHO has maintained its relevance through global efforts to improve WASH, including via the UN.

Since the Strategy primarily focuses on global-level interventions, it is necessary to further clarify the role and accountability of country offices in implementing it. WHO will need to broaden the focus of the next Strategy to address a wider range of WASH issues – including climate change, the impact of water resource availability on WASH services, and emergencies – while strengthening linkages with primary health care (PHC)-oriented health systems and ensuring alignment with GPW14 and the UN System-wide Strategy for Water and Sanitation. GEDSI elements need to be articulated more clearly in the next Strategy to reflect the goals of GPW14 and the UN System-wide Strategy for Water and Sanitation.

Effectiveness

The Strategy has been implemented successfully and has proven realistic in its ambitions, despite the constraints under which the WASH function operates within WHO. Challenges include the relatively low prioritization given to WASH within the Organization; the impact of COVID-19 and other emergencies; and the decline of WASH funding within WHO and of staffing at the country level. The quantity and quality of normative outputs are high, particularly considering the rigorous development process and the growing demands on the WSH Unit, especially for additional guidance on implementing the various tools and approaches promoted. However, there is a need for a robust results framework and monitoring process, aligned with GPW14, to effectively track progress in the Strategy's implementation.

WHO's convening power in WASH is evident at the global level, with the WSH Unit playing a pivotal role in steering sector strategy and securing global commitments. A key question is whether the next Strategy could provide a framework for action at the country level, as opposed to a menu of thematic options for country offices to choose from or align with. The current Strategy only addresses the role of the WSH Unit at the global level. However, action would depend on the presence of WASH staff in WHO country teams.

Efficiency

WHO has aimed to maximize its limited human and financial resources by fostering cooperation within the WSH Unit and collaborating with other units in the ECH Department, across all three levels of the Organization and beyond – including other WHO departments, UN partners and external stakeholders.

Despite limited core funding and therefore reliance on earmarked donor contributions, there is potential for further efficiency gains. Improving core funding would allow for optimal staff allocation across priority intervention areas, while clarifying country-level objectives and aligning them with GPW14 would enhance overall effectiveness. Alongside a results framework, there is a need for an enhanced but realistic resource mobilization strategy that the unit can drive, and a narrative-based financial report to demonstrate a balanced allocation of resources across priority areas.

Coherence

WHO has a clear mandate in the global WASH architecture on WASH and health and successfully fulfils its leadership role overall through effective collaboration. However, at the regional and country levels, this mandate has not yet consistently translated into effective disease prevention and control through sustainable access to water supply and sanitation services in high-risk areas. Strengthening specific implementation partnerships could help to fill these gaps. Despite strong collaboration at the global level, in particular with UNICEF, there is room for further strengthening of partnerships and clarifying WHO mandates, roles and comparative advantages at regional and country level.

Sustainability

WHO has scaled up advocacy, communication and capacity development initiatives, and there is strong awareness and

good levels of use of key WSH knowledge products, which suggests that, in principle, Strategy implementation promotes sustainability. Despite the strong and renewed focus on training and capacity development, continued demand for training exists at country level both within WHO and with country stakeholders.

WHO plays a vital role in contextualizing global guidance and embedding Strategy content into national and partner systems and approaches. To further support the contextualization and implementation of its guidance and monitoring at country level, WHO should clarify and capitalize on its comparative advantage in supporting its progressive implementation at country level, particularly given human and financial resource constraints. This should be supported by a revised approach to capacity-building, advocacy and communication considering resource constraints.

RECOMMENDATIONS

Recommendation 1 – Develop a new WASH strategy based on WHO established core areas of work in WASH (including setting standards, guidelines, strengthening WASH systems at country level, monitoring, and promoting evidence-based policy and research), while integrating newly identified priority areas where WHO contributions add significant value (e.g. climate change resilience, WASH in emergencies including cholera, antimicrobial resistance, primary health care, infection prevention and control, vector-borne diseases, cholera, (NTDs) as well as GEDSI). The new Strategy should enhance intersectoral engagement and be aligned with both internal and external strategies of key WASH actors (including
UNICEF), primarily GPW14 and the UN System-wide Strategy for Water and Sanitation.

Timeframe: Next six months. Action: WHO

Recommendation 2 – To implement the new Strategy, develop an operational plan anchored in the GPW14. This plan should be accompanied by a results (monitoring and evaluation) framework that outlines clear accountabilities and defines specific roles for headquarters, regional and country offices.

Timeframe: Next 12 months. Action: WHO

Recommendation 3 – To position the WHO WASH programme of work more strategically within and beyond WHO, expand and capitalize on internal and external partnerships, leveraging and strengthening awareness and understanding of its utility. This will also support joint advocacy and fundraising efforts.

Timeframe: Next 12 months - Action: WHO (across its three levels), and in collaboration with UNICEF, development banks, global health initiatives and partnerships with other key implementation stakeholders

Recommendation 4 – Enhance the sustainability of WHO's WASH and health interventions at the country level by working with key partners to develop strategies and foster country-level partnerships that progressively integrate WASH standards, guidance, and tools into national policies and regulatory frameworks. Additionally, clarify WHO's comparative advantage vis a vis other stakeholders and partners.

Timeframe: Next 12 months - Action: WHO (across its three-levels) and in collaboration with UNICEF and other key partners

1. INTRODUCTION AND CONTEXT

Euro Health Group (EHG) was commissioned to undertake an evaluation to assess the effectiveness and added value of WHO's engagement on WASH, through the activities articulated in WHO's Global WASH Strategy, and inform the way forward for the subsequent strategy (see Vol. II, Annex 1 for the terms of reference (ToR)).

1.1 Background: WHO's mandate and role on WASH

Unsafe water, sanitation and hygiene is associated with a persistent health burden and disproportionately affects marginalized groups, especially women and girls. The WASH burden of disease 2019 update, published in 2023 and carried out by the WSH Unit, reported that diarrhoeal diseases alone resulted in over a million deaths globally, with the majority being children under five and with regional disparities, especially in Africa, Southeast Asia and the Western Pacific. A WHO study estimates that 1.4 million deaths could be prevented each year through improving access to safely managed water, sanitation and hygiene services *(2)*. Recent data further show a resurgence of cholera outbreaks, which could be prevented by safe access to WASH *(3)*. Lack of access to safe water and sanitation is especially acute in least developed countries and in fragile and conflict affected states *(4)*.

Sanitation and hygiene are enshrined in the WHO constitution as a key function of the Organization: "to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene" *(5)*. Building on more than 60 years of guidance on drinking water quality and safety, WHO plays a key role in responding to the recent call by the UN Secretary-General for action on WASH in health facilities *(6)* and has a mandate on WASH through other World Health Assembly (WHA) resolutions *(7, 8)*, global conventions, initiatives and partnerships (e.g. UN-Water *(9)*). WHO is a (co-)custodian of several WASH-related sustainable development goals (SDGs), namely SDGs 6.1 and 6.2 through the WHO/United Nations Children's Fund (UNICEF) Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP), SDG 6.3 through the Integrated Monitoring Initiative with United Nations Environment Programme (UNEP) and UN-Habitat, and SDGs 6.a and 6.b through UN Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) with the Organisation for Economic Co-operation and Development (OECD) *(10)*. According to the WHO WASH Strategy 2018–2025 *(10)*, the added value of WHO in WASH is predominantly related to the strong interlinkages between WASH and health. As an active member of UN-Water *(9)*, a coordination mechanism for UN agencies and programmes, WHO provides leadership and supports global agenda-setting in the WASH sector.

It is important to note, however, that WHO is not an implementing WASH partner at the country level, rather WHO collaborates with government, UN agencies, NGOs and other implementing partners to improve WASH and health-related outcomes. WHO's specific work in WASH involves monitoring at global, regional and national levels of WASH indicators, and the development of evidence-informed norms and technical guidance to partners such as government, UNICEF, World Bank, regional development banks, and organizations like WaterAid, the International Water Association (IWA) and the Sanitation and Water for All (SWA) partnership. Technical assistance, training, capacity-building and knowledge-sharing are other key components of WHO's WASH-related work. WHO actively engages multi-sectoral partners to influence political will and the adoption of effective WASH strategies, regulations and policies. It also works to foster collaboration to advance WASH integration in other health priorities (e.g., infection prevention and control (IPC), cholera, antimicrobial resistance (AMR), NTDs, etc.).

1.2 The WHO water, sanitation and hygiene strategy 2018–2025

The WHO Water, Sanitation and Hygiene Strategy 2018–2025 *(10)*, hereafter referred to as "the Strategy", was developed in response to Member State Resolution WHA64.24 *(11)* and the 2030 Agenda for Sustainable Development. It also takes on board the need for progressive realization of the right to safe drinking-water and sanitation *(11)*, adopted by the UN General Assembly in July 2010**.**

The development and implementation of the Strategy occurred within a context shaped by numerous global challenges and initiatives, particularly the urgent need to accelerate progress toward the WASH-related Sustainable Development Goals (SDGs). The SDGs are currently at midpoint (2023) – a timely moment for considering what course corrections might be needed to enhance the delivery of meaningful outcomes. The SDG 6 Global Acceleration Framework *(12)*, adopted by UN-Water in 2020, aims to deliver fast results at an increased scale as part of the Decade of Action to deliver the SDGs by 2030. The framework was a response to international recognition that SDG 6 – *to ensure availability and sustainable management of water and sanitation for all*[1] – was alarmingly off track, with some setbacks. The most recent GLAAS report *(13)*, which details the latest status of WASH systems in more than 120 countries, is the most extensive data collection from the greatest number of countries to date. The report highlights that while 45% of countries are on track to achieve their nationally defined drinking water coverage targets, only 25% are on track to achieve their national sanitation targets. Less than a third of countries reported having sufficient human resources to carry out key drinking-water, sanitation and hygiene functions. Based on JMP acceleration rate reporting, achieving SDG 6 by 2030 will require a six-fold increase in current rates of progress for safely managed drinking water, a five-fold increase for safely managed sanitation and a three-fold increase for basic hygiene services – more so in least developed countries and fragile states.

The Strategy contains a theory of change, along with a results framework and monitoring and evaluation framework identifying results to be achieved.

Key lessons on effective WASH programming were identified in the Evaluation synthesis report of United Nations system and Development Bank work towards SDG 6 *(14)*. Among other things, the report highlighted the importance of stakeholder engagement; a strong theory of change (ToC); and achieving synergies between WASH interventions and interventions in other related sectors. It also highlighted that SDG 6 indicators are difficult to work with and that there should be more focus on evaluating humanitarian programming related to SDG 6.

Furthermore, achievement of other SDGs cannot be met without meaningful progress on SDG 6 targets. The SDG 3 on health explicitly calls for combating water-borne diseases (SDG 3.3) and for reducing death and illness from unsafe water, unsafe sanitation, and lack of hygiene (SDG 3.9). Demonstrating the impact of WASH on health outcomes is an opportunity for WHO as well as leveraging longstanding platforms and collaboration with health ministries and other policy-makers and health sector partners, to achieve universal and equitable access to safely manage WASH services alongside related WHO targets and approaches such as UHC and the primary health care approach. WHO has several opportunities to showcase the positive impact of WASH on health outcomes, as evidenced by the launch of the Burden of disease report in 2023 *(1)* and WASH/Health leadership at the 2023 UN Water Conference. By working closely with ministries of health, policy-makers and other health sector partners, WHO can leverage existing platforms and collaborations to promote universal and equitable

[1] SDG 6: Ensure availability and sustainable management of water and sanitation for all. Available and sustainable water and sanitation is essential for leading healthy and dignified lives and is intrinsically linked to health, poverty reduction, education and environmental sustainability objective.

access to safely manage WASH services. This effort aligns with WHO's broader goals, including achieving UHC and strengthening the primary health care approach.

In relation to the SDG 13 on climate change there is growing consensus among development partners and implementing agencies on the need for the development of climate-resilient WASH services, and for WASH systems strengthening. Climate change makes weather patterns more unpredictable and increases the frequency and intensity of extreme weather events and natural disasters, such as droughts, floods and cyclones. Climate change puts pressure on existing WASH infrastructure, disrupts water availability and quality and is likely to substantially alter the risk of many vector-borne and other communicable diseases. The sector faces huge challenges in establishing climate-resilient services, particularly in low-income countries with limited human and financial resources, and in strengthening WASH systems within the complex institutional structures of the WASH sectors that span multiple ministries in many countries. These challenges are being addressed by leveraging partnerships that provide greater reach and scale. This approach is key to enhancing efficiency. The Strategy period has also seen an increase in global conflicts and health emergencies, most notably cholera, which has been classified as a Grade 3 emergency.

WHO's thirteenth general programme of work (GPW13) 2019–2023 *(15)* describes how the Organization's efforts will contribute to the health of three billion: one billion through multisectoral actions and addressing environmental risk factors and health determinants; one billion benefiting from better emergency preparedness and response; and one billion through UHC. Several high-profile framework impact indicators centred around these targets have been developed, two of which relate to water and sanitation:

- Target 45: Provide access to safely managed drinking water services for 1 billion more people
- Target 46: Provide access to safely managed sanitation services for 800 million more people

Additional indicators associated with UHC are linked to improving WASH in HCF. WASH activities also support other global strategies, such as Ending the neglect to attain the Sustainable Development Goals: a roadmap for neglected tropical diseases 2021–2030 *(16)*.

The most recent WSH Unit annual report from 2022 *(4)* notes that government leadership and willingness to drive change are vital, with an urgent need to significantly increase political commitment and financial resources for safely managed drinking water, sanitation and hygiene. The same report, referencing JMP data, recognizes that one in five HCFs still lack basic water services, and one in four do not segregate waste safely – against the global target of providing basic WASH services in 80% of HCFs by 2025 and 100% by 2030 in accordance with WHA resolution WHA72.7 *(6)*.

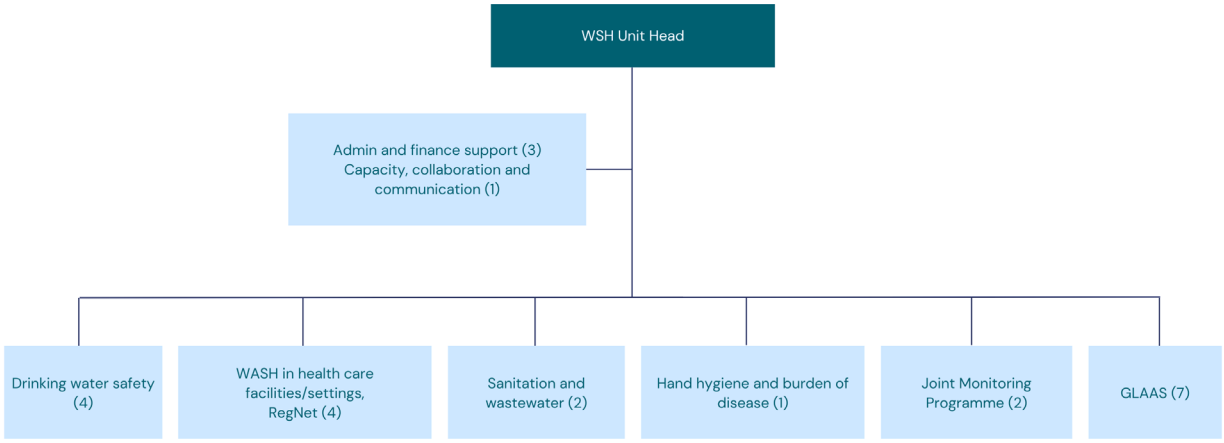
According to the WHO Unit managing the Strategy, implementation has become increasingly demanding as relevant topics under WHO's WASH mandate and roles have expanded and become more complex. For example, monitoring of SDGs 6.1 and 6.2 has become more complex, as targets now focus on service safety and quality, requiring high-quality work while extending monitoring to new areas. In the domain of water quality and safety, there has been a shift towards prevention. Hand hygiene has been introduced as a new focus area during the Strategy period.

Considering such challenges and opportunities, WHO remains adaptive, yet the Strategy must be realistic considering WHO's resource constraints and emphasize the importance of WHO's influence, in part via strategic partnerships with other organizations – not least UNICEF, which has much greater operational capacity. WHO's Alliance for Action on Climate Change and Health *(17)* and UNICEF's Sanitation Game Plan *(18)* are two examples of initiatives offering potential synergies through partnership.

1.3 WHO Water, Sanitation, Hygiene and Health Unit

At WHO headquarters, the Water, Sanitation, Hygiene and Health (WSH) Unit comprises a team of 23 technical personnel (staff and consultants) – refer to Fig. 1 for its current organogram. The WSH Unit is part of the Environment, Climate Change and Health (ECH) Department, which includes units focused on radiation, chemical safety, climate change and health, occupational health and more, under the UHC/Healthier Populations Division at WHO headquarters. The WSH Unit is organized in teams according to the following six thematic areas: drinking-water safety; WASH in health care facilities/settings; sanitation and wastewater; hand hygiene and burden of disease; JMP; and GLAAS, which also includes WASH focal points in the cholera and emergencies teams. These teams are managed by the unit head and supported by three administrative and financial personnel, and various consultants. Work of the WSH Unit is guided by the WHO water, sanitation and hygiene strategy 2018–2025 *(10)*, with eight priority intervention areas[2] and relevant GPW13 indicators.

Fig. 1. Organogram of the WSH Unit in WHO Headquarters as of December 2023



Modified from organizational charts, WHO Water, Sanitation, Hygiene and Health (WSH), World Health Organization, unpublished, December 2023. Brackets indicate number of staff/consultants[3]

The organogram varies slightly from what is reported as part of the headquarters human resources accounting system; however, this may reflect the fluctuation in additional resources secured to support activities for specific pieces of work. The organogram is structured in teams around six of the Strategy's eight priority intervention areas, with the priority intervention areas of "sanitation and wastewater" and "health care facilities" reportedly being mainstreamed across the six WSH teams.

At the WHO regional and country levels, there is a limited number of staff dedicated specifically to WASH and environmental health. In each of the six WHO regional offices there is one dedicated regional WASH advisor and in 158 WHO country offices typically one staff has been nominated as focal point for ECH, some of whom work on WASH. Table 1 below shows the number of countries and ECH allocation per region. Overall, the ratio is 0.76 ECH focal points per Member State and as low as 0.54 ECH focal points per Member State in the Western Pacific Region. Importantly, due to WHO's decentralized governance structure, the WSH Unit does not

[2] Priority intervention areas: drinking-water quality and safety; sanitation and wastewater; WASH in health care settings; global monitoring initiatives (e.g. UN-Water GLAAS and WHO/UNICEF JMP, Burden of Disease); integration of WASH with health and other programmes; Hand Hygiene for All global Initiative; drinking-water and sanitation regulation, through the International Network of Drinking-water and Sanitation Regulators (RegNet); emerging issues on WASH (e.g. climate change, AMR).

[3] A review of staff allocations in WHO's human resources accounting system suggests that the following thematic areas rely on consultant inputs "drinking-water safety" (1 staff, 3 consultants), WASH in HCFs/RegNet (3 staff, 1 consultant) and "GLAAS" (2 staff, 5 consultants).

have direct control or oversight of the number of ECH staff working on WASH at the country level and no direct line management function at the regional or country level.

Table 1. Number of ECH focal points in WHO country offices by region as of June 2024

WHO Region	Member States	Country offices	ECH focal points in WHO country office
Africa	47	47	62
Americas (PAHO)	39	27	29
South-East Asia	11	11	16
Europe	53	31	14
Eastern Mediterranean	21	21	17
Western Pacific	37	12	20
Total	**208**	**150**	**158**

Source: *(19)(20)*).

WHO's current action plan to increase its core predictable country presence *(21)* foresees a significant restructuring of human resources at the country level and a substantial increase in country-level staffing from 1511 positions to 2612 staff. Current plans under the core predictable country presence do not detail future staffing levels working on health determinants/health programming where WASH related issues are expected to fall.

1.4 Object of the evaluation

The object of the evaluation is the WHO water, sanitation and hygiene strategy 2018–2025 *(10)*. The Strategy document refers to its development as based on an organization-wide discussion on WASH priorities and challenges, including experiences and reflections from both regional and country offices, with inputs from partners.

1.4.1 Utility and accountability

The WSH Unit reports that it has used the Strategy as guidance for its work. Responsibility for implementing the Strategy rests with all three levels of the Organization, but oversight of implementation is provided by the WSH Unit. The Strategy serves as a guiding document for WHO and partners to ensure universal access to safe water, sanitation and hygiene, adopt transformative approaches, reduce the associated disease burden and improve global health outcomes.

1.4.2 Strategic approaches of the Strategy

According to the Strategy, the WHO vision for WASH is "to substantially improve health through the safe management of water, sanitation and hygiene services in all settings" with the following six strategic approaches:

1. *Develop, update and disseminate health-based guidance documents and best practice guides, norms and standards* that support standard-setting and regulations at national level, particularly for drinking-water safety, effective surveillance approaches, recreational water quality, sanitation safety, safe wastewater use, WASH in health and educational facilities and WASH monitoring.

2. *Empower countries through multi-sectoral technical cooperation, advice and capacity-building* to governments, practitioners and partners, including on:

    a. health and WASH sector capacities with respect to their public health oversight roles;
    b. national policies and regulatory frameworks;
    c. national systems for effective water quality and disease surveillance, including outbreak response;

d. national systems for WASH monitoring; and
e. national WASH target-setting.

3. *Monitor, research and report reliable and credible WASH data* to inform policies and programmes:
    a. WASH risk factors and burden of disease
    b. the status of key output indicators for WASH (through JMP)
    c. progress towards relevant WASH-related SDG targets[4]
    d. the enabling environment (input indicators) for WASH, including WASH financing
    e. wastewater and SDG 6 interlinkages through the Global Expanded Monitoring Initiative.

4. *Coordinate with multisectoral partners, lead or engage with global and regional platforms and advocate for WASH to*:
    a. influence political will and policy uptake of effective WASH strategies;
    b. increase focus on effective WASH regulations and policies;
    c. expand and strengthen multisectoral collaboration at national level;
    d. coordinate networks of practitioners and partners and collaborating centres; and
    e. support multilateral global- and regional-level instruments, frameworks and protocols in the field of WASH.

5. *Promote integration of WASH with other health programmes*, for example disease programmes for cholera and NTDs, emergencies programmes, quality care and IPC, especially through WASH in HCF, nutrition programmes and AMR programmes.

6. *Respond to emerging issues* such as climate change and WASH, including the impact of water scarcity on public health, and AMR.

1.4.3 Priority intervention areas

The Strategy defines priority intervention areas (PIAs), also referred to as "result areas" or "thematic areas" for the period 2018–2025 (with some areas added after the development of the Strategy). They include:

- drinking-water quality and safety;
- sanitation and wastewater;
- WASH in health care facilities/settings;
- global monitoring initiatives (e.g. UN-Water GLAAS and WHO/UNICEF JMP, both of which contribute to the UN-Water Integrated Monitoring Initiative for SDG 6 *(22)*; burden of disease);
- integration of WASH with health and other programmes;
- Hand Hygiene for All Global Initiative;
- drinking-water and sanitation regulation, through the International Network of Drinking-water and Sanitation Regulators (RegNet); and
- emerging issues on WASH (e.g., climate change, AMR, NTDs, etc.).

The Strategy outlines the imperative for transformation in the SDG context, emphasizing a shift to country-driven target setting, financing, implementation and monitoring, and noting that the role of WHO (and other agencies) must change to more effective technical support to the national institutions charged with these tasks. This includes, among other priorities, a greater end-user engagement in guideline development as well as follow-up actions and supporting tools for regulators and practitioners. A whole-of-government approach is stated as a key enabler for better WASH and health outcomes, and the Strategy emphasizes that WHO needs to increase its intersectoral work (i.e., beyond the health sector and with sectors such as environment, education, finance, etc.). Mainstreaming WASH within WHO by actively incorporating WASH expertise into disease programmes and partnerships is another key transformative approach, as well as an increased focus on sanitation compared to the earlier focus, which was mainly on drinking-water quality and monitoring. Taking gender, equity and human rights into consideration is mentioned in the Strategy, but not as a standalone PIA. This

[4] E.g. SDG 1.4; SDG 3.3 and 3.9; SDG 4a; SDG 6.1, 6.2; 6.3, 6a and 6b; SDG 13; and others.

latter aspect is further analysed in section 4.1 of this report.

1.4.4 Theory of change and results framework for the Strategy

The WHO strategic framework on WASH is presented in Fig. 2 and specifies intervention areas, outputs, outcomes, vision and related principles and strategic approaches. This strategic framework resembles a ToC but does not identify any assumptions or risks. Appendix A of the Strategy presents the WHO ToC for WASH; however, this is more simplistic than the strategic framework and mainly appears as a basic results chain.

The Strategy's associated results framework *(23)* (logframe) stipulates two overall outcome areas and seven related outputs which are aligned with, albeit slightly different from, the outputs presented in the strategic framework in Fig. 2. The outcomes and outputs are defined as follows.

Programmatic outcome 1: National and international WASH and health programmes, regulations and initiatives are based on normative guidance produced by WHO. Risk-based approaches are adopted at national level.

- **Output 1 –** *Drinking water*. Risk management approaches based on up-to-date guidelines for drinking water are available and disseminated to national and international WASH partners.

- **Output 2 –** *Sanitation and wastewater*. Risk management approaches based on up-to-date guidelines for sanitation, safe use wastewater, excreta and greywater and recreational water are available with tools to support implementation and disseminated to national and international WASH partners.

- **Output 3 –** *WASH in health programmes*. Health and other programmes are aware of the importance of WASH and have access to up-to-date technical materials for their programming and policies.

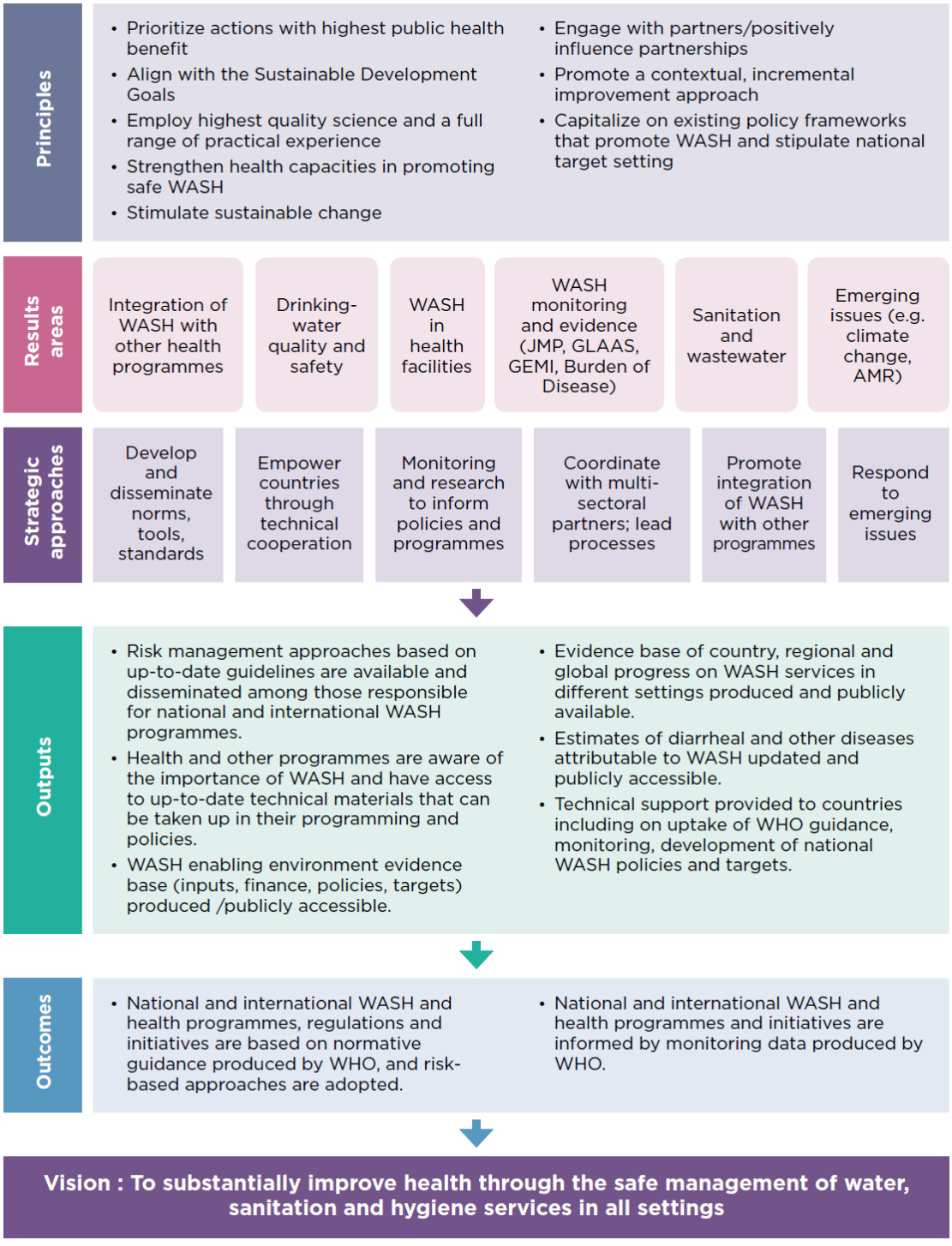
Programmatic outcome 2: National and international WASH and Health Programmes and initiatives are informed by monitoring data produced by WHO as follows:

- **Output 4 –** *JMP*. Robust and up-to-date evidence base of country, regional and global progress on WASH and wastewater services in different settings is produced and publicly accessible.
- **Output 5 –** *GLAAS*. Robust and up-to-date evidence base on a WASH enabling environment (inputs, processes, finance) is produced and publicly accessible.

- **Output 6 –** *Burden of disease*. Estimates of diarrhoeal and other diseases attributable to WASH are updated and publicly accessible.

- **Output 7 –** *Operations*. WHO WASH demonstrates organizational excellence through better targeting of resources, effective partnerships and documented results at the country level.

Fig. 2. WHO Strategic framework on WASH, WASH Strategy 2018–2025 *(10)*



The evaluation team worked with the WSH team and the evaluation reference group (ERG) during the inception phase of the evaluation to reconstruct a ToC building on the strategic framework and the existing ToC and logframe to identify relevant assumptions, risks and other activities that have emerged during implementation of the Strategy. The reconstructed ToC is presented in section 3.2, Fig. 4 of this report. Key differences include that the reconstructed ToC includes intermediate outcomes and, critically, the assumptions on which Strategy implementation is dependent.

1.4.5 Strategy target groups and geographies

Based on specified activities and the Strategy logframe indicators, as well as feedback from discussions with the WSH Unit, the intended audiences for the Strategy are the three levels of WHO (primary target group) and key WHO partners and stakeholders for WASH (secondary target group). Through its activities and associated logframe, the Strategy is assumed to be targeting all three levels of WHO, although more activities and indicator-reporting are relevant for the WHO global level (headquarters). The Strategy notes the following key partners and stakeholders for WASH: Member States, practitioners, research institutions, regional platforms, WASH sector partners, including UNICEF, health sector partners (e.g., Global Task Force on Cholera Control (GTFCC) and external support agencies).

The Strategy, which is global in nature, does not detail which countries have been prioritized for support (financial or human resources) to implement the Strategy, though annual workplans, through associated budgets, contain some country-specific detail.

1.4.6 Budget for Strategy implementation

In terms of financial resources, the amount budgeted for the Strategy period was planned at an estimated US$ 9 million per annum.[5] Approximately US$ 3 million was the planned allocation for headquarters staffing costs, US$ 3 million for headquarters activity costs and a further US$ 3 million for regional and country costs *(24, 25)*.[6] These budget components comprise voluntary specified funding (donor funding), flexible funding (core funding), and/or designated funding (either flexible or specific funding) that usually comes via the Resource Allocation Committee.[7] These designated (centrally allocated) funds – a relatively new initiative since the last biennium – are funds that have been gathered from different donors (typically Norway and Sweden) of which 80% goes to regions and countries and 20% to headquarters. Regions and countries are also directly in receipt of additional funding that is not allocated via the WSH Unit/ECH Department for WASH and/or sourced directly from within the region and/or country that may be used and contribute to WSH related activities.

See also Section 1.3 for staffing and Section 4.3 for further detailed information.

2 PURPOSE, OBJECTIVES AND SCOPE

2.1 Purpose and objectives

The evaluation had a dual purpose of accountability and learning, identifying good practices and opportunities for improvement. In line with the ToR, the evaluation aimed to assess the effectiveness and value of WHO's engagement on WASH and to present scenarios for the future positioning of WHO's WASH Strategy within the Organization and the global water architecture, informing the way forward for the subsequent Strategy. The evaluation included a summative component, which assessed progress of the Strategy implementation to date, and a formative component focused on the way forward. A theory-based evaluation design was applied, which included a mixed-methods approach to data collection and analysis (quantitative and qualitative data, as well as primary and secondary data). This is described in detail in Section 3 on Methodology.

[5] As presented in the WHO ESA Highlight (Annex 5 of 2018 & 2019 A/R; Annex 3 of 2020; Annex 2 of 2021 & 2022).
[6] Evidence from KIIs.
[7] The Resource Allocation Committee is made up of a number of senior managers, including Director EXT, Director Planning, Resource Coordination and Performance Monitoring, Assistants Director-General.

In accordance with the ToR, the evaluation had the following four specific objectives:

1. documenting progress towards the Strategy's objectives and results, the added value and comparative advantage of WHO's role in WASH and its contribution to advancing global, regional and national WASH development;

2. identifying achievements, good practices, challenges, gaps, opportunities and areas for improvement in the design and implementation of the Strategy;

3. identifying the key contextual factors and changes that are affecting implementation of the Strategy and influencing results; and

4. making recommendations for the future on how the Strategy revision in 2025 could adapt to emerging global challenges successfully, while ensuring WHO's contribution to WASH and health remains fit-for-purpose[8] and maintains effective alignment with WHO's broader programme of work.

The evaluation aimed to generate learning and identify improvement opportunities to enhance implementation of the remainder of the Strategy, as well as to inform relevant discussions and decisions for the next iteration of the Strategy, due for renewal in 2025. In addition, lessons from the evaluation are expected to contribute to informing WASH-related aspects of the implementation of the newly approved GPW14 *(26)*, including the related budget and work plans for implementing GPW14 – a process to be initiated during the third quarter of 2024.

2.2 Scope

The evaluation scope included an assessment of the relevance, effectiveness, efficiency, coherence and sustainability aspects of the Strategy and its implementation (refer to ToR in Vol. II, Annex 1). The evaluation focused on Strategy PIAs, including design, implementation of the Strategy and results achieved from 2018 to April 2024 (from start of Strategy implementation to the end of the evaluation data collection period). The evaluation also considered the changing global landscape, especially commitments (including voluntary commitments through the Water Action Agenda, SWA Mutual Accountability Mechanism and G20) *(27-29)* to acceleration in water, climate resilience and the intersections of health and WASH.

The geographical scope was global – with regional and country levels covered mainly through KIIs, group discussions, an online survey and two country case studies (see also Section 3 on Methodology). The evaluation analysed progress against indicators/milestones reported by WHO globally on the Strategy logframe. Regional and country level progress on milestones was not available.

A detailed capacity assessment was not in the scope of this evaluation. However, the evaluation reviewed data concerning financial and human resources to understand resourcing trends, challenges, gaps and opportunities for implementing the Strategy. The evaluation also gathered perceptions on the adequacy of resources through secondary data and various primary data collection methods.

[8] In terms of leadership, normative activities, evidence provision through monitoring, support for Member States in both technical cooperation and professional development, emergency response, knowledge management, global reporting and fostering collaboration.

It is important to highlight here that the scope of work did not include a critical assessment of the content of the normative guidance issued by WHO during the Strategy period, only the extent to which the objectives and results of the Strategy have been achieved. The main report (Volume I) accomplishes this for the Strategy as whole, while Volume II contains a more detailed review of progress and related issues and challenges for each of the PIAs (Annex 9) plus a table summarizing results against the logframe (Annex 10).

2.3 Evaluation audiences

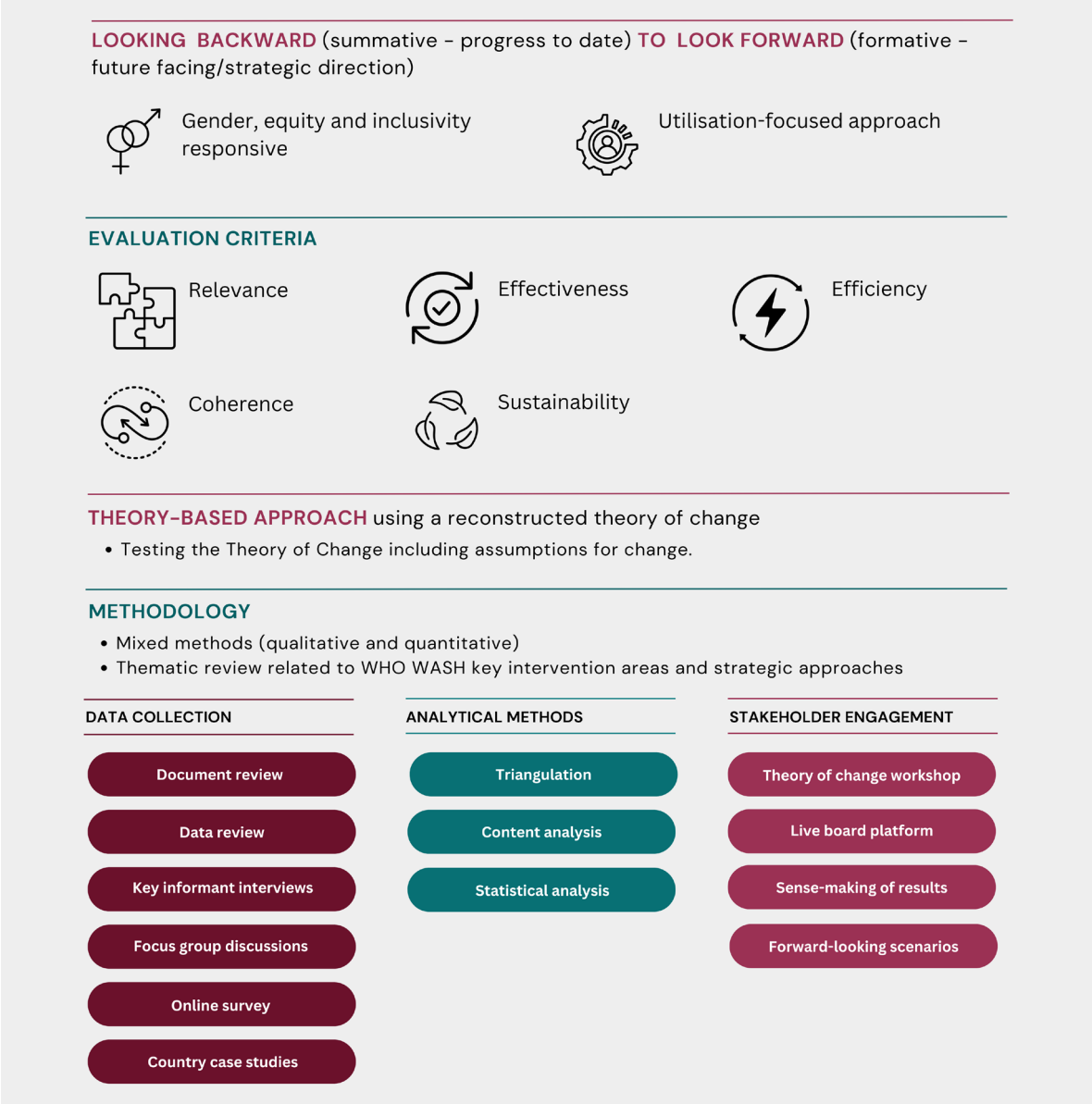
While the owner of this evaluation is the WHO Evaluation Office, the primary audience for the evaluation includes the WSH Unit and the broader WHO ECH Department at WHO headquarters. Other primary audiences include WHO regional and country offices and related WHO departments and programmes. Secondary users of the evaluation include key WHO partners, such as UNICEF, donors, partnership/networks, academia and civil society organizations.

3. EVALUATION METHODOLOGY

3.1 Summary of approach and methodology

The evaluation team developed a theory-based, utilization-focused and gender, equity and social inclusion responsive evaluation approach. The evaluation had both a summative and a formative component, the centre of analysis was a reconstructed ToC and five overall evaluation questions (and related subquestions) reflecting the evaluation criteria of the Development Assistance Committee of the OECD (OECD DAC), namely relevance, effectiveness, efficiency, coherence and sustainability (see Fig. 3). The evaluation used a mixed-methods approach to data collection and data analysis (mix of quantitative and qualitative data). Data were collected through a secondary data and document review, and primary data were collected through KIIs, (focus) group discussions and an online survey. In addition, two country case studies were conducted with country visits of evaluation team members to Ethiopia and the Philippines. Data were analysed through content analysis (qualitative data) and descriptive and statistical analysis (quantitative data) and triangulation. Each of the above elements is described in detail in this section as well as those on ethical considerations and limitations.

Fig. 3. Overview of the evaluation



2.4 A theory-based approach to the evaluation

Considering the complexity of the evaluation and the fact that the evaluation was not amenable to randomization or case control designs nor the use of any other counterfactual scenarios, the most suitable evaluation design was a theory-based evaluation approach. Theory-based evaluations seek to empirically test the links in the causal chain laid out in the ToC, as well as the assumptions upon which the theory is based, and to assemble and analyse data at each stage of the chain to assess whether the suggested relationships occurred and whether or not assumptions were sound and holding true. Theory-based evaluations are particularly appropriate to identify key drivers of change and barriers or challenges that may hinder progress.

The evaluation team worked closely with the WSH Unit team during the inception phase to reconstruct a ToC for the Strategy to allow more detail than in the pre-existing ToC, delineating clear pathways for change along with key assumptions underpinning change. The reconstructed ToC was developed on an interactive

whiteboard (Miro board) and the final version of the agreed ToC is presented in Fig. 4 with evaluation questions (EQs) and critical assumptions mapped to the ToC.

The ToC represented the evaluation's overarching analytical framework and was integral to establishing the evaluation matrix stipulating assumptions, areas of investigation and data sources as well as structuring the tools for data collection, question guides for interview and focus group discussion and case study reporting. The ToC was used in all phases of the evaluation.

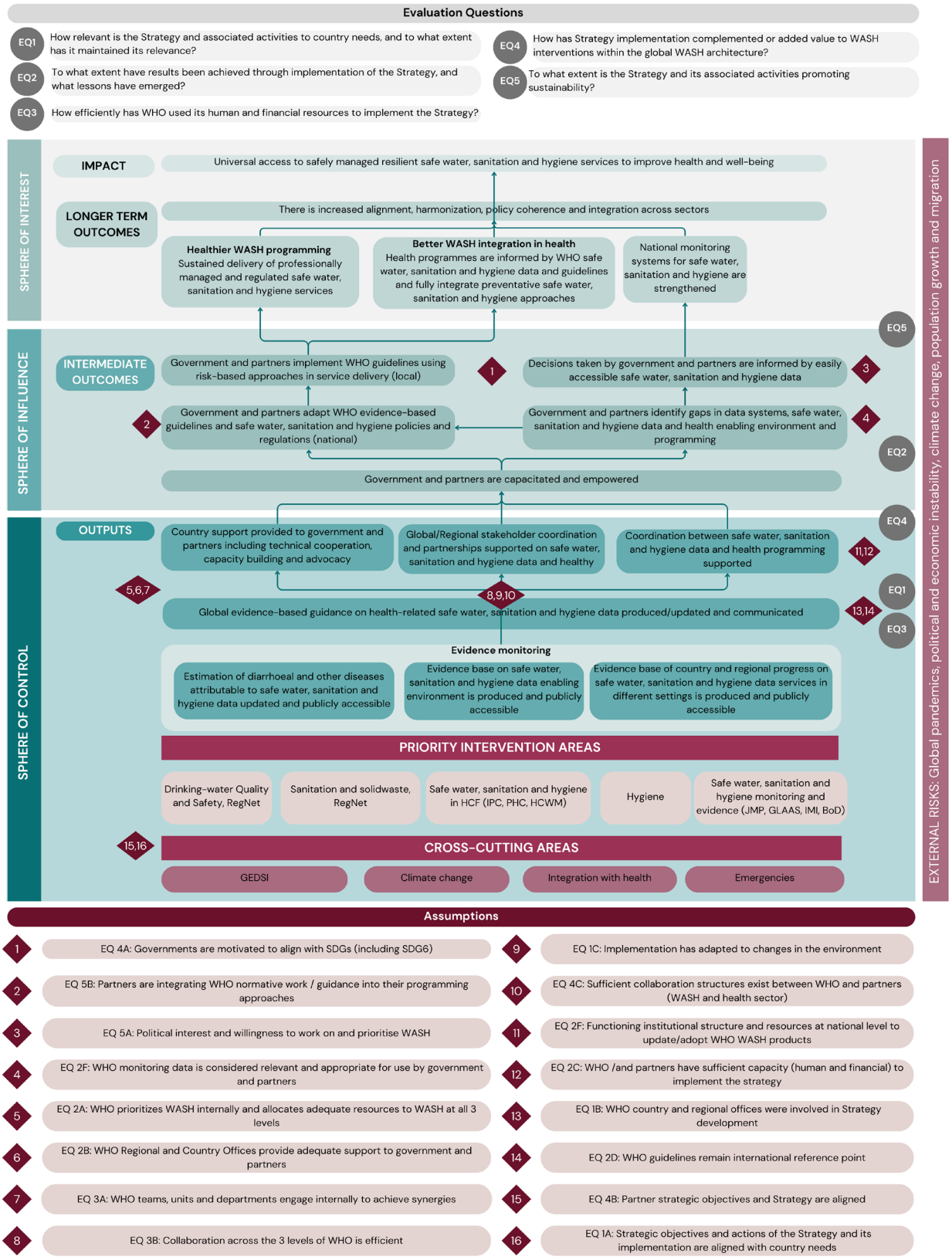
- In the inception phase, the ToC informed the revision of the evaluation questions and sub-questions and the development of tools for data collection. It also helped the evaluation team to understand the Strategy implementation logic in more detail.

- During the data collection phase, the ToC was used to identify evidence gaps and guide the evaluation team in refining key informant (KI) questions to focus on specific assumptions. Additionally, it functioned as a tool to enable the evaluation team to periodically review emerging findings at key junctures throughout the evaluation.

- At the analysis stage of the evaluation, the ToC served as a tool for assessing the evidence against the EQs by testing key assumptions and developing an overarching assessment of how, why and to what extent the results chain was being realized and whether assumptions underpinning change held true.

For the evaluation report, each findings section includes a short assessment of the ToC and assumptions in relation to the findings for each EQ.

Fig. 4. Reconstructed theory of change for the WHO WASH Strategy 2018–2025



2.5 Utilization-focused evaluation

The evaluation team adopted several principles of a utilization-focused evaluation approach *(30)* by involving primary audiences throughout the evaluation process at key junctures. The evaluation team applied a utilization-focused/learning lens through the following specific approaches:

- The inception evaluation workshop conducted with the WSH Unit and the ERG in January 2024 – an in-person meeting to reconstruct the ToC, discuss EQs and gain overall agreement on the sampling strategy, including pre-selection of countries for case studies.

- Using an interactive Miro board at different stages to allow for interactive participation of key evaluation stakeholders (mainly WSH and the ERG). During the inception phase the Miro board was used to obtain comments and input on the reconstructed ToC. The board also included a guided recording and explanation of the reconstructed ToC by an evaluation team member to allow for flexible reviewing to accommodate stakeholders' schedules. In the analysis and reporting phase, the Miro-board was used to comment on draft recommendations and suggest prioritization and accountability for the recommendations.

- Bi-weekly virtual touch-base meetings were held between the evaluation team, the WSH evaluation focal point and the WHO evaluation manager for emerging issues (technical and evaluation-operational) throughout the evaluation period. This helped situate the findings and assisted in closing evidence gaps. This close and recurrent collaboration facilitated access to relevant KIs and improved the response rates for the online survey.

- Engagement with the Head of the WSH Unit (virtual) during the early analysis phase gave the evaluation team valuable insights and feedback on emerging findings and framing and context.

- WHO key stakeholders (WSH Unit and ERG) participated in a virtual sense-making workshop at the end of July 2024 where key findings, draft conclusions and recommendations were discussed. This engagement provided opportunities for stakeholders to provide ideas, viewpoints and information that helped the evaluators deliver actionable recommendations.

- Dissemination meetings (in-person) were conducted to discuss key findings, conclusions and recommendations with key stakeholders, including external partners at the Stockholm Water Week in August 2024. The meeting included around 30 representatives from a wide array of partners and organizations.

- Development of useful learning products has been supported to communicate the key lessons and provide evidence in an appropriate format.

2.6 Gender equality, disability and social inclusion responsive approach

The evaluation incorporated GEDSI and human rights principles in its design and implementation to ensure due consideration was given to assess potential gender and equity concerns. This was achieved as follows.

- An evaluation team member was designated to be responsible for leading efforts to integrate this approach throughout the evaluation's methods, tools, analysis and findings.

- An evaluation question (EQ 2.1) was dedicated to examining how comprehensively GEDSI aspects – particularly regarding marginalized groups – were integrated into the design and implementation of the Strategy. It also assessed the potential implications of any lack of focus on GEDSI and provided recommendations for the next Strategy. In addressing this question, the evaluation explored how WHO is advancing GEDSI in its WASH normative products, technical assistance and activities, as well as the extent to which countries and development partners are adopting or enhancing this GEDSI approach within the WASH context. Additionally, the evaluation examined the extent to which gender, disability and other equity dimensions were disaggregated in monitoring, including current initiatives such as the JMP household and schools' data.

- KII questions were formulated in a way that captures the extent to which GEDSI responsiveness was considered in the design and implementation of the Strategy.

- Equal representation of the views of men and women was sought in the samples of interviewees and survey respondents, and survey respondents were monitored for any gender representation bias and its possible implications. The gender disaggregation of KIs and survey respondents is presented in the Methods section.

- Disaggregated data presentation and analysis were provided whenever available; however, activities were generally reported without disaggregation.

- Confidentiality was ensured and ethics standards *(31)* were upheld to safeguard human rights during the evaluation.

- The team was gender-balanced, with both men and women in senior roles.

2.7 Evaluation questions

The ToR presented five high-level evaluation questions (EQs) corresponding to the five OECD DAC evaluation criteria of relevance, effectiveness, efficiency, coherence and sustainability. In addition, 21 sub-EQs were proposed in the ToR. During the inception phase, the evaluation team worked with the WSH Unit to have a more focused look at the proposed high-level and detailed sub-EQs in the ToR to determine the intended purpose of the questions, with a view to harmonizing, consolidating and grouping to avoid duplication. This helped apply a more strategic lens to determine how the Strategy enables WHO to add value and use its comparative advantage in a sustainable manner. Table 2 presents the evaluation criteria, the high-level EQs and sub-EQs. Vol. II, Annex 2 provides the EQs as provided in the ToR and justification for changes. The full evaluation matrix is presented in Vol. II, Annex 3.

Table 2. Evaluation criteria and evaluation questions

OECD DAC criteria	Evaluation question
Relevance	**EQ1: How relevant is the Strategy and associated activities to country needs, and to what extent has it maintained its relevance?**
	EQ 1.1: To what extent is the Strategy design and its implementation relevant and how has implementation adapted to changing circumstances? EQ 1.2: To what extent is GEDSI (Gender Equality, Disability and Social Inclusion) adequately addressed by the Strategy and associated implemented activities?

Effectiveness	**EQ2: To what extent have results been achieved through implementation of the Strategy, and what lessons have emerged?**
	EQ 2.1: Is the Strategy on track to meet its targets? and what have been the successes, best practices, and main challenges? EQ 2.2: What external and contextual factors affected the achievement of results?
Efficiency	**EQ3: How efficiently has WHO used its human and financial resources to implement the Strategy?**
	EQ 3.1: Has WHO struck an appropriate balance in the allocation of resources (personnel and funding) across its priority areas of WASH work at headquarters level? EQ 3.2: How has WHO sought to use its limited human and financial resources to greatest effect and what are the lessons learned to improve efficiency?
Coherence	**EQ4: How has Strategy implementation complemented or added value to WASH interventions within the global WASH architecture?**
	EQ 4.1: How does Strategy implementation contribute to the SDG 6 Global Acceleration Framework and how does it align with and complement initiatives of partners? EQ 4.2: How well has WHO coordinated and collaborated in its WASH sector support with partners when implementing the strategy?
Sustainability	**EQ5: To what extent is the Strategy and its associated activities promoting sustainability?**
	EQ 5.1: To what extent is the Strategy and its implementation supporting an enabling environment for sustainable health gains? EQ 5.2: To what extent have WASH approaches and tools promoted via the Strategy been embedded in national strategies and systems as well as in the strategies and approaches of major development partners?

2.8 Data collection methods

The evaluation used a mixed-method approach combining qualitative and quantitative methods for data collection, review, triangulation and analysis.

- Quantitative data included logframe progress on milestones, WHO results data, WASH data portals (i.e. the Water safely portal *(32)*, WASH in HCF portal *(33)*, JMP WASH data portal *(34)*, GLAAS data portal *(35)*) and quantitative elements of the online survey. Analysis of financial data included allocation and use of financial resources, despite limitations (see limitations in section 3.11).

- Qualitative data included document review, KIIs, (focus) group discussions, open-ended questions of the online survey, and country case study reports. Qualitative data provided deeper insights into the ToC assumptions, enablers and barriers for results, as well as lessons, context and challenges.

The various main data collection sources (document and data review, KIIS and group discussions, country case studies and an online survey) are elaborated below, including the purpose, associated sampling strategy and scope.

2.8.1 Document and data review

Purpose: The evaluation required an extensive review of documents and data sources to provide evidence on Strategy implementation progress, challenges, successes, enablers and barriers. The document and data review served as critical evidence for the evaluation. During the data collection phase, the evaluation team systematically extracted evidence against the EQs and ToC assumptions, which allowed **them** to interrogate the ToC.

Sampling: Documents and data were purposively selected to provide a relevant and comprehensive review. The WSH Unit and WHO Evaluation Office provided access to a range of documents, which was further supplemented by the evaluation team's identification of relevant data and documents from WASH global data portals.

Scope: In total, over 600 documents were reviewed during the evaluation period (see Annex 11 for the full list). Key documents and data included: Strategy documents and associated logframe with annual progress data; annual reports of the WHO's global work on WASH including financial data, previous evaluations, annual reports of JMP; WHO WSH communication and training products; WASH donor agreements and reports; WHO WASH related meeting documents and reports; technical briefs and normative guidance developed by WSH; as well as WSH workplans; organograms; division of role agreements (Memorandum of Understanding) on WASH between WHO and key partners and related global and regional strategies. In addition, WASH data portals were queried (i.e. the water safely portal *(32)*, WASH in HCF portal *(33)*, JMP WASH data portal *(34)* and GLAAS data portal *(35)*).

2.8.2 Key informants for individual interviews/group discussions

Purpose: KIIs and small group discussions were critical sources of data that generated rich insights cutting across all EQs and ToC assumptions. These qualitative data were used to triangulate and complement the document and data review and other data sources, such as the online survey and the case study reports. Data from the interviews assisted in explaining how and why change occurred or did not occur.

Sampling: The evaluation followed a strategy of purposive sampling for KIIs and group discussions. The purposive samples aimed at selecting specific sources of information, which were as illustrative and diverse as possible and provided for generation of rich learnings and recommendations. At the global and regional level, the WSH Unit in collaboration with the evaluation team and with input from the WHO Evaluation Office developed an initial list of categories of KIs, based on a stakeholder mapping undertaken during the inception phase. This was followed by a robust and transparent process to identify key stakeholders at country, regional and global levels. The evaluation team reviewed the stakeholder mapping and literature, sought advice on relevant informants and supplemented this with their own knowledge of critical players in the field – including implementing partners, donors, government representatives, UN agencies, international networks, regional water councils, national councils, institutions, agencies, academia and collaborating centres.

Conduct: Interviews were conducted virtually using Microsoft Teams, and each interview lasted for about one hour (face-to-face interviews were preferred for the country case studies – see below for further description of KIs and Section 3.6.3 on case studies). Most interviews were conducted through individual KIIs. Some partners and collaborators preferred small group discussions as opposed to individual interviews. The conduct of four online country group discussions involving key WHO country office staff and relevant government partners generated insight into country-level implementation from different regions and complemented country perspectives gathered by the online survey and country case studies. Semi-structured interview guides (developed by the evaluation team for KIIs and group discussions) are presented in Vol. II, Annex 4, and these generic examples were further tailored to each interview or group discussion.

Description of informants: Altogether, 174 people had an opportunity to share their experiences and opinions through KIIs or small group discussions, of which just under half identified as female. The evaluation reached saturation with very little new information generated and repetition of issues/themes during the final interviews – an important sign of sampling adequacy adding rigour in qualitative research *(36)*. A diverse group of stakeholders was interviewed during the evaluation. Most informants were WHO staff (31%), followed by

national councils, agencies and institutions (21%) and government representatives (17%). A summary of the number of KIs by main stakeholder group and level (global, regional, and country) is depicted in Table 3 below. Vol. II, Annex 7 provides more insight into the specific organizations, departments, institutions and networks consulted through interviews and group discussions.

Table 3. Number of informants interviewed or participating in (focus) group discussions, by stakeholder group and level

Representatives from:	Global level	Regional level	Country level (excluding country case studies)	Country case studies in Ethiopia and Philippines	Total number of informants
Academia	5			5	10
Donors	10			3	13
Governments			12	17	29
HCFs				3	3
International networks	10			3	13
National councils, agencies and institutes			8	28	36
Regional water councils and networks		3			3
UNICEF	8	1		4	13
WHO	29	7	5	10	54
Other UN agencies	3				3
Total number of informants	65	11	25	73	174
% of female informants	49	55	48	47	48

2.8.3 Country case studies

Purpose. The country case studies for this evaluation served two main purposes:

- to generate evidence addressing the evaluation questions, acting as a triangulation point for the global evaluation; and
- to provide insights into how WHO supports countries in operationalizing key components of the Strategy and analyse how this support functions in practice across selected WASH thematic areas at the country level.

Sampling: The budget and scope of the evaluation allowed for conducting two deep-dive country case studies with in-country missions. Given the small number of cases, the overall approach to case sampling was purposive as opposed to representative. The overall approach to sampling was to select cases that were positive outliers, i.e., *having substantially engaged with WHO* during the Strategy period, allowing for learning across WHO's WASH strategy intervention areas. The evaluation team compiled a list of 21 potential countries with whom WHO had undertaken substantial engagements since 2018. To select between these countries, the evaluation team and the WSH team identified the following specific selection criteria for the final sampling:

- countries from different regions, representing various WASH contexts (humanitarian, development) and stages of progress on SDGs;
- presence of a dedicated WASH-focused individual or team in the country office presence in the regional office as well is an advantage);
- countries that are active in all/most WHO WASH strategy intervention areas (drinking-water quality and safety, sanitation and wastewater, WASH in HCF, WASH monitoring and accounts, integration of WASH with health and other programmes, climate resilience, emerging areas);
- a range of WASH related partners with some government uptake of WHO WASH outputs;
- relevant WHO strategy areas implemented in rural and urban areas;
- logistically feasible and safe to travel to the country; and
- countries that have not hosted a recent major evaluation.

The list of 21 countries was mapped against the selection criteria above. The next step included a pre-selection of a smaller set of countries based on this mapping, which was presented to WHO regional WASH advisors during the inception visit in January 2024, resulting in a pre-selection of eight countries that met the selection criteria presented above and which could serve as good learning examples. The final selection of two countries out of the eight was based on feasibility and interest of country offices in participating in the evaluation. This aspect was sought by the WHO Evaluation Office, reaching a final selection of Ethiopia and the Philippines.

Conduct: Country case studies involved in-country travel of an evaluation core team member with primary data collection over five working days. Data collection methods for country case studies included: a document and data review before the country visit; face-to face KIIs; and (focus) group discussions during the country mission and follow up KIIs after the mission, as applicable. In each country, the evaluation team conducted KIIs, mainly face to face, with around 10 key stakeholders and 2–6 group discussions each with 3–16 stakeholders. The final identification of relevant stakeholders depended on the intervention areas that country stakeholders had engaged with WHO on. See Vol. II, Annex 5 for the country case study protocol providing more detail. Country case study reports for Ethiopia and the Philippines are presented in separate annexes.

2.8.4 Online survey

Purpose: An online survey was conducted to gather additional data and evidence for the EQs and ToC assumptions at country level. Results were mainly used as a triangulation point for other evidence generated through the evaluation.

Sampling: The online survey targeted WASH country-level key stakeholders (WHO internal as well as WHO external stakeholders). Countries targeted for the online survey included all countries with a dedicated WHO country office. In total, 143 countries across all WHO six regions were targeted. A purposive sample frame within each country for the online survey was developed to capture evidence relevant to the specific EQs and ToC assumptions and included:

- WHO internal stakeholders, namely the WHO country office representative, nominated WASH focal point and/or a focal point for Environment, climate change and Health and/or other relevant WHO country office staff from departments/teams related to WASH (up to 5 nominations); and

- WHO external stakeholders, namely representatives from key WASH partners in-country (key government staff, UNICEF WASH staff, civil society organization WASH partners) (up to 8 nominations).

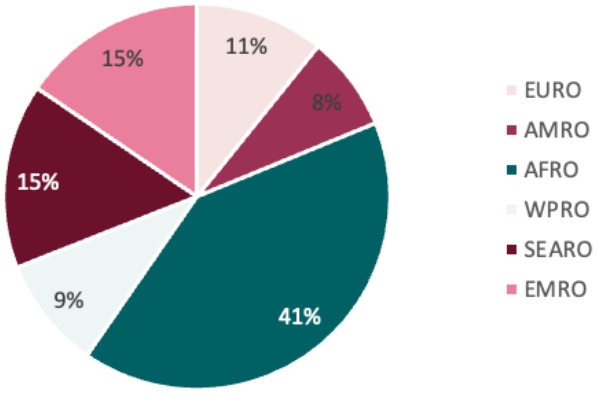
The survey targeted around 13 respondents per country. However, in some countries fewer stakeholders were appropriate or fewer were nominated. The agreed list of target respondents was developed by the WSH Unit and regional and country offices in collaboration with the WHO Evaluation Office, based on the sampling frame listed above. In total, 714 stakeholders across 143 countries received the survey link.

Content: The online survey concentrated on obtaining evaluative information that was directly relevant to the widest possible range of EQs or ToC assumptions while balancing the time most respondents are willing to devote to completing this type of survey. The survey consisted of 19 quantitative questions (a Likert scale when appropriate and with the option of adding a comment to all quantitative questions) and four open-ended questions (see Vol. II, Annex 6 for the survey questions and analysis).

Conduct: The survey was administered by EHG using Survey Monkey, an online survey tool. The survey was available in English, French, Spanish and Russian. Respondents had an initial deadline of two weeks to complete the survey. The survey was open for about one month between 18 April 2024 and 21 May 2024. Four reminder emails were sent to survey link recipients during this period to increase the response rate.

Description of survey respondents: In total, 213 responses were received from the targeted sample of 714, which equals a response rate of 30%. Respondents represented all six WHO regions and 98 of the 143 targeted countries. Most respondents (51%) represented WHO country offices. Of the remaining respondents, most represented national governments, ministries, or agencies (27%). Only 7% (n=15) of the respondents represented UNICEF. Of the total number of respondents, 42% identified as female, 54% as male, and the remaining 4% either did not wish to disclose or identified as non-binary. In terms of regional distribution, respondents from the WHO African Region were overrepresented in the sample, but the WHO African Region is also the largest region with most countries and respondents targeted for the survey (see Fig. 5 for the regional distribution of survey respondents). Response rates per region ranged from 22% in the WHO Regional Office for the Americas and Western Pacific Regional Office to 39% in the South-East Asia Regional Office.

Fig. 5. Survey responses by region (%)



Source: Evaluation survey (213 respondents). WHO Regional Offices for: Europe (EURO), the Americas (AMRO), Africa (AFRO), the Western Pacific (WPRO), South-East Asia (SEARO), the Eastern Mediterranean (EMRO).

The survey questions along with the key results and data analysis (Vol. II, Annex 6) have been analysed and referenced throughout the report findings as applicable.

2.9 Data analysis

Data collection tools have been designed to closely align with the ToC and assumptions to allow for analyses that can also be synthesized where feasible. In analysing the available data and evidence, the evaluation team undertook the process exemplified below (Fig. 6).

Fig. 6. Data analysis process

Evidence generated from each data collection method was analysed, coded and assembled in evidence tables in Microsoft Excel, which were structured according to the EQs and ToC assumptions. This approach enabled triangulation and analysis across the scope of work, as well as allowing evidence for the conclusions and recommendations in the final report to be traced to the evidence upon which they were based.

Following completion of the data collection period, the evaluation team held an analysis workshop in which the team, drawing on all sources of evidence, came together to develop emerging findings. Emerging findings were tested and discussed with the primary recipient (WSH Unit Head) shortly after the workshop and subsequently further developed, taking on advice on where to place emphasis while still ensuring that the evaluation could speak to the agreed EQs and testing of the reconstructed ToC and its assumptions.

2.9.1 Analytical methods

While the ToC provided the overarching analytical framework for the evaluation, the team applied a mix of different analytical tools to inform the findings and recommendations. These are elaborated further below.

Qualitative data

Qualitative data from primary data sources such as KIIs, group discussions, and qualitative survey results as well as secondary qualitative data (document review) were analysed using content analysis methods, with coding of data against evaluation questions and ToC assumptions. All raw data were collected in evidence matrices based on the ToC assumptions and evaluation questions. This ensured that the analysis considered and triangulated all relevant secondary and primary data, thereby reducing the risk of evaluation bias and improving the robustness of findings. The subsequent process involved a reflective process deriving overarching themes. This mainly deductive coding approach ensured that findings could be directly linked to relevant EQs and ToC assumptions and that themes could be drawn out to generate a robust synthesis, while

at the same time allowing for an inductive coding approach as new themes emerged (e.g., on options and recommendations for the way forward). MS Excel was used for data coding.

Quantitative data

Quantitative data analysis of available financial data and human resource data was undertaken in relation to EQ 3.1, focusing on assessing if WHO had struck an appropriate balance in the allocation of resources (personnel and funding) across its priority areas of WASH work at headquarters level as well as human/financial resources deployed at regional and country level for WASH (part of EQ 3.2). Limitations were, however, noted for the analysis of financial data – see section 3.11.

Other quantitative analysis included data from WHO WASH annual reports, Strategy logframe indicators, WASH data from publicly available data portals, and online survey quantitative results. Quantitative survey data results were cleaned and analysed using MS Excel, and descriptive statistics were generally utilized to summarize data. Relevant quantitative survey data results were disaggregated by respondent type (WHO staff vs non-WHO staff and WHO staff vs government staff). After disaggregation, a two-sample t-test was run in SPSS on specific survey results to assess if noted differences across subpopulations were a by-chance finding or if these differences were statistically significant. However, responses across the disaggregated subpopulations were fairly similar, and the sample size of subpopulations was thus too small to assess statistically significant differences across respondents' type. Meaningful disaggregation by region was not possible, given low number of respondents from some regions.

Triangulation and strength of evidence ranking

The evaluation triangulated all evidence gathered, where triangulation is defined as the extent to which the range of evidence points to the same finding across and within categories of data sources. The evaluation relied on triangulation both across and within source categories of data. For example, the evaluation triangulated the responses of different KIs at global, regional and country levels to ensure that differences of experiences and opinions were not lost in the analysis and that evidence was supported across the KI categories. Coding all qualitative data and populating the evaluation evidence matrix by evaluation question supported the triangulation process. The information obtained through KIIs, and group discussions was also triangulated and compared with the document review and country case study reports. Similarly, the results of the online survey were compared and triangulated with the opinions and experiences related by KIs as well as the document review. Triangulation in the analysis thus took place at multiple levels including:

- data drawing on multiple sources of information from document and data review, KIIs, group discussions, online survey results and country case studies; and

- respondent types, for example between KIIs at global, regional and country levels, implementing and external partners and different categories of stakeholders.

In line with good evaluation practice, the evidence was assessed for the "quality" as well as the "quantity" of the evidence. A strength of evidence rating (see Table 4, below) was used to orientate the users of the evaluation report to the strength of each finding, based on the level of evidence triangulation that was possible.

- Quality of the evidence: The team considered aspects such as the source and reliability of the quantitative data and qualitative information (where possible/relevant) and any obvious bias (e.g.

information bias, recall bias, selection bias – see limitations in Section 3.11).

- Quantity of the evidence: The team assessed the extent to which findings are consistent after being triangulated across sources of information. In terms of interviews, the team considered how many responses support the same view or instances in which views might have been contradictory.

Table 4. Strength of evidence rating for key findings

Rating	Assessment of the findings by strength of evidence
Strong (1)	• The finding is supported by data and/or documentation which is categorized as being of high quality; **and** • the finding is supported by majority of consultations across data sources and risk of bias is at a minimum.
Moderate (2)	• The finding is supported by data and /or documentation with high or acceptable quality; **and/or** • the finding is supported by majority of the consultations across data sources and risk of bias is at a minimum.
Limited (3)	• The finding is supported by data and/or documentation which is categorized as being of questionable quality; **or** • the finding is supported by only a few consultations (KII and/or online survey); **or** • the finding is supported by contradictory consultations.
Poor (4)	• The finding is supported by data and/or documents which is categorized as being of poor quality; **or** • the finding is supported by few consultations categorized as being of poor quality/biased

2.10 Generation of recommendations

The draft recommendations were derived from conclusions and findings with a clear line of sight. In line with the utilization-focused evaluation approach, the draft recommendations were discussed with key WASH stakeholders (WSH, others in WHO, ERG and external sector partners), including at World Water Week in Stockholm in August 2024, to ensure the recommendations are relevant, feasible, practical and actionable.

2.11 Validation of tools

All tools developed for the evaluation were tested and validated before being finalized. This included testing draft semi-structured interview guides, which were modified accordingly before data collection phase interviews were conducted. The evaluation team ensured face validity of the online survey questionnaire by having experts who understood the topic, including members of the WHO WSH team, read through the draft questionnaire and provide feedback, which was then incorporated. A second step to ensure face validity was for an expert on questionnaire construction to check the survey for common errors, such as double-barrelled, confusing and leading questions. The survey further included consistency checks as a method to improve reliability. The evaluation team piloted the draft online survey before its launch. A pre-test of the translations was also conducted before launch of the survey.

2.12 Ethical considerations

The evaluation conforms to the 2020 United Nations Evaluation Group Ethical Guidelines for Evaluation *(31)* and adheres to the principles of integrity, accountability, respect and beneficence. EHG and the evaluation team were responsible for safeguarding and ensuring ethics at all stages of the evaluation cycle. This included

ensuring informed consent; protecting the privacy, confidentiality and anonymity of participants; being culturally sensitive and being sensitive to the potential risk of discrimination; respecting the autonomy of participants; and ensuring that the evaluation did not harm participants.

The following ethical issues and measures were noted for data collection.

- The evaluation did not include individual beneficiaries or beneficiary communities or children.
- Participants in KIIs and the online survey were informed, prior to data collection, about the purpose of the evaluation and how the data collected would be used, and participants were assured that their responses would be treated confidentially.
- The informed consent of participants to provide information was obtained verbally (as part of KII and transcript).
- Participation in the online survey was on a voluntary basis: by accepting to respond to the survey and submit the results, the respondent was assumed to have given confirmed consent.
- The online survey was confidential, and participants were not asked information which could identify them in the future.
- Audio recordings of interviews were only carried out with prior permission. No citations in the evaluation report are traceable to a specific person or their titles or functions.
- Participants' privacy was protected, and data were kept confidentially. EHG's data security system complies with the EU General Data Protection Regulation. Only relevant data were collected; data are kept securely and confidentially. All interview notes and potential audio recordings have been stored on a project specific Microsoft SharePoint owned by EHG and will be deleted after the evaluation has concluded.

2.13 Limitations

Key limitations encountered during the evaluation process are highlighted in Table 5 below, as well as related mitigation strategies. Despite these limitations, the evaluation team finds that there was strong evidence overall to support the findings, conclusions and recommendations

Table 5. Limitations and mitigation

Limitation	Mitigation
Target setting and milestones • The Strategy and the corresponding results framework did not have targets for 2025, and milestones were reportedly developed retrospectively. This complicated the ability of the evaluation team to substantially address EQ2.1 "Is the Strategy on track to meet its targets?"	• Progress assessed against set milestones instead of 2025 targets. • Summary developed of results reported by WSH during Strategy period for relevant PIAs. • Findings for EQ 2.1 (Section 4.2.1) framed with the perspective that milestones were set retrospectively.
KIIs and online survey • The evaluation methods applied were generally prone to both selection and information bias. • Overrepresentation of survey responses from the WHO African region compared to other WHO regions.	• Introduction of selection bias was minimized through ensuring a diversity of informants, a large number of KIs/survey respondents and saturation for interviews/group discussions. • Responses to the survey from the WHO African region were overrepresented; however, this aligns with the geographical focus areas of the strategy implementation as confirmed by the WSH team. • To mitigate the impact of social desirability bias and to stimulate honesty and truthful answers, all informants including survey respondents were guaranteed confidentiality. • Triangulation was applied during the analysis to minimize bias by comparing information across different categories of KIs/respondents, the document review and the survey results. • Assessment of potentially biased data was included in the strength of evidence ranking – if data were assessed as biased, a lower ranking was provided for the finding.
Country case studies • Limited number of country case studies (2) not representative of country level experiences and progress.	• The sample of countries was purposefully chosen to generate the richest possible insights within the resources available to assess how contextual issues have hindered or enabled positive results and draw learnings and triangulate with other evidence. • The country case studies were complemented by virtual small group interviews at country level and with survey data for country level perspectives across 98 countries on WHO's role and added value in the WASH sector.
Data availability and quality • Financial data analysis was presented and disaggregated in various ways which proved challenging to cross-reference and analyse. • Activities reported during the strategy period were not disaggregated sufficiently to allow a GEDSI data analysis**.**	• The potential impact of data quality concerns and data unavailability has been highlighted in the respective findings section (Sections 4.1 and 4.3).

Limitation	Mitigation
Contribution • Assessing WHO's direct contribution to Strategy progress was challenging in some instances due to multi-partner contributions to some outputs/outcomes and lack of reported progress on others.	• For some results in the Strategy logframe, WHO is the lead or only partner, suggesting that its contribution has been significant. For others (e.g., Outcome Indicator 2.3.), assessing WHO's contribution was challenging in the absence of information in the result on what had happened in each country; even then it might not have been possible to measure the extent of each partner's contribution. Furthermore, WHO has not reported results for some outcome indicators (e.g., 1.3, 2.4).
Evaluation breadth versus depth • The wide range of WASH-related subjects and activities covered by the Strategy made it difficult to undertake a "deep dive" into any of the PIAs with the time and human resources available.	• The report avoids making comments on the technical content of specific WSH activities and outputs and instead draws out cross-cutting findings relevant to the Strategy as a whole.

4. EVALUATION FINDINGS

Findings for each of the subquestions corresponding to the main evaluation questions are presented separately under each EQ, starting with a summary box of key findings and their respective strength of evidence rating. The rationale and evidence for each key finding is then further elaborated in a summary box. Each EQ section ends with a summary of the ToC analysis pertaining to that EQ.

4.1 Relevance

Overall, the evaluation found that the Strategy is aligned to WHO's organizational mandate and the global 2030 Agenda for Sustainable Development. Its design and implementation respond to country needs and have adapted to changing global circumstances. Additionally, WHO plays a key role in setting the global WASH agenda. Yet GEDSI remains insufficiently articulated.

This section presents the specific findings related to EQ 1*:* **How relevant is the Strategy and associated activities to country needs, and to what extent has it maintained its relevance?** The EQ was addressed through two subquestions.

- EQ 1.1: To what extent is the Strategy design and its implementation relevant and how has implementation adapted to changing circumstances?
- EQ 1.2 To what extent is GEDSI adequately addressed by the Strategy and associated implemented activities?

4.1.1 EQ 1.1: To what extent is the Strategy design and its implementation relevant and how has implementation adapted to changing circumstances?

EQ 1.1 considers specifically the use of evidence and learning to inform Strategy design and implementation and its relevance regarding the GPW13, the ECH Departmental strategy and to country needs. Finally, this question also explored the extent to which Strategy implementation has responded to emerging issues and new declarations and commitments. The quality of evidence for this subquestion is ranked as strong, based on a combination of documentary evidence, triangulated with KIIs, case study and survey responses, where relevant.

Table 6. Summary of key findings related to EQ 1.1

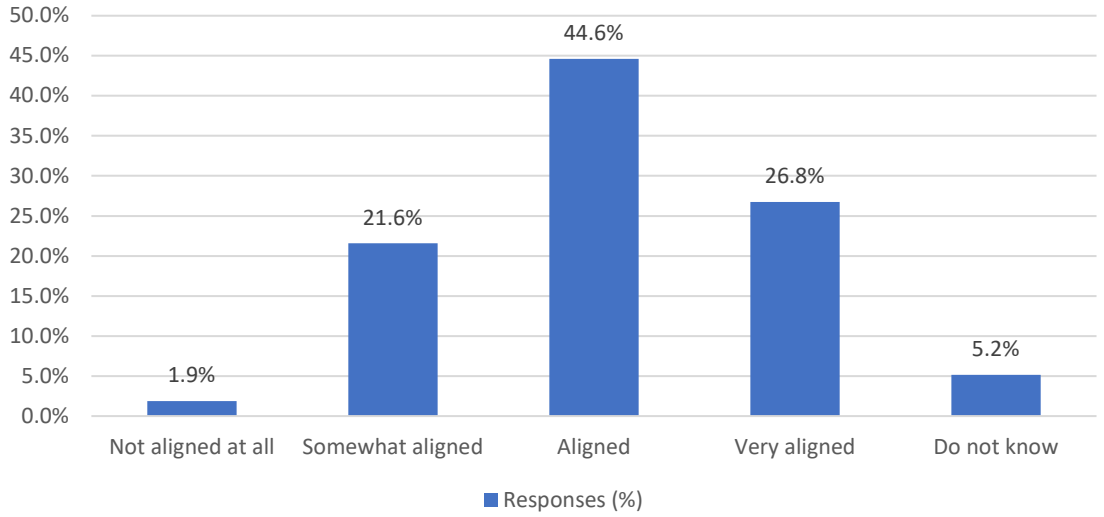
Summary of key findings related to EQ 1.1	Strength of evidence rating
Finding 1.1: Ensuring access to safe WASH services is highly relevant to global needs and critical to promote and protect health.	Strong
Finding 1.2: WASH activities are well aligned to country needs, but the Strategy does not prioritize specific target geographies or populations.	Strong
Finding 1.3: Familiarity with the WASH Strategy varies among target audiences.	Moderate
Finding 1.4: The Strategy serves mainly the WHO WASH team at the global level with limited accountability for implementation at the country level.	Strong

Summary of key findings related to EQ 1.1	Strength of evidence rating
Finding 1.5: The results framework and associated monitoring processes do not provide a sufficient basis for tracking progress in Strategy implementation.	Moderate
Finding 1.6: WASH normative guidance and tools are invaluable outputs of the Strategy and have been tailored to country needs	Strong
Finding 1.7: The draft GPW14 (2025–2028) gives greater prominence than GPW13 (2019–2023) to environmental health, with climate change as one of its six overall strategic objectives. WASH also features more than in GPW13.	Strong
Finding 1.8: WHO has been responsive to emerging issues and new commitments since the Strategy was developed.	Strong
Finding 1.9: There is a demand for climate resilient WASH to be covered more extensively in the next WASH Strategy.	Strong

Finding 1.1: Ensuring access to safe WASH services is highly relevant to global needs and critical to promote and protect health. Access to safe WASH services is a highly relevant and critical global concern. WASH is considered a basic human right; it links directly to SDG 6 and is fundamental to achieve Universal Health Coverage and SDG 3. WASH is also a central determinant of health, with an important role in promoting health and reducing the burden of disease. An estimated 1.4 million deaths annually from diarrhoea, acute respiratory infections, soil-transmitted helminths, and undernutrition could be prevented with safe WASH *(37)*. A significant proportion of the global population is affected by poor access to WASH services: 2.2 billion people lack access to safely managed drinking water and 3 billion lack access to safely managed sanitation (1.5 billion lack access to basic sanitation). Access is particularly challenging in rural areas, least developed countries and fragile contexts *(38)*. To meet the global target of universal access by 2030, progress needs to increase six times faster for safely managed drinking water, five times faster for safely managed sanitation and three times faster for basic hygiene – these figures are higher in LDCs and countries in fragile contexts. A substantial number of countries still does not have adequate WASH in HCF and hospitals *(39)*.

Finding 1.2: WASH activities are well aligned to country needs, but the Strategy does not prioritize specific target geographies or populations. Survey responses, presented in Fig. 7, show that over 70% of respondents from all stakeholder groups (WHO 75% and non-WHO 68%) found that WHO's support and guidance is aligned or well aligned with country WASH needs. Survey respondents indicated critical support in water safety planning, water quality guidelines, wastewater reuse, WASH in HCF (including WASH-FIT), emergency preparedness and response, infection prevention and control, NTDs, TrackFin (through the development of WASH accounts using the TrackFin methodology which tracks financing to sanitation, hygiene and drinking-water), JMP and GLAAS. The Ethiopia and Philippines country case studies show that efforts are relevant to country needs, with several thematic areas aligning with national WASH programmes and national WASH and environmental health strategies. Country-level KIs stated that the work of WHO is always aligned or largely well-aligned with country needs.

Fig. 7. Extent to which WHO's support and guidance is aligned to country WASH needs and priorities (all stakeholders)

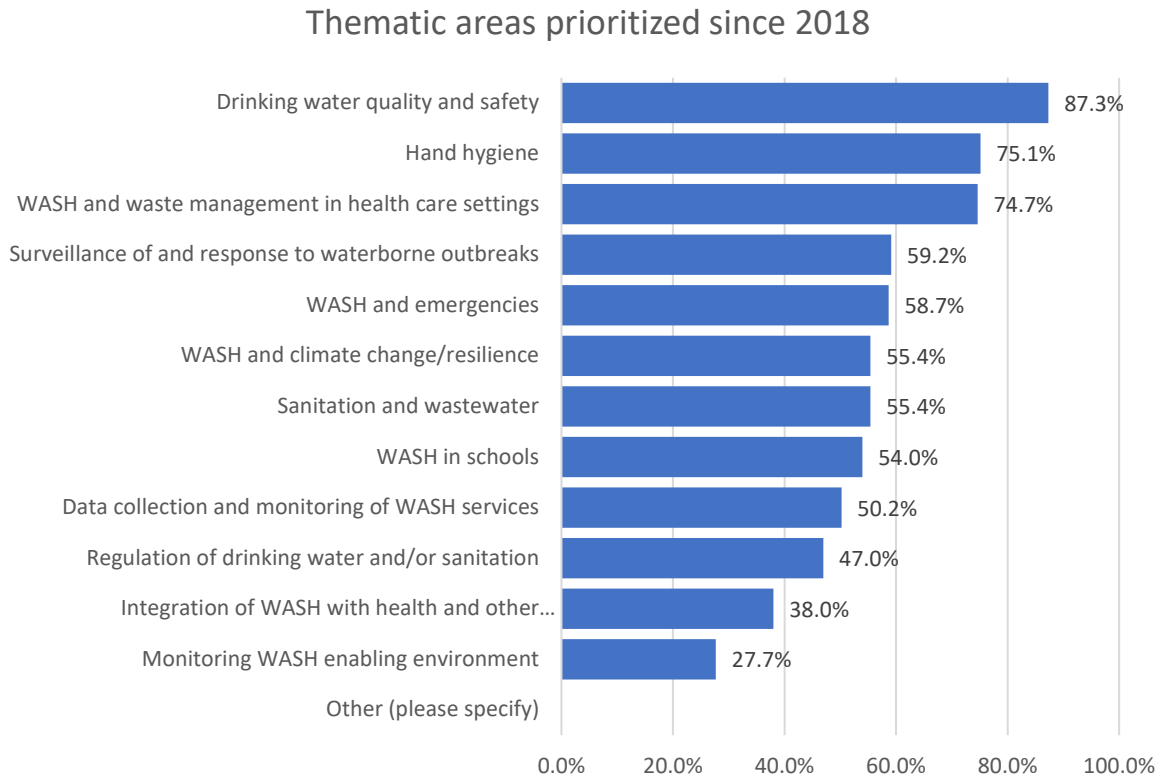


Source: Evaluation survey 2024. All stakeholders (213 respondents).

WHO's alignment in WASH with country needs is seen as logical because most countries are, in principle, committed to the SDGs.

The survey indicates a high degree of overlap between countries' priority WASH thematic areas and the work of WHO, as shown in Fig. 8.

Fig. 8. Respondents view on prioritized thematic areas in the country where they work (since 2018)

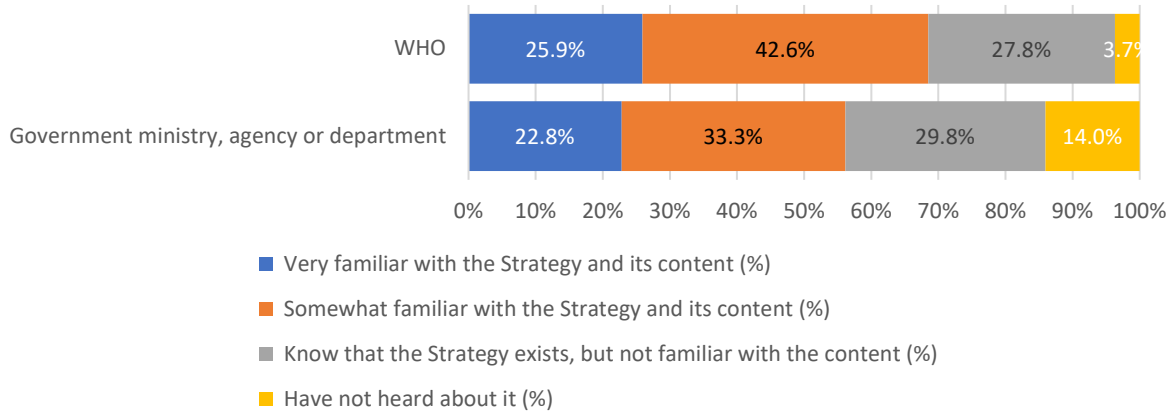


Source: Evaluation survey 2024. All stakeholders (213 respondents).

Despite the availability of JMP data on country, rural and wealth quintile access, the Strategy does not analyse which specific regions, countries or populations should be prioritized for support, nor the criteria for doing so. However, according to WSH personnel, in practice funding is prioritized based on country needs, implementation capacity and most importantly the presence of a WHO WASH focal point.

Finding 1.3: Familiarity with the WASH Strategy varies among target audiences. Feedback from both internal and external stakeholders indicates that the Strategy is less well-known among external organizations. The survey results show that not all WHO WASH country staff were familiar with the Strategy – 4% of WHO staff at the country level had not heard of the Strategy, 28% were aware of the Strategy but not its contents. KIIs confirmed that some WHO WASH staff were not aware of the Strategy at all. For government respondents, 14% had not heard of the Strategy and 30% knew of the Strategy but not its contents (Fig. 9). The survey itself generated awareness of the Strategy, with some KIs (from government and WHO) expressing surprise to learn that the Strategy had existed since 2018 without them becoming aware of it.

Fig. 9. Familiarity with WHO WASH Strategy amongst WHO staff



Source: Evaluation survey 2024. Data for Government stakeholders (57 respondents) and WHO (103 respondents).

Finding 1.4: The Strategy serves mainly the WHO WASH team at global level, with limited accountability for implementation at the country level. The WASH Strategy *(10)* was developed by the WHO headquarters WSH Unit as a voluntary exercise to clarify within WHO and with external partners the position of WASH in health and to outline areas of transformation for WHO. The Strategy covers a broad range of thematic areas that are priorities for the WASH sector globally (see Section 1.4.3) and to an extent some are relevant to national needs.

Countries and regions were consulted by the WSH Unit during the development of the Strategy, an exercise that was viewed as useful and appreciated by WHO staff. However, WASH priorities at the country level are generally set by government in response to local realities and priorities and within other frameworks, such as the Protocol on Water and Health in Europe *(40)*. The global WASH strategy provides a "menu of options" or thematic areas for prioritization based on the country context. Several WHO stakeholders interviewed, as well as WHO internal reports, noted that the priorities and interest of the WHO country representative determined how far a country got involved in WASH *(41)*. According to WHO country office staff, national WASH priorities at the country level, including a lack of priority given to WASH, determine sector priorities – not the Strategy itself. WHO country staff from the Philippines noted that the Strategy is used more at the regional level to check that countries are providing technical support within the Strategy parameters.

One WHO staff member from HQ inferred that "Global programming often means headquarters programming". This is a perception shared by a WHO staff member at the regional level who stated, "There are some components of the Strategy that don't have the full elements for implementation in the field. They are much more for the headquarters lens, I would say…".

The nonbinding nature of the Strategy for WHO's regional and country offices creates a lack of accountability at the country level. This was described by one stakeholder as akin to country offices "paddling their own canoes". The complex decentralized structure of WHO, combined with the low prioritization of WASH, leads to inconsistent implementation of the Strategy across different levels of the Organization.

Finding 1.5: The current results framework and associated monitoring processes do not provide a sufficient basis for tracking progress of Strategy implementation. The logframe aligns closely with the Strategy, and the output and outcome statements are generally clear, especially around the planned normative outputs. A key limitation of the logframe is that much like the Strategy itself, it primarily outlines the scope of work for the WSH Unit at the global level, while providing less clarity on the role of country offices in implementing the Strategy. Where country-related indicators feature, they relate only to the total number of countries adopting normative guidance or monitoring processes or receiving technical support (currently 6 out of 27 output indicators in the latest logframe). From the perspective of the WSH Unit, the Strategy offers a menu of thematic options which country offices can refer to when developing their WASH plans, but it does not go beyond that to define what processes country offices should follow to develop country-level plans and targets.

The Strategy describes the role of regional offices as supporting regional fora, regional monitoring and providing technical support to countries to implement WHO guidelines and tools. The most recent logframe identifies activities to achieve this through implementation support for the development of WASH accounts using the TrackFin methodology, sanitation safety planning, and WASH in HCF and regional events, training and workshops. However, these activities are not tracked systematically.

WSH Unit personnel have confirmed that the logframe is an attempt to translate the Strategy into measurable targets. However, no final 2025 targets were set for outputs and outcomes. WSH personnel indicated that intermediate milestones are often set retrospectively (based on what has already been done), making it hard to discern the overall level of ambition of the Strategy. The logframe is more of a workplan for headquarters outputs than a framework for achieving GPW13. These factors compromise the evaluation team's ability to respond to EQ 2.1 on whether the Strategy implementation is on track to achieve its targets.

Country-level outputs relevant to the logframe are not tracked systematically, or at least do not feature in detail in annual WASH reporting. Hence there is no clear overview of how many countries are adopting and implementing the various guidance documents and monitoring tools developed by WHO. It is also unclear what constitutes technical support to a country office, especially considering that an increasing amount of this support is delivered online.

Finding 1.6: The draft GPW14 (2025–2028) gives much greater prominence than GPW13 (2019–2023) to environmental health, with climate change as one of its six overall strategic objectives. WASH also features more than in GPW13 ***(42)***.

GPW13 makes limited reference to WASH and the critical role it can play in health outcomes. Access to safe water is mentioned as an indicator to achieve the healthier population target of one billion more people enjoying better health and well-being.

The Strategy identifies how WHO contributes to the GPW13 goals and the Secretary-General's call to action on WASH in HCF *(43)* with increased access to water and sanitation and the increased number of HCFs with improved WASH, as shown in Table 7. Yet the means of verification in column 3 below for WHO's contribution would require measuring implementation of sanitation safety planning and WASH in HCF at the country level, even though WHO does not have an implementation role.[9] As an organization that offers normative guidance and limited technical support to countries (where personnel and funding are available), WHO has minimal control or direct involvement in increasing access to WASH services, aside from exerting influence indirectly.

The revised ToC (January 2024, presented in Fig. 4) confirms that WHO's unique contribution lies at the intermediate outcome level, an area over which WHO headquarters does not have direct control.

Table 7. WASH targets in GPW13 and in response to the UN Secretary-General's call for action

Collective goal to be pursued in GPW13	WHO's unique contribution	Means of verifying WHO's contribution
Access to safely managed drinking water services for 1 billion people	Monitor and report on access to safely managed drinking-water services. Support adoption of the WHO Guidelines on Drinking-water quality and inclusion of risk-based Water Safety Planning in national policies and programmes. In target countries, support and strengthen drinking-water regulators, surveillance agencies and similar institutions for oversight of drinking-water safety.	Number of countries with water-safety planning policies using risk-based approaches. Number of countries with national targets aligned with the SDG criteria for safe management of drinking-water.
Access to safely managed sanitation services for 800 million people	Monitor and report on access to safely managed sanitation services. Support adoption of the WHO Guidelines for Sanitation and Health and inclusion of risk-based Sanitation Safety Planning for sanitation access and safe excreta management through partnerships and implementation in target countries. Support countries in their strategies to end open defecation.	Number of countries implementing WHO Sanitation Guidelines for Sanitation and Health and sanitation safety planning. Number of countries with national targets aligned with the SDG criteria for safe management of excreta.
Increase the number of HCFs in low and middle-income countries with basic water, sanitation and hygiene to 100% coverage by 2030	Implement national WASH in HCF packages (assessments and analyses, targets, standards, budgeted action plans and monitoring and review). Work with partners to improve services, hygiene behaviour and access financing.	Number of countries that have implemented national packages.

Source: WASH targets in the GPW13 and in response to the UN Secretary-General's call for action; *(10)*.

[9] There are countries, according to KIs, where WHO leads on WASH and Waste in HCF standards, roadmap development and training and to a lesser degree procurement (e.g., Ukraine). However, this is more notable in emergency settings.

The WASH Strategy clearly articulates the role of WHO and its boundaries in influencing access to WASH as:

> generating and disseminating standards and guidelines, strengthening health sector capacities in providing WASH support and public health oversight through surveillance and regulation, promoting the generation of evidence and empowering countries through technical cooperation to strengthen national systems and institutions, set health-based WASH objectives, carry out safe management and to establish effective monitoring of WASH inputs and outputs. *(10)*

The draft GPW14 *(42)* gives greater prominence to environmental health and climate, with WASH mainstreamed through the GPW joint outcomes. WASH is referenced across all three pillars of the GPW14 goal –to promote, provide and protect health and well-being for all – emphasizing its role as a critical determinant of good health. Table 9 in Vol. II, Annex 12 shows the strategic objectives of GPW14 and the various joint outcomes where WASH is mentioned. Although WASH-related indicators have been identified in the GPW [10], some of these carry forward the WASH access indicators from GPW13, presenting accountability challenges for WHO.

WHO's WASH contribution is also clearly articulated and recognized in the WHO Global Strategy on Health, Environment and Climate Change from 2020, covering the period to 2030. This Strategy emphasizes the link between poor WASH and public health risks and notes the implications of climate change on water scarcity and security *(44)*. WASH is highlighted as a key intervention topic for health improvements and UHC. The WASH Strategy aligns with the Global Strategy on Health, Environment and Climate Change, ensuring that countries integrate the pillars of Water and Sanitation Safety Planning into their national strategies and include adequate hygiene measures in water safety plans (WSPs). It also prioritizes ensuring that all HCFs have access to safe water, sanitation and hygiene and that sanitation and wastewater barriers are established to combat antimicrobial resistance. Notably, the departmental strategy links implementation platforms and activities (including direct country support) to the outcomes, outputs and overall impact of WHO's role *(44)*.

Finding 1.7: WASH normative guidance and tools are invaluable outputs of the Strategy and have been tailored to country needs. WHO-produced WASH normative guidance and tools were described by governments and partners as high quality, reliable, authoritative, well researched, rooted in empirical evidence and developed in a consultative manner. Several KIs described WHO's normative guidance as "gold standard" and as "key reference material".

Documentary and KII evidence show increasing efforts by WHO to tailor guidance and tools to country implementation over the Strategy implementation period. Two examples are the WASH in HCF package of support (web portal, Eight Practical Steps, guides for conducting a situation analysis) and the work on hand hygiene, which includes the HH4A partnership with UNICEF and has led to the development of national hand hygiene roadmaps and the forthcoming guidelines on hand hygiene in community settings (2025). As part of its three-year long development process, this guideline has included 10 champion countries in the development phase to provide feedback to improve implementation. These efforts are paying off with implementers, with the change summarized by one country level policy-maker who has interacted with WHO for 20 years:

[10] WASH-related indicators of the GPW14 are: mortality rate attributed to unsafe WASH (same as SDG 3.9.2); safely managed drinking water services (same as SDG 6.1.1); safely managed sanitation services (same as SDG 6.2.1a); basic hygiene services (same as SDG 6.2.1b); coverage of essential health services (SDG 3.8.1); service readiness (% of facilities with service capacities and readiness to deliver UHC package); coverage of WASH in communities and health care facilities.

> I find that the normative work that they're [WHO's] doing is becoming more and more useful from a boots-on-the-ground perspective and context. When I was first interacting with WHO it was very high level, it was so high level that it was difficult to see how it [guidelines] can be applied. And it didn't seem to be written with that in mind. This is changing. It is becoming more useful.

Finding 1.8: WHO has been responsive to emerging issues and declarations since the Strategy was developed. Since the strategy was published, there have been ongoing efforts to consult with countries and include their feedback into WHO outputs *(45, 46)*. The Strategy's implementation has been dynamic, evolving in response to country needs by providing more tailored and actionable guidance.

This was evident across KIIs in several stakeholder groups and the document review and country case studies. As one external stakeholder noted: "The Strategy has been a starting point, a launch pad not an end point." Another stakeholder said: "There are many things that are not noted in the strategy that WHO is actually doing now." Examples include gender monitoring, climate-resilient WASH monitoring, wastewater environmental surveillance, development of hand hygiene guidelines, etc.

WHO has been responsive to emerging crises, such as COVID-19, through the rapid development and dissemination of hand hygiene guidance. In response to climate change, WHO issued a climate change supplement to the Strategy in 2023 *(47)*, accompanied by increasing incorporation of climate change into existing guidance.

WHO has also responded to new UN declarations and commitments, including WASH in HCF, and uses data, evidence and learning to inform design and implementation, e.g. research on the effectiveness of WASH interventions in preventing diarrhoeal disease in children to support burden of disease evidence, and to co-design along with champion countries systems-strengthening guidance and an implementation toolbox for hand hygiene. The WSH Unit has also collaborated with other divisions in WHO to strengthen WASH guidance as discussed under EQ 2.

KIs suggest that WHO's ongoing adaptation of the Strategy and its willingness to take on emerging issues could be partly attributed to the openness of the WSH Unit in headquarters. It is perceived by WHO staff as flexible, adaptable and responsive to needs. The Unit is seen also as highly collaborative within WHO and with external partners (see finding 4.4.2 in EQ 4).

Finding 1.9: There is a demand for climate resilient WASH, amongst other key topics, to be covered more extensively in the next WASH Strategy. A diverse range of topics was suggested by KIs and survey respondents to include in the next Strategy. However, the most mentioned thematic topic was climate resilient WASH. Other common themes include WASH in emergencies (humanitarian settings, refugee and migrant populations), inclusive WASH and more focus on GEDSI, and WASH in HCF. The current Strategy does not have a specific focus on or a section dedicated to WASH and climate resilience, although a climate change supplement to the Strategy was issued in 2023 *(48)*. GEDSI is discussed under EQ 1.2.

In response to the survey question of "What should WHO's next Global WASH strategy emphasize or focus on?", WHO respondents highlighted the importance of resource mobilization, strategic financing, advocacy for increased funding from governments and donors, streamlined monitoring, capacity-building and strengthened coordination and partnerships. These are clear requests for support for systems-strengthening beyond introduction of normative guidance. Government survey respondents also mentioned support for WASH strategies, data collection, capacity-building, WASH standards and regulations and support to achieve SDG 6.

4.1.2. EQ 1.2: To what extent is GEDSI adequately addressed by the Strategy and associated implemented activities?

This question explores the extent to which the Strategy and its implementation has explored GEDSI, including different marginalized groups and related use of disaggregated data and monitoring.

Table 8. Summary of key findings related to EQ 1.2

Summary of key findings related to EQ 1.2	Strength of evidence rating
Finding 1.10: GEDSI considerations are critical to advance on WASH indicators, but the Strategy missed an opportunity to explicitly articulate its contribution to GEDSI principles.	Strong
Finding 1.11: Through Strategy implementation, WHO has made constructive efforts in integrating GEDSI into global monitoring and normative guidance.	Strong
Finding 1.12: Stakeholders find that WHO adequately addresses gender but more could be done to systematically address GEDSI.	Strong
Finding 1.13: There is scope to assign a GEDSI focal point within the WSH Unit to drive the agenda forward.	Strong

Finding 1.10: GEDSI considerations are critical to advance on WASH indicators, but the Strategy missed an opportunity to explicitly articulate its contribution to GEDSI principles. The GPW13 places strong emphasis on "Leaving No One Behind" and on reaching those furthest behind, such as marginalized, stigmatized and geographically isolated people of all ages, including women and girls, the poorest, persons with disabilities, indigenous peoples and vulnerable populations (such as migrants, internally displaced persons and refugees) in fragile and conflict-affected countries.

Under the GPW13, WHO commits to gender mainstreaming, including bringing a gender lens to needs analysis and programme design, and working for the rights of people with disabilities, marginalized or vulnerable groups and advocating for mainstreaming SDG 5. WHO's commitment to leaving no one behind, gender equality and equitable rights to health is given stronger emphasis in the draft GPW14.

A GEDSI lens is essential for ensuring no one is left behind in accessing safely managed WASH. A GEDSI lens is needed to identify and overcome inequality, discrimination and social exclusion in WASH policies, strategies and access to services, including identifying multiple dimensions within GEDSI (e.g., women with disabilities) and the intersection of GEDSI with other issues, such as climate change or conflict-affected people.

The WHO WASH Strategy refers to the triple billion goal of GPW13 and recognizes the human right to safe drinking water and sanitation and the SDGs but does not specifically refer to SDG 5. The 2018 version of the ToC in the Strategy and the corresponding logframe do not make any explicit reference to addressing the most marginalized or to GEDSI principles. It is not evident from the ToC and logframe how WASH is contributing to GEDSI goals of the GPW13 and tackling those currently left behind to gain equitable access to WASH.

Both water supply and sanitation thematic areas in the Strategy articulate a change objective of reducing inequalities in access by targeting endemic areas and vulnerable groups and by tailoring interventions to better interrupt disease transmission. The link to this statement and the activities in the Strategy is missing.

Light reference is made to JMP monitoring of inequities and country support to WASH where there are protracted emergencies.

Some donor and partner KIs noted that they would appreciate more explicit GEDSI "signalling" in the Strategy, e.g., in the aspect of human rights, as explained by one KI: "There could be more signals from WHO on issues of human rights that could be picked up by (us) to keep awareness among utility managers and academia to the issues of human rights."

Some KIs felt that more could be done to identify areas and populations in greatest need and prioritizing them, whether vulnerable to climate change or areas of long-term conflict, fragile states and informal settlements. Others suggest the Strategy should consider how vertical collaboration with partners can occur to strengthen GEDSI within WASH implementation and increase impact.

Finding 1.11: Through Strategy implementation, WHO has made constructive efforts to integrate GEDSI into global monitoring and normative guidance. WHO's contribution to global reporting on gender, equity and inclusion through the JMP *(49)* and GLAAS *(13)* analyses was noted as influential by several KIs. These global reports can shape thinking and set new ways of assessing data.

Attention to inequalities predates the current Strategy. The JMP convened a taskforce in 2017 to consider what more could be done on inequalities. Further work was undertaken in 2021 on monitoring gender equality in WASH. Inequalities, which were featured as an issue in the JMP 2020–2022 report (2023), highlight the level of effort needed in low-income countries, and the scale of people in need in fragile contexts and those who are displaced. This is positive for raising global attention. The 2022 GLAAS report, as well as previous reports *(13)*, includes a section on Leaving No One Behind, focusing on underserved populations and people living in poverty. Another section focuses on gender and WASH, covering women in the WASH workforce, gender and safely managed services and menstrual hygiene management. Tracking gender mainstreaming expenditure as a significant part of official development assistance expenditure is also noteworthy.

The challenge and limitations of disaggregating household data for gender analysis are noted in the literature *(50)*. Some KIs also voiced concern that if WHO reported conclusions using limited data for GEDSI they would be vulnerable to criticism (e.g., menstrual hygiene management or water collection hours spent by women and girls). This was seen as "overclaiming reality".

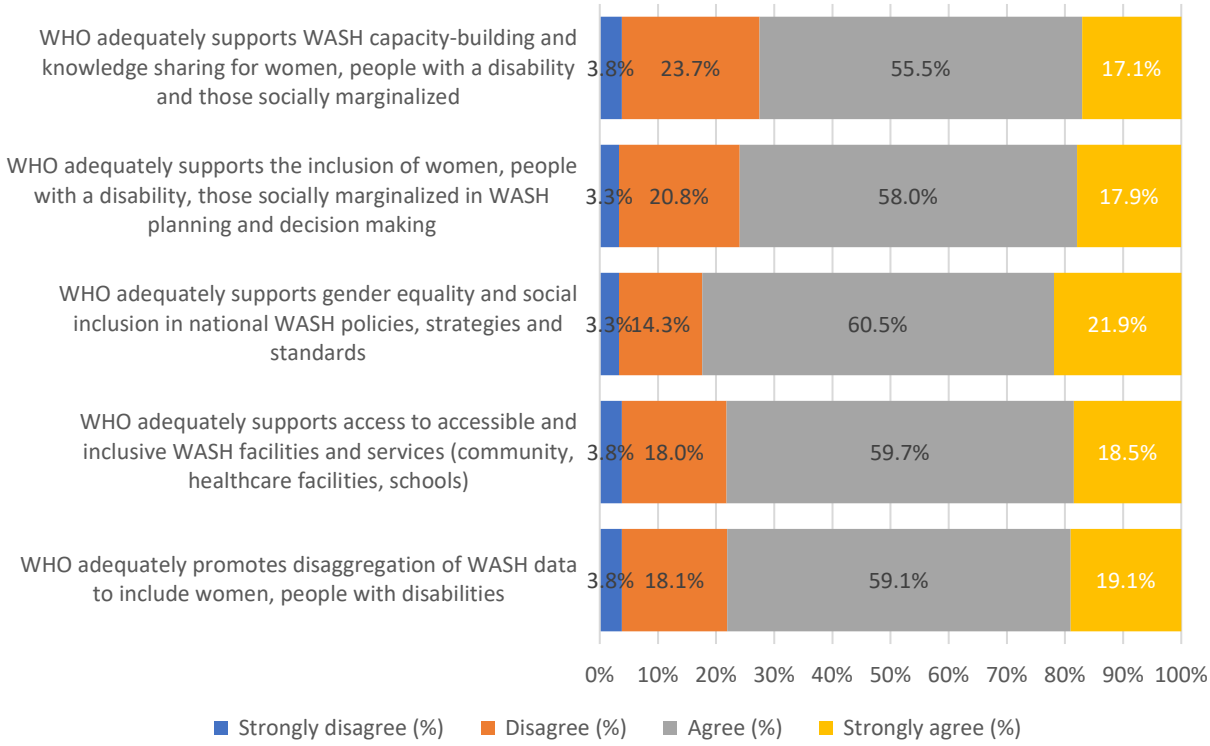
There are promising strands of mainstreaming GEDSI principles in recent guidance on NTDs (social inclusion) *(51)*, IPC and forthcoming guidance on hand hygiene. GEDSI is also covered in sanitation safety planning guidelines (limited to representation on the assessment team and consideration of the exposure group), and the latest WSP guidance considers a broad range of equity issues *(52)*, building on previous equity guidance *(53)*. WSP guidelines for small water supplies addresses small, rural and vulnerable communities *(54)*. WHO has a role as a founding partner in the collaborative Sanitation Workers Initiative, which puts a spotlight on marginalized sanitation workers, advocating for research *(55)*, recognition and dignity of these workers through workshops, blogs and more. WASH in HCF guidance has a strong focus on primary HCFs and maternity settings, which serve the most marginalized. GEDSI has been well incorporated in WASH in HCF, including in training guidance, technical notes and WASH FIT (2nd edition) methodology and indicators. A toolkit developed by the South-East Asia Regional Office on mainstreaming GEDSI in WASH in HCF, aligned to the Eight Practical Steps *(56)*, provides excellent practical tips and ideas across all dimensions of gender, disability and social inclusion, including of ethnic minorities and LGBTQIA+ people *(57)*. Although initiated regionally, this publication has universal themes but is not yet linked with the Eight Practical Steps on the WASH in HCF

webpage and could be given better prominence *(56)*. An Open WHO course, "Mainstreaming gender equality, disability and social inclusion in WASH in HCF" (based on the toolkit), has been well received, attracting 3023 enrolments and 1030 completion certificates in the four months since its launch in March 2024 *(58)*. This suggests a demand for GEDSI knowledge and skills in WASH. Most course registrants are aged 20–39 years and are students and medical or health staff, most enrolments are from India, Ethiopia and Nigeria. A link to the course could be provided through the WASH in HCF website, washinhcf.org.

The involvement of NGOs and academia such as WaterAid, NGO NTDs Network, Emory University and the Institute for Sustainable Futures University of Technology Sydney, as well as the passion and drive of a few GEDSI advocates within WHO (both male and female) has been pivotal to the integration of GEDSI into global WASH guidance and monitoring initiatives.

Finding 1.12: Stakeholders find that WHO adequately addresses gender, but more could be done to systematically address GEDSI. Respondents to the survey show strong agreement that WHO provides adequate support for GEDSI in WASH (Fig. 10).

Fig. 10. WHO support for GEDSI approaches within WASH



Source: Evaluation survey 2024. All stakeholders (213 respondents).

The highest level of agreement came from government respondents, while those most critical of WHO support for GEDSI were WHO staff. Only 19.4% of WHO staff strongly agreed that WHO adequately supports capacity-building and knowledge for women, people with disabilities and those socially marginalized, compared to 61.8% of government respondents. Nearly 25% of female respondents disagreed or strongly disagreed that WHO adequately supported GEDSI within WASH, compared to 20.2% of male respondents and 33.3% of respondents of another gender.

Non-government informants from the Philippines found that the approach to GEDSI was "general". The regulatory requirements were met in various guidelines; however, there was no special attention to gender or

people with disabilities, transgender or third gender people (of significant relevance in the Philippines) and marginalized groups beyond this. Similar sentiments were expressed by informants from Ethiopia, with one stakeholder group commenting that "WHO does not lay much emphasis on GEDSI".

Examples of KII feedback from WHO staff include that GEDSI is covered but "does not get enough emphasis" and that there is room to do more GEDSI work related to targeting "ethnic groups, people with disabilities and other aspects of GEDSI".

The recent evaluation of the Department of Foreign Affairs and Trade of the Australian Federal Government (DFAT), "Strengthening the quality and sustainability of water, sanitation and hygiene services, including in health care facilities program", found that GEDSI (and climate change) outputs did not score as high in four countries as other outputs *(59)*. Another donor saw WHO's GEDSI work as "more gender-aware than gender-transformative" and yet another donor noted that WHO was "not doing so well on equity and inclusion" *(60)*. Informants also noted a missed opportunity to go beyond access to services and support women to be part of decision-making, with women's voices heard as part of the UN resolution on sustainable, safe and universal water, sanitation, hygiene, waste and electricity services in health care facilities, passed in December 2023 *(61)*.

Both informants and survey respondents noted the need for awareness-raising and training at the country level to support ministries and utilities in understanding GEDSI and human rights; mainstreaming of GEDSI in all stages of the programming cycle, e.g., planning, implementation, monitoring and evaluation; as well as inclusion of people in informal settlements and displaced people.

Finding 1.13: There is scope to improve GEDSI focus and consistency. GEDSI was highlighted by WHO staff and partner organizations as important for WHO's WASH work, but implementation was described as uneven. Informants noted that the agenda was sometimes pushed by people who were interested and passionate about GEDSI while at other times, there was a lack of intentional design of GEDSI in WASH. There was no consistent strategy for GEDSI in WASH.

This is unsurprising, considering WHO's broader organizational history, which has at times lacked a comprehensive gender mainstreaming strategy *(62)*. GPW13 is the present strategic framework for gender, equity and rights. WHO's Gender, Equity and Rights Unit sits within the Office of the Director-General and has overall responsibility for coordinating the Organization's work on integrating these cross-cutting areas. However, WHO staff informants felt that the Unit provided limited support and was not pro-active at initiating dialogue.

Another challenge, as noted by some WHO staff, is that WASH has traditionally been a field dominated by highly technical experts, with a focus on science and engineering, and has lacked a strong foundation in GEDSI integration. Some thematic areas such as RegNet are reported by informants to be male dominated and GEDSI issues seldom raised. The RegNet terms of reference for members is gender blind *(63)*. This is an example of where WHO could use its influence to promote more women in RegNet by encouraging gender balanced representation from countries in the terms of reference. The gender, equity and human rights evaluation *(63)* noted internal factors which affected WHO's ability to integrate these dimensions, such as supportive leadership from senior management and the availability of dedicated resources in countries to mainstreaming. The WSH Unit does not have an appointed champion for GEDSI, although there is a GEDSI/GER focal point at the department level, but it would benefit from resources to help respond to GPW14 objectives of Leaving No One Behind and gender equality and the right to health for all people.

One survey respondent noted that GEDSI mainstreaming needs to progress from strategy at headquarters level to action at country level to:

> implement and ensure gender equality, inclusion of disability and other minority groups in the community in WASH planning and response, a proper strategy and implementation plan can be considered by the WHO headquarters and the Regional Office focusing on appropriate actions at the country office level.

4.1.3 ToC summary assessment for EQ1- Relevance

The ToC assumptions for Relevance largely hold true, as explained in Box 1.

Box 1. Theory of change assessment for EQ 1 – Relevance

Relevant assumptions underpinning the ToC in relation to EQ 1 are as follows.

(1A) Strategic objectives and actions of the Strategy and its implementation are aligned with country needs.
Assessment: Based on the evidence, this assumption holds true. Most countries have committed to SDG 6, yet water and sanitation are off track to reach the SDG targets by 2030. The WASH Strategy and its implementation contribute to achievement of the SDGs.

(1B) WHO country and regional offices were involved in Strategy development.
Assessment: This assumption largely holds true. Consultation occurred in the development of the Strategy; however, country priorities are influenced by other factors, and while some countries and regions had input into Strategy development, their influence is greater on how the Strategy is implemented.

(1C) Implementation has adapted to changes in the environment.
Assessment: This assumption holds true. The evidence shows that implementation of the Strategy has adapted to changes in the environment and that increasingly implementation has been cognizant of country needs.

4.2 Effectiveness

The evaluation found that, overall, WHO's WASH strategy is being implemented effectively despite the challenges faced and is achieving its objectives.
This section presents findings related to **EQ 2: To what extent have results been achieved through implementation of the Strategy and what lessons have emerged?** The EQ is assessed via two sub-questions:

- EQ 2.1: Is the Strategy on track to meet its targets, and what have been the successes, best practices, and main challenges?
- EQ 2.2: What external and contextual factors affected the achievement of results?

Vol. II, Annex 9 provides a more detailed assessment of progress in each of the thematic areas targeted by the Strategy, Vol. II, Annex 10 provides a summary of progress against the logframe as reported by the WSH Unit since 2018. This section draws together overall findings and lessons on effectiveness common to all or most thematic areas.

4.2.1 EQ 2.1: Is the Strategy on track to meet its targets, and what have been the successes, best practices, and main challenges?

This question assesses Strategy implementation against logframe targets with attention to GEDSI and climate activities across indicators. The quality of the evidence for the findings under this question is strong at output level, based on a combination of documentary evidence triangulated with KIIs, case study findings and survey results (see summary box of key findings, below).

As highlighted in Table 5 Limitations and mitigations in section 3.11, assessing WHO's contribution to results is relatively straightforward where WHO is the lead or only partner, as is the case with many of the output level results. It is much harder to assess the extent of WHO's contribution where multiple partners have been involved, something which applies especially to outcome level results where indicators relate to the number of countries adopting WHO guidance and/or incorporating it into national standards or targets. For example, outcome indicators 2.2 and 2.3 concern the number of countries with national targets aligned to SDG criteria for safely managed sanitation and water supply, respectively. Vol. II, Annex 10 summarizes results reported by the WSH Unit against the Strategy's logframe at output and outcome level.

Table 9. Summary of key findings related to EQ 2.1

Summary of key findings related to EQ 2.1	Strength of evidence rating
Finding 2.1: Results reported against the logframe since 2018 indicate that progress is generally on track across the thematic areas, with most targets and milestones (where set) achieved.	Strong
Finding 2.2: The high quality of normative guidance produced by the WSH Unit was noted by KIIs and survey respondents at all levels, within and beyond WHO.	Strong
Finding 2.3: The WSH Unit delivers a prolific output of publications, despite its modest in-house staffing.	Strong
Finding 2.4: A valued contribution from WHO at country level (at least where country offices have dedicated WASH/environmental health personnel) lies in adapting and contextualizing global guidance to ensure that it is locally relevant and usable.	Strong
Finding 2.5: WHO is highly influential in global agenda-setting in WASH.	Strong
Finding 2.6: The low priority afforded to WASH within WHO operations at all levels is a critical constraint.	Strong
Finding 2.7: WHO WASH funding and country staffing have declined substantially in recent years, and this decline is continuing, except in the case of emergencies.	Strong
Finding 2.8: Within WHO, the extent of integration of WASH into other health programmes varies and could be taken further in some cases.	Moderate
Finding 2.9: Climate resilience has progressed from an emerging to a mainstream issue for the WSH Unit and has been incorporated into much of the normative guidance, partnership-based advocacy and other efforts –	Moderate

Summary of key findings related to EQ 2.1	Strength of evidence rating
but more guidance is needed at country level.	

Finding 2.1: Results reported against the logframe since 2018 indicate that progress is generally on track across the thematic areas prioritized by the Strategy, with most targets and milestones (where set) achieved. (See Vol. II, Annex 9). Across the thematic areas covered by the Strategy, planned outputs relate mostly to the publication, dissemination and national adoption of tools and approaches, with WHO headquarters providing related orientation, training and technical support at national level and sector monitoring via JMP and GLAAS.

Results to date tend to confirm that the planned outputs and outcomes are mostly realistic and achievable, though ambitious in terms of the volume and range of guidance that the WSH Unit plans to produce and disseminate. They are also framed in recognition of WHO's normative role; while some concern not only the adoption but also implementation of approaches and tools (for example, in relation to sanitation safety planning and WASH in HCF), no targets are set for improvements in access to WASH services, the quality of those services or changes in WASH-related morbidity.
In the case of country technical support, it is difficult for the evaluation to draw any conclusions on the levels of ambition and achievement. This is because targets have often been set retrospectively, and what constitutes country support is not clear for every thematic area, bearing in mind that an increasing amount of support is provided online.

Regarding the implications for WHO regional and country offices, indicators in the Strategy logframe target the number of countries formally adopting normative guidance and/or receiving technical assistance from WHO headquarters but do not define how country-level WASH priorities will be identified and addressed by WHO.

SUCCESSES AND GOOD PRACTICES

Finding 2.2 The high quality of normative guidance and monitoring data produced by the WSH Unit was noted by KII and survey respondents at all levels, within and beyond WHO. WHO WASH guidance continues to be recognized as authoritative worldwide and is cited as grounded in solid scientific evidence and informed by contributions from respected experts in the WASH and health sectors. Survey respondents cited the Guidelines on drinking-water quality and JMP data as examples of authoritative and widely used WHO WASH publications. However, external partners indicated that they found GLAAS data harder to engage with, partly because enabling environment information is more complex than quantitative data on access to WASH facilities.

Finding 2.3. The WSH Unit delivers a prolific output of publications, despite its modest in-house staffing. Reported achievements under the strategy are impressive given the significant resource constraints of the WSH Unit. This is made possible by the Unit's highly collaborative approach, which draws on consultants and collaborators from partner organizations to help develop the normative guidance.

The WSH Unit also collaborates with a range of global partners and platforms to disseminate its guidance and provide related orientation and training. For example, the WSH Unit has provided support to UNICEF's

Sanitation Game Plan at the global and regional level (via webinars) by helping senior staff make a strategic shift in programming from ending open defecation to achieving safely managed sanitation.

Some WSH informants felt that the different technical functions within the Unit tend to work in silos, and that there could be a more holistic approach to the development of some normative guidance – for example, by linking water safety planning and sanitation safety planning. The inclusion of sanitation in the work of RegNet appears to be a positive step in this direction.

Finding 2.4. A valued contribution from WHO at country level (at least where country offices have dedicated WASH/environmental health personnel) lies in adapting and contextualizing global guidance to ensure that it is locally relevant and usable. This was highlighted by stakeholders in both the Ethiopia and Philippines case studies and is consistent with the findings of the 2023 evaluation of WHO's normative role at country level *(64)*. However, WHO's ability to do this is limited in country offices where there is no dedicated WASH/EH specialist. This also has implications for sustainability (see Finding 5.9).

Finding 2.5. WHO is highly influential in global agenda-setting in WASH. For example, the WSH Unit played a key role in the formulation and adoption of the SDG 6 Global Acceleration Framework *(12)* and in securing the World Health Assembly Resolution on WASH in HCF in 2019 *(6)*. At the country level, however, WHO is not always the most visible external support agency in the WASH sector, especially in countries where it has no full-time WASH/EH personnel. The evaluation survey tended to confirm that other agencies – not least UNICEF – are often seen as playing a more prominent role.

CHALLENGES

Finding 2.6. The low priority afforded to WASH within WHO operations at all levels is a critical constraint. This concern was raised by multiple internal (and some external) respondents at all levels. At the global level, respondents noted that enhanced attention to hand hygiene during the pandemic did not elevate the position of WASH within WHO operations for the long term, and in the sector at large. The inadequacy of WASH in HCF remains a global challenge. Several internal respondents also commented that WASH will only be given priority within WHO country operations if the WHO representative is personally convinced of the case for it – and some are not. Similarly, not all recognize a need for WHO to be substantially engaged with institutions beyond the health sector – particularly the ministry of water and sanitation, and water/sanitation utilities – despite the stated intentions of GPW13 (and GPW14) to address the determinants of health. A related challenge is that national government partners do not always prioritize WASH (see Finding 2.14).

Securing the buy-in of regional directors and WHO representatives is vital if the WASH agenda is to move forward within WHO at the country level. Internal informants at all levels highlighted the importance of this buy-in, especially given that WHO is a highly decentralized organization. Regional offices have considerable autonomy, and neither they nor the country offices are under an obligation to implement the WASH strategy.

Finding 2.7. WHO WASH funding and country staffing have declined substantially in recent years, and this decline is continuing, except in the case of emergencies. This is confirmed by WSH internal consultations in 2021 (direct follow-up action in response to the virtual WSH retreat of that year) and 2023 as part of an ECH review, plus KIIs with regional and country office staff and survey respondents. The 2021 consultation with WASH focal points at the country level sought to understand the challenges they faced and explore how they could be better supported by WHO headquarters. The consultation report noted the following:

> In many, if not most countries, the number of Environmental, Health and Climate officers is low, and when a person leaves, it is not uncommon for the position to go unreplaced […] increases the likelihood that the new 'WASH responsible' person has no or limited orientation in WASH broadly or the WHO WASH knowledge set, tools and guidelines *(45)*

Some respondents also noted that the professional grade associated with some country and regional WASH positions has gone down in recent years. In addition, when specialists vacate posts, if they are replaced, then the new officer may have no WASH experience or relevant qualifications. In Nepal, for example, the country office had an international WASH specialist at Grade P5 some years ago, who was deployed in the Ministry of Water Supply and Sewerage. Today the WSH focal person is based in the WHO office and assigned a lower grade.

An informal staffing survey in 2023 found that, over the previous decade, there had been an average reduction of 48% in ECH positions at regional level and 65% at country level. Some internal KIs attributed this decline, in part, to rethinking based on the results of functional reviews conducted in recent years. These reviews involved consultations with national governments on what should be WHO's priority areas of focus, and, once again, WASH was often low on the list.

The decline in WASH staffing at the country level makes it increasingly difficult for WHO to play its intended role in WASH advocacy, orientation and training, contextualizing guidance for country use, or to exercise its convening power in the WASH sector. Furthermore, the Ethiopia country case study shows that, even in countries with a WASH specialist, this role is compromised where there are insufficient funds available to cover the cost of holding orientation and training events.

It is important to acknowledge that funding shortages are not unique to the WASH and EH function within regional and country offices. The Ethiopia case study (see annex), for example, found that the country office overall faces a significant funding shortage and has recently cut 55% of its staff posts.

Finding 2.8. Within WHO, the extent of integration of WASH into other health programmes varies and could be taken further in some cases. Currently, the most active collaboration between WSH and other programmes is in the areas of emergencies, AMR, IPC/HCF and (increasingly) NTDs. Vol. II, Annex 9 includes a detailed review of progress on WASH integration into other WHO health programmes. Regarding public health emergencies, COVID-19 dominated WSH's work over the strategy period. WHO reacted rapidly to the pandemic, initially updating WASH relevant emergency guidance but then shifted towards a preventive approach with hand hygiene promotion.

WSH has also collaborated closely with the NTD NGO Network (NNN), and both WSH and NNN collaborate across WHO departments. Both internal and external collaborations are reportedly going well.

In the case of cholera, WSH collaborates closely with the WASH focal point in WHO's epidemic diarrhoeal diseases team. It has provided technical support to GTFCC and worked with partner agencies, for example on the application of sanitation safety planning in cholera hotspots and the use of household water treatment technologies. A potential gap highlighted by internal KIIs was that most of WSH's guidance on cholera control is currently focused on development contexts and needs to be adjusted to emergency settings. WSH action to address this is reportedly ongoing.

WSH's work on integrating WASH and AMR has been part of a UN interagency partnership focussing on advocacy, global awareness-raising and capacity-building. One specific achievement by WSH has been to

mainstream WASH and AMR in its work on WASH in HCF, Hand Hygiene for All (HH4A) and environmental surveillance.

At the country level, WHO's performance in integrating WASH into other health priorities was generally seen as good or very good by the majority of survey respondents. WHO was seen as performing strongest in relation to COVID-19, where 84% of respondents rated integration "good" or "very good". Integration was also seen as strong for cholera, with 72% of stakeholders rating it "good" or "very good". The integration of WASH and NTDs at national level was rated "good" or "very good" by 57% of stakeholders despite strong integration efforts at the global level.

An important lesson related to COVID-19, Ebola and cholera reported in consecutive annual reports is the role of HCFs in preventing the spread of disease outbreaks. HCFs were typically the first point of engagement with those suffering from these diseases, underscoring the importance of WASH facilities in providing health and infection control services. WSH experience in public health emergencies also points to the need for a broader approach to infectious disease prevention and control at HCF, school and community level. However, there is currently no strategic direction discernible in this area of work judging from annual reports alone.

In all the intended areas of integration, the chronic underfunding of public WASH infrastructure is an ongoing challenge to the implementation of effective WASH interventions.

Finding 2.9. Climate resilience has progressed from an emerging to a mainstream issue for the WSH Unit, and more guidance is needed at the country level. In the original Strategy document, climate change was presented as an emerging issue relevant to WASH. No outputs or outcomes on climate resilience were included in the programme logframe, but the Strategy identified change objectives relating to a strengthened evidence base on climate, WASH and health linkages; intersectoral planning and collaboration at all levels; and the inclusion of climate considerations in relevant WASH risk assessment and management approaches and WASH monitoring systems.

WSH Unit staff indicated that since 2018, climate resilience has moved from being an emerging issue for the Unit to a mainstream one, a shift confirmed by the 2023 publication "Addressing Climate change. Supplement to the WHO Water, Sanitation and Hygiene Strategy 2018–2025". Over the course of the Strategy period, WSH has done a great deal to integrate climate resilience into its normative guidance – something already accomplished for water safety planning before the Strategy was adopted – and into sector monitoring via JMP and GLAAS.

WSH staff acknowledge that more needs to be done to support the assessment and understanding of climate change risks relating to WASH and associated responses. One particular concern is that the analysis of climate data is a complex and resource-intensive task needing specialist expertise that might not be available in government agencies and utilities at subnational or even national level. Limited understanding of what constitutes climate resilient water or sanitation services is also an ongoing challenge for the sector as a whole, which was confirmed by the Ethiopia case study. Respondents in and outside of government highlighted that there is insufficient guidance available on this area (not just from WHO) and on related infrastructure options.

WSH has been very active in global advocacy for addressing climate resilience in WASH, and at the 2022 United Nations Climate Change Conference, WHO led the first sanitation-specific session showcasing climate risks, adaptation measures and opportunities for cross-sectoral resilience and mitigation through reuse. The session launched the UNICEF-led call to action on climate-resilient sanitation. WHO, together with UNICEF and Sanitation and Water for All, also organized a full thematic day on "Climate, Water and Sanitation

Solutions for Health and Sustainable Development". *The Climate Resilient Sanitation Coalition* was formed in 2022 in response to a Joint Call for Action at the 2022 United Nations Climate Change Conference and aims to integrate sanitation into global and national climate policy and practice. It is a growing collaboration of international organizations, research organizations and practitioners representing almost 35 organizations including WHO, UNICEF, UN-Habitat, World Bank, USAID, the German development agency GIZ, Asian Development Bank, Bill and Melinda Gates Foundation, WaterAid, the Foundation of Netherlands Volunteers (Stichting Nederlandse Vrijwilligers "SNV"), Water and Sanitation for the Urban Poor (WSUP), and Green Climate Fund *(65)*.

4.2.2 EQ 2.2: What external and contextual factors affected the achievement of results?

Table 10. Summary of key findings related to EQ 2.2

Summary of key findings related to EQ 2.2	Strength of evidence rating
Finding 2.10: The content of each country office's work plan emerges in part from dialogue with national government – primarily the health ministry – and they do not always prioritize WASH.	Strong
Finding 2.11: The COVID-19 pandemic was an enabler in that it generated more attention to HH4A; but lockdowns were also a major interruption to government and development agency operations.	Strong
Finding 2.12: Beyond COVID-19, conflicts and other emergencies have caused major disruption to routine government activities and external support in some countries.	Moderate

Finding 2.10 The content of each country office's work plan emerges in part from dialogue with national government – primarily the health ministry – and they do not always prioritize WASH. Internal KIs, especially at the regional and country level, indicated that WHO country co-operation strategies are developed in close collaboration with national governments, primarily health ministries, and these do not always see WASH as a priority and/or see it as the responsibility of a different ministry and of UNICEF more than WHO (see also Finding 2.6).

Finding 2.11. The COVID-19 pandemic was an enabler in that it generated more attention to HH4A; but lockdowns were also a major interruption to government and development agency operations. The enhanced priority given to hand washing during the pandemic has declined since the emergency ended, but it remains to some extent in many countries. The pandemic also added urgency to expanding the use of online training including for WASH, for example via Open WHO and webinars. This change has become permanent and internal respondents at all levels see it as a positive development, both extending the WSH Unit's reach and making it more accessible.

Finding 2.12. Beyond COVID-19, conflicts and other emergencies have caused major disruption to routine government activities and external support in some countries, though the evaluation did not find a wealth of specific evidence on this. The Strategy devotes limited attention to WASH emergency preparedness, rather the WSH Unit seems to have been involved more in emergency response (for example in Ukraine). This might be in part because the Global WASH Cluster is led not by WHO but UNICEF; nevertheless, some WSH respondents identified a need for the Unit to do more on emergency preparedness.

4.2.3. ToC summary assessment for EQ2 – Effectiveness

The evidence for ToC assumptions for Effectiveness holding true is mixed (see Box 2).

Box 2. Theory of change assessment for EQ – Effectiveness

Relevant assumptions underpinning the ToC in relation to EQ 2 include the following.

(2A) WHO prioritizes WASH internally and allocates adequate resources to WASH at all three levels.

Assessment: The WSH Unit forms part of ECH Department, which prioritizes WASH, but the subject has remained somewhat marginal within WHO overall at all levels. Not all WHO Representatives prioritize engagement beyond the health sector – some see this as UNICEF's job.

(2B) WHO regional and country offices provide adequate support to government and partners.

Assessment: Regarding country office support, the assumption holds true for only some countries. WHO staffing and funding for WASH at regional and country level have declined substantially in recent years, and country office support to government on WASH is severely constrained where there is no dedicated WASH and environmental health specialist.

(2C) WHO and partners have sufficient capacity (human and financial) to implement the strategy.

Assessment: The assumption on WHO and partner capacity largely holds true at global level; staff are stretched but harness external capacity for the development of normative guidance. It does not hold true for all country offices due to the limited number with dedicated WASH staff. Many national government partners lack the resources for implementation at scale, especially where this involves capital expenditure (for example, for WASH in HCF and expansion of WASH services in endemic areas).

(2D) WHO guidelines remain international reference point.

Assessment: This assumption holds true regarding the use of WHO guidelines across thematic areas.

(2E) Functioning institutional structure at national level to update/adopt WHO WASH products

Assessment: The assumption on institutional structures does not hold true for all countries. Some have multistakeholder platforms/working groups for WASH and health that can be a vehicle for adopting or updating guidance. However, the WASH sector is fragmented in many countries; not all health ministries have a substantial WASH section or department; and lead responsibility for WASH may lie with the Ministry of water (or similar).

(2F) WHO monitoring data is considered relevant and appropriate for use by partners and governments.

Assessment: This generally holds true although developing the capacity to monitor the use of "safely managed" services remains a work in progress in many countries.

4.3. Efficiency

Overall, the evaluation found that declining funding trends and increased levels of earmarking over the past decade have challenged WHO's capacity to implement the strategy. However, WHO has optimized the use of available human and financial resources.

The findings presented in this section relate to **EQ 3: How efficiently has WHO used its human and financial resources to implement the Strategy?** This evaluation question is addressed through two subquestions:

- EQ 3.1: Has WHO struck an appropriate balance in the allocation of resources (personnel and funding) across its priority areas of WASH work at headquarters level?

- EQ 3.2: How has WHO sought to use its limited human and financial resources to greatest effect and what are the lessons learned to improve efficiency?

It should be noted for this section that due to expenditure and human resources data constraints, the efficiency analysis proved challenging. It was not possible to determine a true budget to compare against actual expenditure data for both human resources and activity expenditure. This is attributed to the fact that the Strategy is not clearly costed nor clearly linked with either targets or unit costs, nor supported by a narrative form of financial reporting. Whilst it was not possible to conduct a robust efficiency analysis of Strategy implementation, the evaluation is able to provide an assessment of resourcing and highlight areas of efficiency/inefficiency for each of the sub-EQs.

4.3.1 EQ 3.1: Has WHO struck an appropriate balance in the allocation of resources (personnel and funding) across its priority areas of WASH work at HQ level?

This subquestion explores the extent of balance in the allocation of human and financial resources across priority areas of WASH work at the headquarters level.

Table 11. Summary of key findings related to EQ 3.1

Summary of key findings related to EQ 3.1	Strength of evidence rating
Finding 3.1: An estimated 1–2% of the global flexible budget is reported to have been allocated to WSH[11] despite the high burden of disease attributable to unsafe drinking-water, sanitation and hygiene conditions.	Strong
Finding 3.2: Allocation of personnel across the priority areas is widely considered as being constrained at headquarters, while resource constraints (human and financial) are even more evident at regional and country level and has been in decline over the past decade.	Strong
Finding 3.3: GLAAS has the highest level of activity expenditure, followed by cross-cutting activities and JMP.	Strong
Finding 3.4: The WSH Unit has historically not benefited significantly from flexible (core) WHO funds.	Strong
Finding 3.5: Resource mobilization involves a complicated internal and external (with donors) negotiation, resulting in unpredictability of funding; in turn the way resources are mobilized makes it hard to allocate sufficient funding to specific thematic areas.	Strong
Finding 3.6: There is scope to improve the way the WSH strategy is linked with financial reporting.	Strong

[11] KII.

Finding 3.1: An estimated 1–2% of the global flexible budget is reported to have been allocated to WSH[12] despite the high burden of disease attributable to unsafe drinking-water, sanitation and hygiene conditions.

WHO reports that the total WASH attributable disease burden among children aged under five years amounted to 395 000 deaths and 37 million disability-adjusted life years, which included 273 000 deaths from diarrhoea. Furthermore, more than three quarters of all WASH-attributable deaths were in the WHO Africa and South-East Asia regions, 15–18 times higher than in the European region *(66)*.

Finding 3.2: Allocation of personnel across the priority areas is widely considered as being constrained at headquarters, while resource constraints (human and financial) are even more evident at the regional and country level, where they have been in decline over the past decade.

As highlighted in Section 1.3, the estimated annual budget for WASH programming is US$ 9 million, broken down into approximately US$ 3 million for headquarters staffing costs, US$ 3 million for headquarters activity costs and a further US$ 3 million for regional and country costs. As set out in Section 1.2 (Staffing structure of WSH Unit) there are different human resources levels across different PIAs. There are also different categories of personnel: headquarters staffing; consultants (some longer-term whilst others recruited on an ad-hoc basis); project-specific consultants; and consultants and staff (JMP and GLAAS) recruited by partner organizations. Furthermore, there are in-kind contributions in the form of advisory groups.

According to the accounting system, the number of core headquarters level personnel is on average two persons for each of the main PIAs with nominal personnel time allocated to cross-cutting PIAs ("Integration of WASH with health and other programmes" and "Emerging issues on WASH"). The staffing and activity expenditure by PIA is provided in Table 12 below.

Table 12. Headquarters staffing and activity expenditure by PIA (in US$)

Thematic area	Headquarters staffing	Activity expenditure	Total	% of overall
Cross-cutting	2 439 057	4 113 357	6 552 414	18%
Drinking water quality	1 504 398	1 665 929	3 170 327	9%
GLAAS	3 780 424	5 558 978	9 339 402	26%
HCFs	2 323 632	2 711 354	5 034 986	14%
JMP	3 726 885	2 692 861	6 419 746	18%
RegNet	1 004 891	199 407	1 204 298	3%
Sanitation	2 605 492	1 757 826	4 363 318	12%
Subtotal	**17 384 780**	**18 699 712**	**36 084 492**	**100%**

Source: evaluation team analysis of *(24, 25)*.

WSH Unit staff repeatedly expressed concern that they were stretched and had growing requests for additional work. While recognizing the collaboration and partnerships with others (see Section 4.3.2, EQ 3.2 Finding 3.7 and Section 4.4, EQ 4 Coherence), staff expressed their concern at being expected to do everything

[12] KII.

from IT, facilitation, technical input, training, navigation of internal administration, for example for producing publications, and resource mobilization.

The workload of WSH is in part supported through consultants. Whilst the actual numbers of additional consultants recruited during the period of the Strategy is not clear, it is accounted for under activity expenditure and with one external partner highlighting the approach as, "a risk of diminishing technical expertise of their staff, you end up with a small permanent staff who are much more managerial and doing QA rather than getting into the technical details."

At **regional** level, the regional office generally has one WASH advisor and one to two technical assistants. On average, the number of positions has been reduced by 48% over the last decade *(67)*,[13] and consultants are engaged as and when needed, for either specific projects or for country activities.[14] However, the engagement of additional personnel at country and regional level is dependent on funding. Funding levels for WASH activities have also declined by 50% over the last decade *(45)*

At **country** level, the consensus is that there is a lack of resourcing (human and financial), which has been consistently declining. This has been reported during the 2021 consultation and the 2023 ECH mapping survey identifying an average reduction of 65% of ECH positions in WHO country offices over the last decade; on average, country offices funding has declined by 38% over the last decade *(45)*.

The sentiment of inadequate resources at country level was further echoed during KIIs, where a mixed view on the extent to which WASH features or is prioritized by country offices was expressed. The country case studies (see Box 3) also illustrate human resource constraints and uncertainty about staffing continuity for WASH.

Box 3. Human resource constraints

In the **Ethiopia** WHO Country Office, there is only one person assigned to WASH in development contexts with a focus on national level orientation and training and the development of frameworks, strategies and guidelines rather than implementation on the ground. This focus, and limited staffing for WASH, imposes limits on the breadth and depth of WHO engagement in WASH.

In the **Philippines**, the WHO Technical Officer for Environment and Occupational Health has multiple roles related to environmental health – WASH, chemical safety, food safety, occupational health, air quality, etc. Around 60–70% of the individual's time is spent on WASH since that is where the funding is available; approximately 10–20% is spent on conducting assessments for the health emergency team; and 20% is spent on other projects, such as maternal and child health, where there is a recent interest in integrating WASH.

The Technical Officer coordinates with other WHO health programmes given available budget, so WASH is implemented in their programme. However, if a request comes from the Department of Health to support an area of environmental health, then only limited support (such as attending meetings) can be offered if there is no budget. Piggybacking on other financial opportunities, e.g., through donor-funded health programmes, has been opportunistic but does not address severe underfunding for WHO's WASH

[13] In the case of the WHO Western Pacific Regional Office there used to be four people with strong capacity, now reduced to one person plus one secondee.
[14] All six regional KIIs.

work.

The technical officer brings a rare skill set for WHO offices, by combining engineering training with the ability to conduct field assessments and engage in capacity and policy development. The provision of specialist technical advice is appreciated by generalist UNICEF WASH staff and Department of Health. The technical officer also has long WASH sector knowledge and was described as a "national treasure".

Finding 3.3: GLAAS has the highest level of activity expenditure, followed by cross-cutting activities and JMP.[15] GLAAS has the highest level of headquarters staffing/consultants (22%) and activity expenditure (30%), accounting for 26% of the total WSH budget. Both have remained relatively high across both biennials (see Fig. 11), due primarily to the cost of supporting primary data collection for GLAAS country surveys, although some of the allocated staff time and resources are used to support other WSH activities and contribute to Unit Head costs. JMP has the second highest level of headquarters staffing (21%) but not the second highest level of activity expenditure, instead it is the cross-cutting PIA activity expenditure (covering Integration of WASH with health and other programmes; and Emerging issues on WASH) (22%) that exceeded JMP (14%) across the total period. Cross-cutting expenditure includes HH4A, which is considered a new PIA; however, the data do not allow the evaluation team to explore how much of the cross-cutting budget is allocated to hand hygiene.

RegNet receives the smallest proportion of funding both in terms of headquarters staffing and activity expenditure across the period, at 3%. Based on the activities to date (see also Section 4.2 and Vol. II, Annex 9 – thematic area on RegNet). RegNet has primarily convened meetings and hosted a virtual forum and thus had relatively limited costs. However, with the recent drafting of the RegNet Strategy (2023–2030), the level of activity is likely to increase.

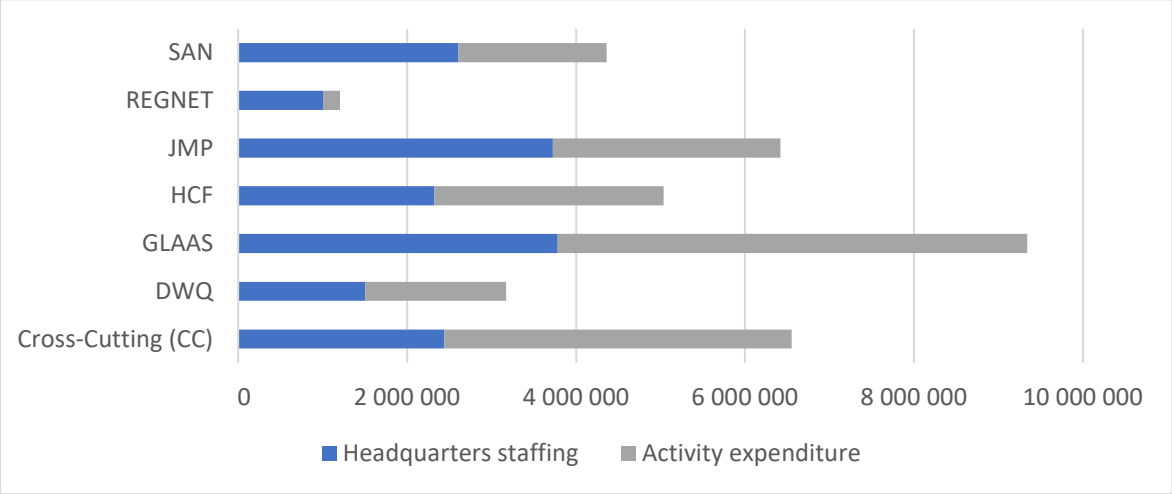
Drinking Water Quality is also a relatively low level of expenditure, at 9%. WSH have indicated that, since WHO is well-known and has the longest running PIA, donors tend to see it as a core WHO activity that should be funded from the regular budget.

There are three separate financial reporting tools and data sets, making it challenging to assess the allocation of resources across the thematic areas.[16]

[15] See Annex 8 Financial analysis summary, Tables 4–8 for all the referenced figures.

[16] Referencing Section 1.2 staffing structure, the cross-cutting staffing person numbers do not necessarily correspond with the headquarters staffing costs for the PIA. However, the staffing costs do not take into account additional consultants recruited, who are accounted for under activity expenditure. Still there seems to be some mismatch between staffing numbers as reported by the accounting system for human resource allocation (as reported in Section 1.2) and the accounting system reporting headquarters staffing costs (as reported in Annex 8 Financial Tables 4–8). Added to this is the fact that despite the financial data depicting amounts relating to categories of "workplan", "expenditures" and "utilization", the Unit of measure relates to the broad thematic area rather than any specific Task or Subtask name as set out in the Workplan Structure documents used for budget planning. Furthermore, whilst the broad thematic areas correspond to the logframe output areas, there is no clear audit trail link between the logframe, and the Task or Subtask categories as set out in the Workplan Structure documents.

Fig. 11. Allocation of headquarters staffing and activity expenditure by PIA (2018–2023)



Source: evaluation team analysis of *(24, 25)*.

Finding 3.4: The WSH Unit has historically not benefited significantly from flexible (core) WHO funds. The WHO budget components comprise voluntary specified funding (donor funding provided for highly specified project work), highly flexible funding (core funding, assessed contributions/core voluntary contributions) and/or designated funding (flexible or specific funding by thematic area) that usually emanates from WHO's Resource Allocation Committee/ Planning, Resource Coordination and Performance Monitoring departments (PRP). Based on the data provided by the WSH Unit for both headquarters staffing and activity expenditure, the proportion of specified donor funding significantly outweighs WHO flexible core funding. This reliance on donor funds was stated by informants as fairly unique within the Environment, Climate Change and Health Department (ECH), albeit not necessarily unique in the wider WHO organization, according to KIIs.

KIs and documentary evidence indicates the reducing interest of donors in funding staff costs and therefore the need to secure core funding to fill the gap. During the first two years of the Strategy period, flexible funding did not cover international salaries. In contrast, in 2020–2022 despite a decline in donor funding, an increase in flexible funding occurred.

Whilst we have no insights into the true picture of WHO expenditures at regional and country levels, the data available (as presented in Table 13 below and Annex 8, Table 8) show the overall declining amount and proportion of funds that have been channelled through headquarters and allocated to regional/country offices. Additional funds are available to and secured by regional/country offices but are not directly part of the WSH reported budgets. For example, Ethiopia acknowledges that whilst no information was shared on the country office budget for WASH, the Health and Environment biennial work plan includes tasks related to WASH in HCF, climate resilient WSP and JMP/GLAAS. Furthermore, informants reported that some donors prefer to engage directly with country offices rather than going via headquarters, whereas others have built the relationships at headquarters level and prefer to have funds pooled centrally.

Table 13. Proportion of headquarters funds allocated to regional and country offices (in US$)

Implementation Regional Office and Country Office (donor funds)	2018–2019	2020–2021	2022–2023
Headquarters funding	11 762 319	8 296 545	10 052 442
Regions/countries	4 046 737	3 218 942	2 004 628

Subtotals	15 809 056	11 515 487	12 057 070
% Regions/countries	26%	28%	17%

Source: Evaluation team analysis of WSH award distribution implementation by region and country offices *(68)*. There are some differences in total amounts with the other tables presented – the raw data sources are different and cannot be reconciled.

Another source of evidence is the breakdown and subsequent allocation from GPW13. An estimated 1–2% of the global flexible budget is reported to have been allocated to WSH (note that GPW as a strategy is underfunded). A total of US$ 168 million out of the US$ 4.9 billion is allocated to Health and the Environment globally, of which US$ 53 million is for headquarters, which is where most of the WASH work is completed. Flexible funding allocations are decided at the Office of the Director-General and Planning, resource coordination and performance monitoring department level. Funds are then distributed to a division in two to three tranches with set amounts in years one and two and a potential residual allocation toward the end of a biennium, as and when needed.

Taking the amounts for 2022–23 (which decreased from biennium 2020–21) as an example, US$ 39.6 million were allocated to the Healthier Populations division, of which US$ 11.9 million was sent to the ECH Department. Of this, 92% filled staffing gaps across the department. This echoes the point that the WSH unit has historically not benefited significantly from flexible funds.

Finding 3.5: Resource mobilization involves a complicated internal and external (with donors) negotiation resulting in unpredictability of funding. In turn, the way resources are mobilized makes it hard to allocate sufficient resources to thematic areas. Despite fragile and fluctuating core funding, historically there has not been a resource mobilization strategy. However, there is a six-month operational planning process prior to the start of a new biennial implementation period. In reality, the process takes eight to nine months due to the greater focus on alignment and support to countries, leading to an extended number of meetings to reach agreement on priorities.[17] Funds are raised across all three levels of the Organization, although there is a lack of understanding about how much funding is raised by the different levels.[18] Three factors influencing how funding is secured are reported/identified as: time availability; headquarters having access to significant donors and donors wanting to engage with headquarters, whilst in other cases donors want to engage at the country level; and the Contributor Engagement Management tool, which currently allows headquarters to see what regional and country offices are putting in in terms of the donor. The Contributor Engagement Management tool is reportedly improving in the next biennium to ensure all levels can see what is coming in and from which donor. Another activity that contributes to reviewing plans and priorities is the WSH team annual retreat (see Section 4.3.2, Finding 3.7).

Example of the EC Health Emergency and Preparedness and Response Grant: headquarters and the Regional Office for Africa separately developed proposals for the same area of work – water and emergencies – 2 proposals combined, submitted and accepted.

Based on the abovementioned approach of planning, the percentage of secured funding at the start of a biennial versus what needs to be captured during the year fluctuates from biennial to biennial and depends on when larger grants are negotiated and agreed. However, there is a WHO organizational requirement to have

[17] Follow-up meetings with finance team.
[18] KIIs; Ethiopia country case study.

approximately six months funding available in advance to cover staffing costs (i.e., approximately US$ 1.5 million for WSH), and to have funding available in advance for a minimum of three months to cover activity costs (i.e., approximately US$ 1.5 million for WSH).

Finding 3.6: There is scope to improve the way the WSH Strategy is linked with financial reporting. The Strategy document is not accompanied by a financial plan, however a recent draft resource mobilization strategy (not availed to the evaluation team) has been prepared. Furthermore, despite an estimated global budget of US$ 9 million per annum being reported within each of the WSH annual reports,[19] there is no associated narrative or detailed financial breakdown. As highlighted in a previous finding, the estimated US$ 9 million total is broken down with approximately US$ 3 million allocated for headquarters staffing costs, US$ 3 million for headquarters activity costs and a further US$ 3 million for regional and country costs *(24, 25)*.[20] Based on the raw data provided by the WSH unit *(24, 25)*, the combined expenditure of headquarters staffing costs and headquarters activity costs broadly align with the estimated figures (see Vol. II, Annex 8 Financial analysis, Tables 4–8). However, two discrepancies were noted. First, there is a discrepancy with the planned US$ 3 million per annum allocated to regional/country offices. The data provided report an overall average of only 50%, ranging between US$ 2 million and 4 million per biennium. Second, there are discrepancies in reporting between the different data sets for headquarters (donor) funding, most significantly for biennium 2020–21 and 2022–23.[21] This suggests complexity in the financial accounting system and may explain the absence of an annual financial report.

The number of different financial data sources, disaggregated by slightly different criteria and from different sources, demonstrated how incredibly complicated the system appears to be.

4.3.2. EQ 3.2: How has WHO sought to use its limited human and financial resources to greatest effect and what are the lessons learned to improve efficiency?

This subquestion examines synergies across the WSH unit, the integration of WASH into other WHO health strategies and actions, efficient collaboration across the three levels of the Organization, scaling-up of effective and scaling-down of ineffective approaches, and timeliness of implementation.

Table 14. Summary of key findings related to EQ 3.2

Summary of key findings related to EQ 3.2	Strength of evidence rating
Finding 3.7: Good cooperation across the WSH unit has contributed to efficient use of its limited human and financial resources.	Strong / moderate
Finding 3.8: A range of opportunities exist to enable closer coordination and improve synergies within WHO, including joint resource mobilization, joint training, joint missions and joint planning and programming.	Strong / moderate
Finding 3.9: Substantive efforts aimed at improving collaboration across the three levels of the Organization have yielded results.	Strong
Finding 3.10: There are more examples where activities have been scaled-up, as opposed to the scaling-down of potentially ineffective activities.	Moderate

[19] As presented in the WHO ESA Highlight (Annex 5 of 2018 & 2019 A/R; Annex 3 of 2020; Annex 2 of 2021 & 2022).
[20] As well as evidence from KIIs.
[21] The evaluation team will be happy to receive comments/fact checking on this point.

Finding 3.7: Good cooperation across the WSH unit has contributed to efficient use of limited human and financial resources. The annual retreats provide an opportunity to identify and discuss lessons learned during the year *(69)*, as well as plans and priorities for subsequent years *(70-72)*. These retreats included participants from WHO regional and country offices and were conducted virtually during and initially after the COVID-19 pandemic, reverting to an in-person meeting in 2023. Other examples demonstrating cooperation across the WSH unit include JMP and GLAAS establishing, with UNICEF, the Joint Strategic Advisory Group *(73)* of external members to bring in independent, strategic thinking across both thematic areas. The WHO WSH team also continues to convene and participate in the WHO RegNet, established in 2008 as "a global forum to share and promote best practices in regulating drinking-water and sanitation services, with the aim to protect the public's health" *(74)*[22] (noting that sanitation has been more recently introduced, where previously only water was covered).

Neither the KIIs nor the online survey have provided direct responses specifically related to cooperation across the WSH unit. Instead, the emphasis of cooperation is indirectly evident through the Regional Advisors' calls[23] as a mechanism to facilitate synergies across the WSH unit. Regional and country offices respondents also confirmed positive timely and responsive engagement from across the WSH Unit.

Finding 3.8: A range of opportunities exist to enable closer coordination and improve synergies within WHO, including joint resource mobilization, joint training, joint missions and joint planning and programming. Based on Finding 2.8, collaboration of WASH with other WHO units and departments has been successful overall, but there is room for improvement. In response to the online survey and through KIIs, respondents suggested additional ways that WHO can improve coordination and synergies internally. They include promoting coordination and collaboration between departments and other relevant WHO programmes to address the health-environment nexus in WASH programmes; using available resources "in a wise manner" and undertaking joint trainings and missions across other units and departments; co-developing WASH interventions that address specific health issues; encouraging a more holistic approach to WASH interventions through data sharing and integration; and streamlining data collection and analysis to identify trends, gaps and areas requiring greater focus.

Strengthening human resource capacity in country offices and contributing to the joint mobilization of funding for country support were also considered opportunities to enable closer coordination and improved synergies. This included having a well distributed team across WASH activities rather than one person for everything and potential for joint/co-funding and coordinated financing.

Climate change was reported as a thematic area with opportunity for close coordination and improved synergies, given that WASH is one of the four fundamental requirements in climate resilience and that the impact of climate change on health is a major opportunity for WHO.

Finding 3.9: Substantive efforts on improving collaboration across the three levels of the Organization have yielded results. Early in the strategy period, insufficient synchronization between headquarters, regional and country offices planning was identified as a challenge and risk *(75)*. An associated mitigation strategy aimed to have regular, virtual exchanges between headquarters and regional offices about plans and activities, as well as having countries and regions included in team retreats *(69)*. There is substantial documented evidence as

[22] Participation of different members of the WSH team is evident through the summary reports of the RegNet meetings (10th-13th).
[23] Evidence consists of multiple data sources (notes on regional advisor calls; triangulated by KIIs).

reported in subsequent annual reports, WASH retreat notes and Regional Advisor meeting notes on the action taken and level of impact this inclusive approach has had.

However, WHO staff working on WASH consultation *(45)* (2021) highlighted a number of near- and medium-term technical and strategic actions (to be implemented by the end of July and the end of December respectively) in response to listening and learning about WASH challenges and opportunities at the country office level. Technical actions were primarily focused on sharing information and contacts, including the development and sharing of an induction package for WHO country offices and sharing a WHO country office WASH staff list and directory, highlighting country-level accomplishments and launching an internal platform to share material and collaborate. Strategic actions included developing materials that demonstrate WHO's core required actions on WASH across different levels, highlighting the catalytic impact of these efforts. These actions also involved presenting the case for WHO's engagement on WASH at the country level, inviting all WHO staff to subscribe to the WSH newsletter, organizing a briefing meeting with WHO Representatives on WASH initiatives, exploring the potential development of a WSH or WSH/ECH communication strategy, and mobilizing an ECH working group to support resource mobilization.

At the headquarters and regional levels, most regional advisers feel supported across the thematic areas. The documented evidence is largely triangulated by KIIs with several regional offices reporting having regular, almost daily calls with headquarters and vice versa, with one regional office stating "WSH team leading by example maintaining a positive relationship with regional offices". KIs also perceived that regional engagement varies across different topics. For example, there seems to be stronger integration and linkages with AMR, IPC/HCF and WASH in emergencies, compared to areas like malaria, maternal, newborn and child health or cholera. Additionally, the clarity of collaboration established in one region is not always mirrored in other regions.

Overall, country offices expressed generally positive levels of satisfaction with the support they received. The online survey found largely positive satisfaction levels among WHO country office staff (69% satisfied or very satisfied with the support they receive from the regional office), as well as pockets of uncertainty (6% very dissatisfied), primarily due to low levels of financial support, as well as some countries receiving support from a regional office whilst others have not. These results are also mirrored in the country case studies of Ethiopia and the Philippines. For example, the WHO Regional Office for Africa, based in Brazzaville, has a WASH focal point who provides occasional guidance to the Ethiopian WHO country office. However, ongoing technical support is limited and usually occurs in the context of specific initiatives, such as GLAAS data collection, the recent development of updated guidance on WASH in HCF or WASH accounts.

The country office focal point has a direct line of communication with the headquarters WSH team, but progress reports are submitted to the regional office with headquarters in copy to ensure that the regional office is kept informed of country-level developments. The regional office also plays a role in organizing training events.

In the Philippines, coordination with the Western Pacific Regional Office is very good, aided by proximity to the country office in Manila. The Technical Officer has an efficient relationship with staff at WSH headquarters, contacts them directly for advice on water, sanitation, hygiene and climate change and responds to direct requests for information from the WSH team at headquarters. Advice from the Regional Adviser is sought on other issues.

While there is direct, two-way communication between headquarters and country offices, it is questionable to what extent this is an efficient collaboration. Countries recognize that direct support from headquarters is sometimes built on personal relationships. The frequency of engagement varies across countries and regions, especially in regions where there is limited support and resources.[24] This essentially shifts the burden back to headquarters, which is also resource- constrained.

In the annual report 2022, a focus on improving partnership collaboration (see EQ 4 related to Coherence) and across the agency was proposed as being required rather, than strengthening further WASH WHO internal collaboration.

Finding 3.10: There are more examples where activities have been scaled up, as opposed to scaling down potential ineffective activities. Whilst there is no overall systematic tracking of activities and approaches to map what activities and approaches are/should be scaled up or scaled down, there are documented examples. For example, at the global level, plans for and/or achievement of scale-up include responses to Member States' demand for support, JMP, WASH FIT, hand-hygiene activities and COVID-19 responses. Providing training and support for countries (i.e. related to sanitation guidance, Sanitation Safety Planning) *(76)* has also been scaled up when and where resources allow. Using virtual technology to expand training outreach has also enabled country level scale-up (i.e. Viet Nam, WASH in HCF *(69)*, WSP and water quality and safety training and technical support *(77)*). Good collaboration, internally and externally, provides an opportunity to consider what should be scaled up, as does developing a set of case studies (incorporating the monitoring and learning loop).

Regional-level mechanisms for scale-up, according to informants, have included using WHO collaborating centres for training and translation of materials; events that provide a platform to communicate "key evidence-based messages, disseminating norms and guidelines"; and "fostering integration of WASH" *(69)*. The "scaling up of engagement with regulators through RegNet is also a priority channel for disseminating and scaling WHO sanitation guidelines and tools" *(78)*, an aspect that was echoed during KIIs. Furthermore, the Annual Report (2022) highlights that Ethiopia mobilized internal resources to scale up climate resilient WSP implementation. The same report also highlighted that the Eastern Mediterranean Region achieved success in scaling up WASH in HCF, as well as integrating WASH in other programmes.[25]

There is less evidence in relation to the scaling-down of activities, aside from those that are delayed or not scaled up due to resource constraints. There are examples presented within the logframe results (Vol. II, Annex 10) where certain output indicators have been adjusted or stopped, beyond those which have already achieved targets.

Finding 3.11: There were no major concerns reported regarding the timeliness of implementation during the Strategy period, aside from delays caused by COVID-19. These delays were partially offset by the rapid response in preparing related guidance and adapting to virtual methods for development and dissemination. An isolated example mentioned that at times the procurement processes take a long time; in contrast another KI mentioned that the direct communication between country and headquarters is helpful for countries and regional advisors to the extent that one call to headquarters saves one week in researching.

[24] KIIs.
[25] Such as climate change, occupational health and safety, NTDs, IPC, emergencies, health care waste management and integrated management of services for tuberculosis and HIV/AIDs.

4.3.3. ToC summary analysis for EQ 3 – Efficiency

The ToC assumptions for Efficiency partially hold true, as explained in Box 4.

Box 4. Theory of change assessment for EQ 3 – Efficiency

Relevant assumptions underpinning the reworked ToC (see section 3.2) in relation to EQ 3 are as follows:

(3A) WHO teams, units and departments engage internally to achieve synergies.
Assessment: With the available evidence, this assumption partially holds true. There is good engagement and synergy within the WSH Unit and between the WSH team across the three levels of WHO whereas linkages across the units within the ECH Department (and across departments) to achieve synergies vary.

(3B) Collaboration across the three levels of WHO is efficient.
Assessment: The assumption holds partially true. The evidence shows that the collaboration across the three levels is good, and satisfaction levels are also good. However, there is a question about the efficiency of direct linkages between headquarters and country offices when headquarters is also resource constrained.

4.4 Coherence

The evaluation found that, overall, WHO clearly contributes to the SDG 6 Global Acceleration Framework and complements other initiatives in a coherent manner. Coordination and collaboration with external partners are strong at the global level while roles are less clear at the regional and country levels.

The findings presented in this section relate to **EQ 4: How has Strategy implementation complemented or added value to WASH interventions within the global WASH architecture?** The evaluation question was addressed through two subquestions.

- EQ 4.1: How does Strategy implementation contribute to the SDG 6 Global Acceleration Framework and how does it align with and complement initiatives of partners?
- EQ 4.2: How well has WHO coordinated and collaborated in its WASH sector support with partners when implementing the Strategy?

Findings for these two subquestions are presented separately below.

4.4.1. EQ 4.1: How does Strategy implementation contribute to the SDG 6 Global Acceleration Framework and how does it align with and complement initiatives of partners?

This question addresses complementarity with external WASH actors, partners and initiatives within the SDG 6 Global Acceleration Framework at all levels; the complementarity with WHO external health actors, partners and initiatives at all levels; and the added value of WHO's support to WASH and health. The quality of evidence for this evaluation question was generally strong. The key sources of information to answer this question were KIIs, triangulated with documentary evidence, survey responses and the case studies conducted for this evaluation.

Table 15. Summary of key findings related to EQ 4.1

Summary of key findings related to EQ 4.1	Strength of evidence rating
Finding 4.1: WHO has a clear and unique mandate for WASH and health according to its constitution and WHA resolutions. WHO's mandate at global level is well recognized by external WASH stakeholders but is not fully appreciated across WHO and less evident at country level.	Strong
Finding 4.2: WHO adds value by providing global leadership on WASH and Health and actively fulfilling its role as a normative, standard-setting organization.	Strong
Finding 4.3: WHO has played a foundational role in the development of the SDG 6 Global Acceleration Framework and continues to drive forward related initiatives.	Strong
Finding 4.4: External health stakeholders view the WSH team as playing a key role in the prevention and control of communicable diseases. They see WHO as having an important seat at the table, which could be further leveraged for disease prevention through safe WASH services.	Moderate[26]

Finding 4.1: WHO has a clear and unique mandate for WASH and health according to its constitution and WHA resolutions. WHO's mandate at the global level is well recognized by external WASH stakeholders but is not fully appreciated across WHO and less evident at the country level. Sanitation and hygiene are enshrined in the WHO constitution as a key function of the Organization:

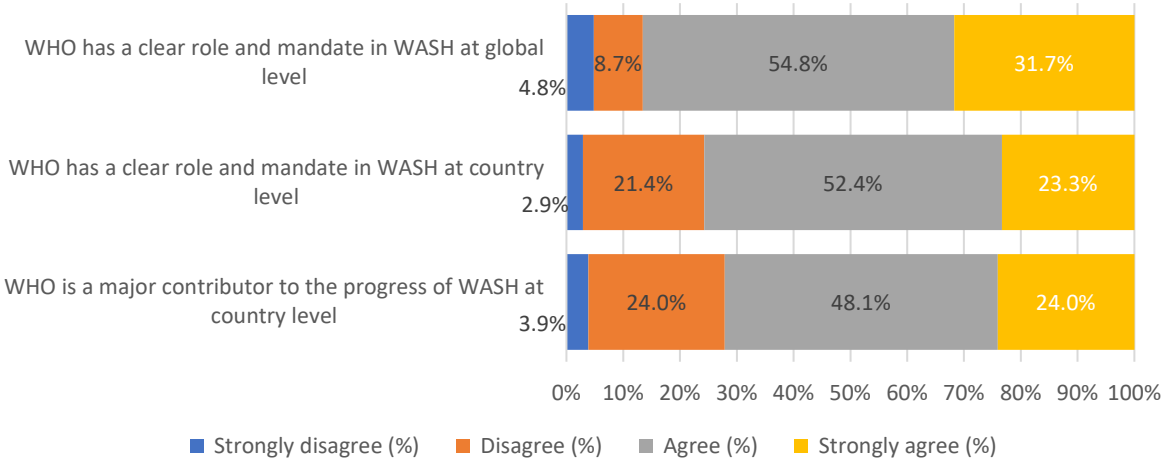
> To promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene. (5)

WHO has a mandate on WASH through the WHA resolution from 2011 *(7)* and specifically for WASH and NTDs through a WHA resolution in 2013 *(8)*. WHO plays a key role in responding to the recent call by the UN Secretary-General for action on WASH in HCF *(6)*.

Survey findings for this evaluation confirm that external WASH stakeholders at country level are appreciative of WHO's mandate on WASH, with 87% of external stakeholders agreeing or strongly agreeing that WHO has a clear role and mandate for WASH at the global level (see Fig. 13). These survey responses are mirrored by KIIs at global and regional levels with external WASH stakeholders from UN, development organizations, civil society and donor partners, who unanimously confirmed WHO's unique role spanning the two sectors of WASH and health. It should be noted that both survey and KII data are biased towards stakeholders that have either directly or indirectly been involved in WHO's WASH work.

[26] The evidence for this finding comes from different stakeholders but is not corroborated across all other health programmes that the WSH team collaborates with.

Fig. 12. External stakeholders view on WHO's role and mandate in WASH



Source: Evaluation survey, capturing the views of non-WHO stakeholders (105 responses).

Leading external stakeholders in the WASH sector and internal WHO KIs articulated that WASH was not a corporate priority within WHO and that there was insufficient internal recognition of WHO's mandate on WASH, which had caused the WASH team in WHO to "suffer" and led to "marginalization" of WASH within WHO.

The decline in human resources (see finding 3.2) and limited core internal funding (see finding 3.1) for WASH over the last decade are also indicative of the lower priority accorded to WASH within WHO. It was noted by both country-level survey respondents and global external and internal interviewees for this evaluation that lack of resources at the country level limited WHO's effectiveness and profile in the sector.

WHO's role and mandate on WASH and health at the country level is less clear than at the global level. As shown in Fig. 13, almost one quarter of non-WHO survey respondents disagreed or strongly disagreed that WHO's role and mandate in WASH at the country level is clear. Furthermore, evidence from some KIIs and WSH consultation with WHO country office WASH staff in 2021 *(45)* indicates that not all WHO country offices fully understand and leverage WHO's mandate on WASH and health.

Evidence from country case studies indicates that WHO's mandate on WASH may not be fully exploited in WHO's country cooperation strategies. The case studies in Ethiopia and the Philippines[27] found that WHO country cooperation strategies do not clearly prioritize WASH beyond cooperation with the health ministry. In the Ethiopia Country Cooperation Strategy, WASH is mentioned as one of seven pillars and under seven specific actions but is not front and centre, despite a high prevalence of NTDs and cholera outbreaks in the country. In the Philippines, there is no current country cooperation strategy, but the previous strategy (2017–2022) refers to WHO's technical support to water and sanitation safety planning and monitoring in WASH without explicitly referring to cross-sectoral collaboration. Internal KIIs confirmed a reluctance of some WHO

[27] See Annexes 11 and 12.

country offices to extend country-level collaboration to ministries beyond the health sector and highlighted the importance of doing so to further WHO's preventative work.

Finding 4.2: WHO adds value by providing global leadership on WASH and health and actively fulfilling its role as a normative, standard-setting organization. There is strong evidence that WHO has actively fulfilled its sector leadership role by influencing and driving the WASH and health agenda over the Strategy period. For example, WHO has been a foundational member of the SDG 6 Global Acceleration Framework (see also finding 4.3, below), which guides the sector's priorities, shaping its content and driving implementation. Another example is WHO's role in calling attention to the topic of WASH in HCF through evidence production combined with global convening. KII data across all global external stakeholders strongly confirm that WHO is actively fulfilling its leadership role in WASH and health. Respondents explained that WHO provided normative authority to the WASH sector by setting standards and harmonizing concepts and measurements that others benefit from, refer to and implement. They pointed to WHO's high-quality guidance based on rigorous, science-based and widely consulted evidence, which gives WHO an authoritative voice in the sector, exemplified in the following quotes from external WASH stakeholders:

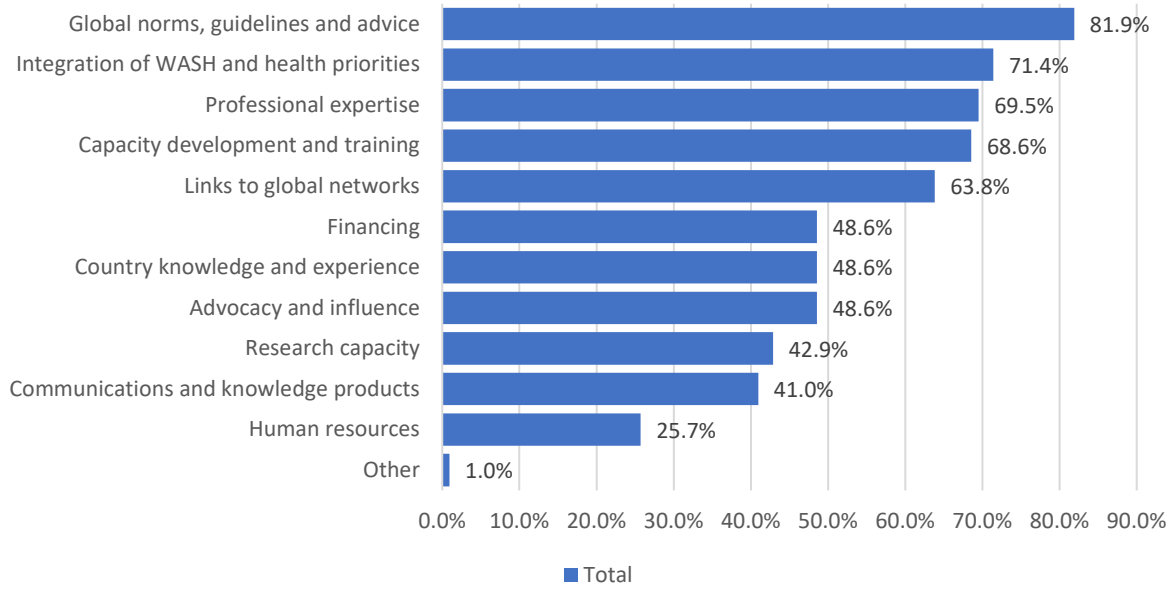
> They have recognition and that makes them able to convene stakeholders in relation to the topics they are mandated for. For example, WHO convenes discussions around water safety planning because they have been leading that. They have not convened groups outside their mandate. They are a very respected partner.

> Among the UN agencies, WHO is probably the leading one, whose voices are most seriously taken. And that is important because there's a lot of competition among the various UN agencies. WHO has always had a long history of doing really high-quality evidence base, guidelines and standards […] there's no hot air with WHO, they are technically sound. WHO is very solid.

WHO WASH partners also explained how WHO, as a standard-setting organization, complements their work. They described WHO as providing an "invisible cast on which the car is built" and as the "scaffolding" guiding their implementation. WASH partners described themselves as bringing "boots on the ground" (e.g., UNICEF and the World Bank have WASH technical staff in many countries) and as providing WHO with access to WASH sector stakeholders at the country level to translate evidence and guidance into practice. WHO internal reflections confirm the Organization's need to lean on WASH sector stakeholders that have a stronger national presence and acknowledge the importance to coordinate and align with them *(71)*. Academic stakeholders valued WHO for its convening power and the weight it brings to their research whilst they provide technical expertise to WHO on specialist subjects.

Survey data mirror the picture at the country level. The main ways WHO adds value to WASH and health at the country level, according to non-WHO survey respondents, are through its normative, standard-setting role (82%), the integration of WASH and health (71%) and professional expertise (70%) and capacity-building support (69%) – as shown in Fig. 13.

Fig. 13 Added value of WHO in WASH and health at country level, according to external stakeholders



Source: Evaluation survey capturing the views of non-WHO stakeholders (105 responses).

Qualitative survey responses elaborate on the "specific role that WHO plays at country level": respondents referred to WHO providing technical support to the adaptation and implementation of guidelines and to advocacy and coordination roles related to WASH sector policies, strategies, regulation, finance and sector coordination. Other topics mentioned frequently are WHO's support to the implementation of global WASH monitoring and surveillance initiatives at the country level, such as GLAAS, JMP or WASH-FIT and WHO's lead role in WASH in HCF and in IPC.

Finding 4.3: WHO has played a foundational role in the development of the SDG 6 Global Acceleration Framework and continues to drive forward related initiatives. As a long-term partner in UN-Water, serving on different task forces and currently holding, through the Unit Head, the role of Vice Chair, WHO has been instrumental in conceptualizing the SDG 6 Global Acceleration Framework by introducing an adapted version of a similar framework used in the health sector. Since its launch in 2020, the Strategy's annual reports *(69, 76, 78)* have documented WHO's consistent engagement with the framework. WHO is centrally engaged in the integrated monitoring initiative on SDG 6, based on its mandate as a co-custodian of several SDG 6-related indicators. This has included promoting relevant initiatives under the framework, the latest being the development of an UN –System-wide Strategy for Water and Sanitation *(79)* and a jointly convened webinar with UNICEF and the World Bank to kickstart the process ('Align to Accelerate') of developing and adopting global indicators for tracking progress in WASH systems strengthening. According to KIIs with external partners, other examples of WHO global initiatives to operationalize the framework include the publication of the State of the World report series on sanitation (2020) *(80)*, hygiene (2021) *(81)* and drinking-water (2022) *(82)*. These reports provided an important basis for implementation initiatives by key partners such as UNICEF's Sanitation Game Plan to reach safely managed sanitation *(18)*.

Finding 4.4: External health stakeholders view the WSH team as playing a key role in the prevention and control of communicable diseases. They see WHO as having an important seat at the table, which could be further leveraged for disease prevention through safe WASH services. WHO's unique mandate on WASH and health makes it an important advocate for the role of WASH in disease prevention, summarized in the publication WASH: a primer for health professionals *(83)*. WHO's guidance, based on extensive technical

knowledge, provides a strong "leverage" for external health actors such as the NTD NGO Network when advocating with governments for implementing preventative measures. The WSH Unit plays an important role in bringing WASH stakeholders to the "health table" to advocate for WASH infrastructure in disease endemic areas and in relation to AMR. As one stakeholder said:

> WASH infrastructure is critical, and AMR could be seen as one of the indicators so, the WSH team should be also willing to exploit that strengthening WASH will significantly impact the AMR response.

A recent meeting of the GTFCC WASH group highlighted the need for strong advocacy for WASH infrastructure for cholera prevention and control *(84)* and pointed to the need for stronger involvement from the side of WASH implementation partners and national governments in cholera discussions. KIIs also indicate the need to think through a multiple-disease lens as the same communities affected by cholera may be affected by other diseases caused by limited access to safe WASH services and/or AMR and/or be affected by humanitarian crises. Consecutive WSH annual reports identify an opportunity for WSH to look at WASH through a multiple-disease lens and to further advocate for the crucial role of WASH in HCF to enable health settings to continue providing health services rather than becoming a source of infection.

4.4.2. EQ 4.2: How well has WHO coordinated and collaborated in its WASH sector support with partners when implementing the Strategy?

This EQ considers key partnerships and coordination platforms with different types of WASH stakeholders at the global level and collaboration with partners, health ministries and other departments at the national level. The quality of evidence for this finding is generally strong, based on KIIs and survey responses triangulated with document review and case studies.

Table 16. Summary of key findings related to EQ 4.2

Summary of key findings related to EQ 4.2	Strength of evidence rating
Finding 4.5: At the global level, WHO has developed a strong partnership with UNICEF that harnesses both agencies' strengths.	Strong
Finding 4.6: At the global level, WHO has a wide range of other key collaborators (academia, funding partners, UN agencies, NGOs, networks, multi-agency partnerships) and works effectively with them along a cycle of evidence production – norm development – global advocacy – dissemination – support for uptake and monitoring. Yet there is scope for more strategic engagement with the World Bank and for making more use of WHO collaborating centres.	Strong
Finding 4.7: At the regional level, WHO collaboration with partners is variable, with room for more clarity on the division of roles between UNICEF and WHO.	Strong
Finding 4.8: At the country level, WHO collaborates closely with health ministries on WASH. However, further cross-sector support is constrained by the level of human resources and funding available and not prioritized in country cooperation strategies.	Strong

Summary of key findings related to EQ 4.2	Strength of evidence rating
Finding 4.9: At the country level, UNICEF is WHO's critical partner, but the level of collaboration and clarity of respective roles varies depending on context.	Moderate[28]
Finding 4.10: There are opportunities for WHO to play a more active role in WASH sector coordination and in the integration of WASH and health at the country level.	Strong

Finding 4.5 At the global level, WHO has developed a strong partnership with UNICEF that effectively leverages the strengths of both agencies. The relationship between the two organizations is formalized through an agency-wide collaborative framework developed in 2020 *(85)*, but, according to KIIs, this formal agreement is predated and complemented by strong informal collaboration between the WASH sections in both agencies and a longstanding formalized collaboration under the JMP *(86)*. The close working relationship between UNICEF and WHO is enabled by the fact that both WASH teams are structured in similar ways, which makes it easy for team members to autonomously collaborate on specific areas of work. At the global level, the division of roles between the two agencies is clear overall; when there is need for role clarification, this is informally agreed upon, e.g., there is an understanding that UNICEF leads on the topic of "WASH in schools" whilst WHO leads on WASH in HCF; in IPC, UNICEF takes a lead on "IPC in communities" whilst WHO leads on "IPC in health care settings". Generally, according to KIIs, the two organizations divide the work by mandate and according to the availability of staff and resources to work on a topic.

The collaboration between WHO and UNICEF spans strategic and technical levels, creating a robust partnership, which allows the two agencies to mutually benefit from each other's strengths. On the technical side, the agencies have strengthened collaboration across several fields over the Strategy period, including in the areas of public health emergencies, HCF, sanitation, monitoring, and incorporating climate change into existing areas of work. An example of excellent technical collaboration is the global monitoring of SDGs 6.1 and 6.2 under the JMP. The JMP operates through an equal and transparent partnership, based on an equal allocation of staff to the programme by both agencies, a joint strategy *(87)* and related annual workplans and budgets that are executed through regular retreats, joint missions, workshops, conference attendance and publications, according to internal KIIs. The work is guided by a strategic advisory committee, co-chaired by UNICEF and WHO. The agencies' more recent collaboration for GLAAS follows a similar model.

Internal KIs explained that collaboration at the global level works well because the "space is clear on both sides" – the two organizations complement each other, with WHO leading on the normative side and UNICEF on implementation. There is strong evidence that the two organizations have played to each other's strength over the Strategy period. One internal KII described their collaboration as a "playbook" of data and evidence complemented by convening and global advocacy and followed by implementation and monitoring. This playbook is evident in the publications of the State of the World reports and related implementation initiatives but also in the collaboration on HCFs. For example, the State of the World's sanitation report provided a global evidence base, complemented by WHO's technical sanitation and health guidelines *(88)*, with UNICEF's Sanitation Game Plan as an operational tool. The division of labour involves WHO providing technical expertise, such as advisory input on UNICEF's Sanitation Game Plan and guidance on safely managed on-site

[28] Only some KII stakeholder and survey responses confirm this finding, and it is likely to be context specific.

sanitation. UNICEF leverages its extensive country presence to support government adoption and implementation of the Sanitation Game Plan.

Finding 4.6: At the global level, WHO collaborates with a broad range of key partners, including academia, funding organizations, UN agencies, NGOs and networks/partnerships, working effectively across a cycle of evidence generation, norm development, global advocacy, dissemination, uptake support and monitoring. However, there remains potential for more strategic engagement with the World Bank and greater utilization of WHO collaborating centres. Beyond its strong collaboration with UNICEF, the WHO WSH team collaborates with a large and diverse set of external stakeholders to effectively fulfil its mandate of WASH and Health. Collaboration often extends across different **divisions** of the same organization on different topics and involves informal cooperation alongside formal collaboration structures. **It** typically involves multiple agencies and organizations often centred on a specific topic or initiative.

KII respondents from across all groups of partners see WHO as a strong collaborator, not least because the WSH team at WHO is regarded as friendly and accessible, which is reported to enable fruitful collaboration. Many KIs across stakeholder groups highlighted their amicable and constructive working relationship with the team at WHO. One person referred to the working relationship as a "family forum" and "safe space", others characterized the team as "inclusive" and "accessible". One respondent summarized the relationship as follows: "When there are roadblocks or challenges, in any of the work, we come to it with a mutual understanding that we have a shared goal."

Table 17 provides an overview of collaboration partners and areas to demonstrate the breadth and depth of the collaborative relationships that WHO has. Specific aspects of WHO's collaboration are presented below the table, zooming in on individual collaborator groups.

Table 17. Overview of WHO WASH collaboration types, partners and areas

Types of collaborators	Example of key partners	Areas of collaboration
Academia/collaborating centres	UNC-Water, University of Bristol, The London School of Hygiene and Tropical Medicine, Swiss Federal Institute of Aquatic Science and Technology, Department of Sanitation, Water and Solid Waste for Development, Emory University, PUB Singapore, KWR Water Research Institute, NSF The Public Health and Safety Organization	Evidence production, development and update of standards and technical guidelines, strategic direction, dissemination and training
Funding partners and banks	French Development Agency, Bill & Melinda Gates Foundation, Australia Department of Foreign Affairs and Trade, Netherlands Directorate-General for International Cooperation, UK Foreign, Commonwealth and	Funding of key WHO WASH areas of work

	Development Office, The Swedish International Development Cooperation Agency, U.S. Agency for International Development	
UN agencies and the World Bank	UNICEF, UN-Habitat, UNEP, UN-Water, FAO, International Labour Organization, Sanitation and Hygiene Fund, World Bank	Advocacy, dissemination, training, monitoring, implementation at country level
Networks and member-based organizations	IWA, NTD NGO Network, SWA, Rural Water Supply Network	Production of practical guidelines, advocacy, dissemination, training, implementation at country level and monitoring
NGOs/think tanks	WaterAid, World Vision, IRC-WASH, SIWI	Advocacy, dissemination, implementation at country level
Multi-agency partnerships	GTFCC, NGO NTD Network	Advocacy, dissemination, training, monitoring, implementation at country level

***Academia and collaborating centres*:** WHO's work combines fruitful formal and informal cooperation depending on the topic and partner. WHO works with a range of academic organizations and 13 officially designated collaborating centres related to water and sanitation based in different regions of the world *(89)*. Collaborating centres include both research institutes and public-facing organizations, such as the utility Public Utilities Board in Singapore (Singapore's National Water Agency), which brings its practical expertise. According to KIIs, many collaborations are longstanding and involve a formal element specified through terms of reference, as well as informal collaboration to exchange knowledge or to provide a sounding board. KIIs characterized the collaboration structure as flexible, allowing them to "shift gears" when necessary, for example in the case of the COVID-19 pandemic calling for more research on environmental surveillance or on health care waste generation from PPE during the pandemic. While the focus of collaborations with academic partners is on the production of evidence and support to developing global guidelines and standards, including for monitoring, some are also involved in dissemination, training and practical application of global guidance. Some external informants expressed a desire for collaborating centres to be involved more than they currently are.

When it comes to evidence production, KIs discussed a tendency in the WASH sector to become an "echo chamber" because of scientific perspectives of a narrow group of experts in the sector. However, WHO was seen as actively working to overcome this here. An example given was the latest round of the global WASH-attributable burden of disease review.

A second challenge related to evidence production brought up by one KII is that in academia there is a tendency to work in silos when working on food and water safety, for example. Combining both strands of work under a single collaborating centre was suggested as a strategy to overcome silos. Another KI proposed that establishing a network of collaborating centres could also help address this issue, similar to the approach taken for WHO's work on AMR surveillance *(90)*.

WHO maintains a constructive relationship with a core set of *funders/development partners*. It collaborates with donors on a wide range of topics broadly related to joint areas of interest. For example, the collaboration with Global Water 2020 focuses on WASH in HCF, while the work funded by the French Development Agency

(AFD) has a geographical focus on French-speaking countries in the Sahel region. WHO is seen as regularly updating partners on areas of collaboration and as being accessible and constructive. Despite maintaining cordial and constructive relationships, there is a downward trend in funding among WHO's core partners due to a variety of external factors (see also Table 13 in finding 3.4 and ToC assumption 4C).

Among UN agencies, WHO's collaboration with UNICEF is closest. Other partnerships tend to evolve around specific topics. As explained in finding 4.5, WHO and UNICEF have a strong and effective partnership. WHO also closely collaborates with UN-Water around the coordination of the SDG 6 acceleration framework, taking on a leadership role (see finding 4.3). Collaboration with other UN agencies focuses on relevant topics of mutual interest such as the Integrated Monitoring Initiative with the Food and Agriculture Organization (FAO) and UN-Habitat and work on AMR, with FAO, UNEP and other stakeholders, including an emerging collaboration with UNDP.

Currently, WHO's collaboration with the World Bank, a major WASH infrastructure stakeholder, is focused on specific topics, and there is scope for deepening and widening the relationship. The collaboration is largely informal but is supported by a ToR in which the World Bank plays a formal role on the Strategic Advisory Group for the JMP/GLAAS. The engagement between the two agencies is strongest on WASH in HCF; other thematic areas of collaboration include the GTFCC. Since the COVID-19 pandemic, both partners have started to think more strategically about this collaboration. KIs in both organizations suggest that there is room for deepening collaboration across existing areas of work, such as using data for identifying areas in need of WASH infrastructure in the context of other health programmes such as nutrition, NTDs and cholera or collaborating on capacity-building and supporting networks of regulators. At the country level in the Philippines, there is no current collaboration with the Asian Development Bank. However, opportunities for collaboration have been identified in areas such as water and sanitation regulatory system-strengthening, climate change and WASH accounts.

WHO also collaborates effectively with NGOs, think tanks and networks based on partner mandates. Key partners are WaterAid and World Vision, member-based WASH organizations (Rural Water Supply Network, IWA) and think tanks (Stockholm International Water Institute, IRC-WASH). The nature of collaboration depends on the degree of overlap in mandates, objectives and the relative advantages that each partner brings. All partners reported that the relationship is constructive, beneficial and complementary, often involving the co-production of evidence, co-hosting of events and joint advocacy work. For example, WHO's collaboration with IWA involves the co-production of guidance, such as water safety planning, and joint organization of events and co-hosting an online platform on the same topic. The partnership is seen as "symbiotic", whereby both organizations share values but bring different strengths, with IWA being able to reach a large network of researchers and practitioners through sector-specialist journals and events.

WHO effectively advances specific topics through multi-agency partnerships. These partnerships encompass a wide range of issues and involve both internal and external collaboration. For example, on WASH and NTDs, the WSH team works internally with the NTD team in WHO and externally with the NGO NTD Network, according to external KIIs. Products are developed jointly and launched on different sector platforms (see also Box 5). Other initiatives involving multiple agencies include WASH and AMR, the GTFCC and the Sanitation Workers' Initiative. A notable example of effective internal and external collaboration is the WASH in HCF initiative. This work was temporarily supported by a global task force and continues to receive backing from a Group of Friends to enhance global advocacy efforts (see Box 5).

Box 5. Examples of joint WASH-related implementation initiatives/approaches

WASH and NTDs

WSH and NTD teams at WHO work closely with the WASH and NTDs working group of the NGO NTD Network. The cross-cutting working group has around 40 members, mostly from NGOs but also academia and health ministries. Products are co-developed and launched at relevant sector platforms. For example, the WASH and NTD toolkit of 2019 *(51)* was launched through the WASH sector platform Susana as well as through a large NTD programme called ASCEND. The toolkit was updated in 2023 and supplemented in 2024 by an ongoing series of case studies *(91)*. The NGO NTD Network and WHO also hold joint sessions at global conferences, both annual or one-off, e.g., at UNC Water and Health, World Water Week and All Systems Connect.

WASH and AMR

The collaboration on AMR was originally a tripartite relationship that evolved into a quadripartite collaboration between WHO, FAO, United Nations Environment Programme (UNEP) and World Organization for Animal Health. Under the initiative, the agencies jointly prepared a technical paper in 2020 *(92)*, which led to a multipartner trust fund for global political advocacy, awareness-raising and capacity-building on the topic *(78)*.

WASH and HCFs

WSH's successful advancement of WASH in HCF is based on effective internal and external collaboration. Externally, a key partner is UNICEF; other partners include the World Bank, World Vision, WaterAid and Global Water 2020. Between 2020 and 2023, the collaboration was also supported by a global task force comprising 30 key partners and thought leaders. The task force provided input on global strategic direction and coordination and allowed for information exchange and dialogue, which has been critical to the development of the WASH in HCF approach. A UN Group of Friends in support of WASH in HCF was established in 2021. Co-chaired by the Philippines and Hungary, the Group of Friends aims to generate commitment and accountability amongst peer countries on the WHA resolution of 2019 and coordinate the issue across UN organizations and related UN thematic priorities *(93)*. Further developments in 2024 include the launch of a new global framework for action.

Finding 4.7: At the regional level, WHO collaboration with partners is variable, with room for more clarity of the division of roles between UNICEF and WHO. At the regional level, the strength of WHO's collaboration is not as consistent as at the global level, an observation shared by WHO internal and external KIIs. WHO's collaboration with UNICEF is mixed across regions, not helped by the fact that the two agencies cover different regions. Examples mentioned were WASH in HCF and GLAAS. WHO internal reflections confirm a variable relationship at the regional level and point to a potential for more strategic coordination and cooperation *(71, 94)*.

The variability in collaboration with WHO at the regional level is reflected by external stakeholder groups, including academia, NGOs and other UN agencies. In some regions and on certain topics, collaborations work well, while in others, they struggle.

According to KIIs, the intensity of collaboration can depend on individuals as well as different regional denominations across organizations. An example where more consistent collaboration would be particularly

beneficial is the work on WASH and NTDs in the African region, where NTDs are highly prevalent. There is reportedly no regional-level collaboration with the World Bank.

Regional mechanisms directly supported by WHO's global WSH team are positive outliers. For example, external stakeholders report that WHO's collaboration with the African Ministers Council on Water on the African Sanitation Policy Guidelines is strong, and collaboration under the Sahel Alliance is seen as fruitful by external KIIs. The collaboration with RegNet and its regional member groupings, such as ESAWAS, the regulator's association for eastern and southern Africa, is also reportedly effective.

Finding 4.8: At country level, WHO collaborates closely with health ministries on WASH; further cross-sector support is constrained by the level of human resources and funding available.

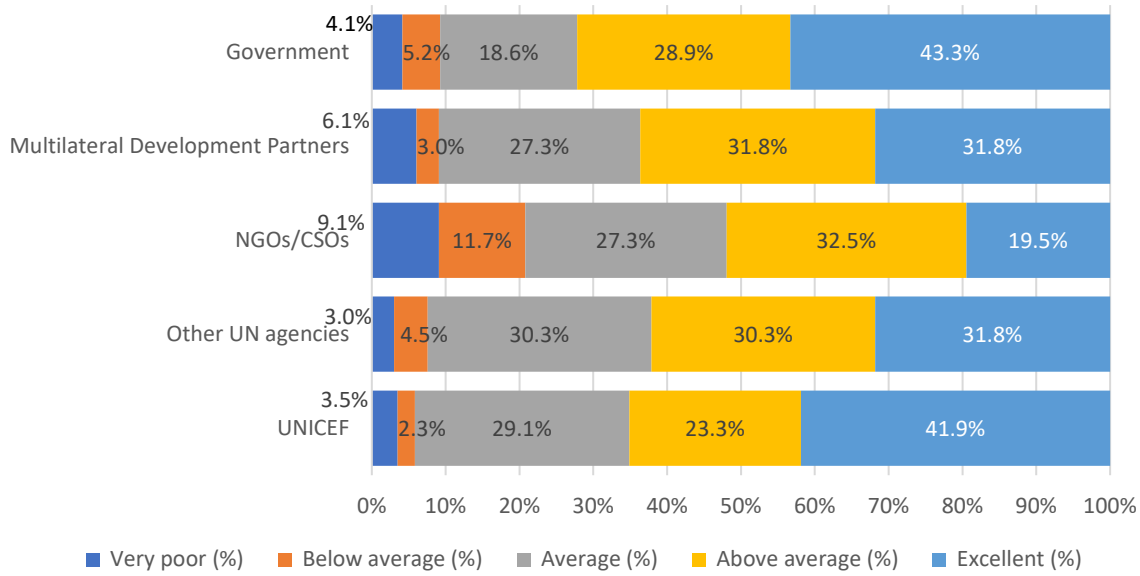
Insights from interviews with stakeholders in Belize, Ethiopia, the Islamic Republic of Iran, Nepal, the Philippines and Ukraine found that the key government contact for WHO at country level is the health ministry. KIIs, country case studies and qualitative survey responses revealed that WASH focal points in WHO country offices can be constrained from exercising a more pro-active convening role on WASH by a lack of funding and mandate recognition. Qualitative survey responses indicate a variability in support to cross-sector collaboration on WASH, and funding is cited several times as a key constraint for country offices. In Ethiopia, the WASH focal point did not even have resources for holding meetings; this may also relate to the lack of inclusion of WASH in the Ethiopia WHO cooperation strategy (see finding 4.1). Across WHO country offices, 158 had an environmental health officer in post (see Table 1, Section 1.2), of which some actively engage in WASH – the exact number is not known and not controlled by the WSH Unit.

However, there were examples of collaboration of the WHO environmental health officer extending to other line ministries, depending on specific aspects of WASH that are supported at country level. For example, in the Islamic Republic of Iran, WHO collaborates with the ministry of agriculture and other relevant stakeholders on sanitation safety planning. In Nepal, WHO supports the ministry of water supply on the topics of water quality and water safety planning through inputs into key sector documents and through training of service providers. In Ukraine, WHO supports the health line ministry in conducting an inter-ministerial policy dialogue on the adoption of the most recent European drinking-water quality guidelines. In Ethiopia and the Philippines, collaboration also extended beyond the health ministries.

There are opportunities for WHO to play a more active role in WASH sector coordination and in the integration of WASH and health at country level. Whilst WHO is seen as a leading and influential advocate for WASH at global level, this was not observed to be the case at country level in the two country case studies. For example, WHO contributes to national WASH sector coordination mechanisms in Ethiopia and the Philippines but is not seen as playing a leading role. Survey responses indicate a demand for WHO taking a more pro-active role: when asked to suggest opportunities for closer cooperation within and beyond WHO at country level, almost all responses referred to WHO needing to coordinate more with external partners. Suggestions ranged from a more active participation in existing sector coordination mechanisms over taking on a leadership role in such fora on specific topics, to supporting intersectoral cooperation in WASH for health and to effectively engage with other UN agencies, local CSOs that support service delivery and with academia. Several respondents also referred to the need for improved financial and human resources to enable WHO to play a significant role in the national WASH sector highlighting, for example, that "without a designated programme officer […] there won't be any work done around WASH".

Finding 4.9 At country level, UNICEF is WHO's critical partner, but the level of collaboration and clarity of their respective roles varies depending on context. Survey responses from non-WHO stakeholders show that 65% rate WHO's relationship with UNICEF at country level as excellent or above average (see Fig. 14).

Fig. 14. WHO coordination and collaboration with partners in its WASH sector support at country level as reported by non-WHO stakeholders



Source: Evaluation survey capturing the views of non-WHO stakeholders (105 respondents).

Country level informants from Nepal, the Philippines and Ethiopia reported a "good partnership for WASH" between UNICEF and WHO. In some contexts, the roles between the two agencies are clear but collaboration could be deeper. In the Philippines, the evaluation found that there is mutual respect between the two agencies, with WHO having a longer track record of working with the government on WASH and UNICEF coming in more recently, after typhoon Haiyan in 2016. However, since COVID-19, the collaboration reportedly stalled, and the relationship has waned. In Ethiopia, relations between the two agencies are cordial but the collaboration is not formally structured. Thematically, the two agencies primarily collaborate on WASH and HCFs and HH4A. UNICEF looks to WHO as a technical expert and WHO relies on UNICEF for essential funding support, e.g., for printing manuals and holding national level training and orientation, which they jointly organize.

Qualitative survey answers point to an overlap in mandate between UNICEF and WHO in some country contexts. One example refers to a situation where WHO is perceived to hold the mandate on supporting water quality monitoring at country level but, because of a lack of funding, relies on UNICEF support. This leads to a situation where UNICEF and WHO appear to be "either duplicating or fighting over space" and consequently to a challenge in presenting the UN organizations as a unified front. The lack of mandate and role clarity at country level was confirmed by several UNICEF KIIs who point out that "there is scope for a bit of mandate clarification across both agencies, especially with all collaboration that is happening now". Thematic examples provided by KIIs referred to WASH in HCF and WASH in emergencies and some situations where there was a clear imbalance in the financial and human resources in WASH between the two agencies.

4.4.3. ToC summary analysis for EQ 4 – Coherence

The ToC assumptions for Coherence partially hold true, as explained in Box 6.

Box 6. Theory of change assessment for EQ 4 – Coherence

The following assumptions in the ToC relate to coherence.

(4A) Governments are motivated to align with SDGs (including SDG 6).
Assessment: This assumption is confirmed, but there is still need for active alignment. Member States (193) agreed to the SDGs at the SDG summit in September 2015. Seventy-eight national governments are "partners" in the UN-hosted Sanitation and Water for All partnership *(95)*. WHO tracks the number of countries aligning their national targets with WHO standards on safe management of drinking water (78) and of excreta along the sanitation chain (36).

(4B) Donor strategic objectives and Strategy are aligned.
Assessment: This assumption holds partially true. There has historically been strong alignment between strategic objectives of key donors to WSH and the Strategy, but several key donors (BMGF, DGIS) are undergoing or expect to undergo a revision of their global development cooperation objectives, with potential resource implications in the short to medium term. There is also a global shift of development assistance funding towards climate-related work.

(4C) Sufficient collaboration structures exist between WHO and partners (WASH and health sector).
Assessment: This assumption generally holds true. There are formal and informal collaboration arrangements with WASH partners and established structures for specific health-related initiatives, such as AMR, NTDs and GTFCC, to which WSH actively contributes. Other health topics, e.g., nutrition or malaria, also have dedicated WASH related programmes or initiatives, but the evaluation did not establish to which extent WSH engages with them.

4.5 Sustainability

Overall, the evaluation found that WHO WASH efforts to support an enabling environment for sustainable health gains have been stepped up. Embedding WASH approaches and tools further in national strategies and systems and in partners' approaches will enhance sustainability.

The findings presented in this section relate to **EQ 5: To what extent is the Strategy and its associated activities promoting sustainability?** This evaluation question is addressed through two subquestions:

- EQ 5.1: To what extent is the Strategy and its implementation supporting an enabling environment for sustainable health gains?
- EQ 5.2: To what extent have WASH approaches and tools promoted via the Strategy been embedded in national strategies and systems as well as in the strategies and approaches of major development partners?

4.5.1. EQ 5.1: To what extent is the Strategy and its implementation supporting an enabling environment for sustainable health gains?

This subquestion specifically considers WHO's advocacy and communications and WASH capacity-building efforts to support Strategy implementation.

Table 18. Summary of key findings related to EQ 5.1

Summary of key findings related to EQ 5.1	Strength of evidence rating
Finding 5.1: Advocacy and communication activities have been scaled up in recent years with the introduction of new tools/new approaches being applied and the publication of certain documents.	Strong
Finding 5.2: Some pre-existing advocacy and communication modalities could be improved and enhanced in terms of timeliness and/or application.	Strong / moderate
Finding 5.3: Internal advocacy and communication (about WASH) could be strengthened across WHO more broadly.	Strong
Finding 5.4: There has been a strong training and capacity-building focus, particularly in recent years, across a number of thematic areas, countries and regions and via new approaches.	Strong
Finding 5.5: Informants and survey respondents suggest continued demand for training.	Strong / moderate

Finding 5.1. Advocacy and communication activities have been scaled up in recent years with the introduction of new tools/new approaches being applied and the publication of certain documents. In recent years, new WASH related portals have been set up that provide a mechanism for advocacy and communication as well as training and learning. For example, the Hand Hygiene portal *(96)*, WASH in HCF *(97)*, GLAAS data portal *(35)*, RegNet SharePoint portal, Water Safety portal *(32)*, Sanitation Safety Planning and internal WASH 3-Level SharePoint Repository. In addition, other existing portals have been enhanced and updated such as the JMP portal *(34)*.

According to survey respondents, the web-based portals are being accessed by a large percentage of both WHO and non-WHO respondents (Fig. 15 and its source, Evaluation survey capturing the views of WHO (103 respondents).

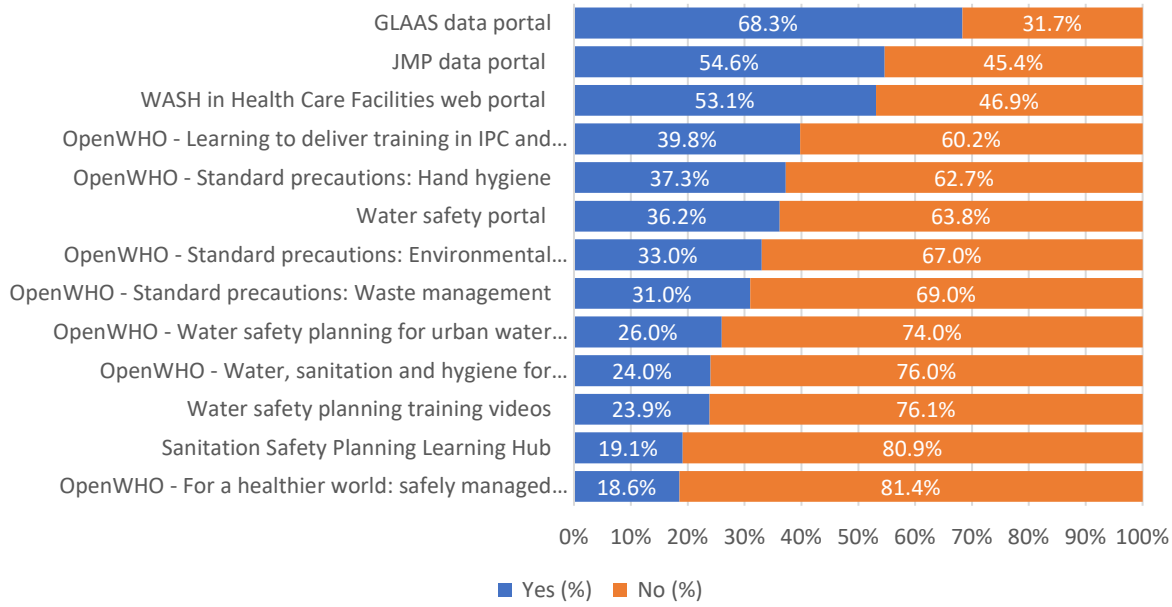
Fig. 6

Another advocacy tool is the State of the World reports for sanitation (2020), hand hygiene (2021) and drinking water (2022) *(80-82)*. Published in partnership with UNICEF and the World Bank in the case of drinking-water and launched at high-profile events such as UNGA as well as dedicated sessions with WCOs, the reports go beyond other global reports to outline the extent of the challenges and offer examples of best practices and successes along with actions that governments and development partners should take to accelerate progress to achieve the related SDG 6 targets.

> "Comprehensive surveys of the links between water, health and development, with actionable recommendations" *(82)*. These types of assessments "are invaluable from an advocacy standpoint."[29]

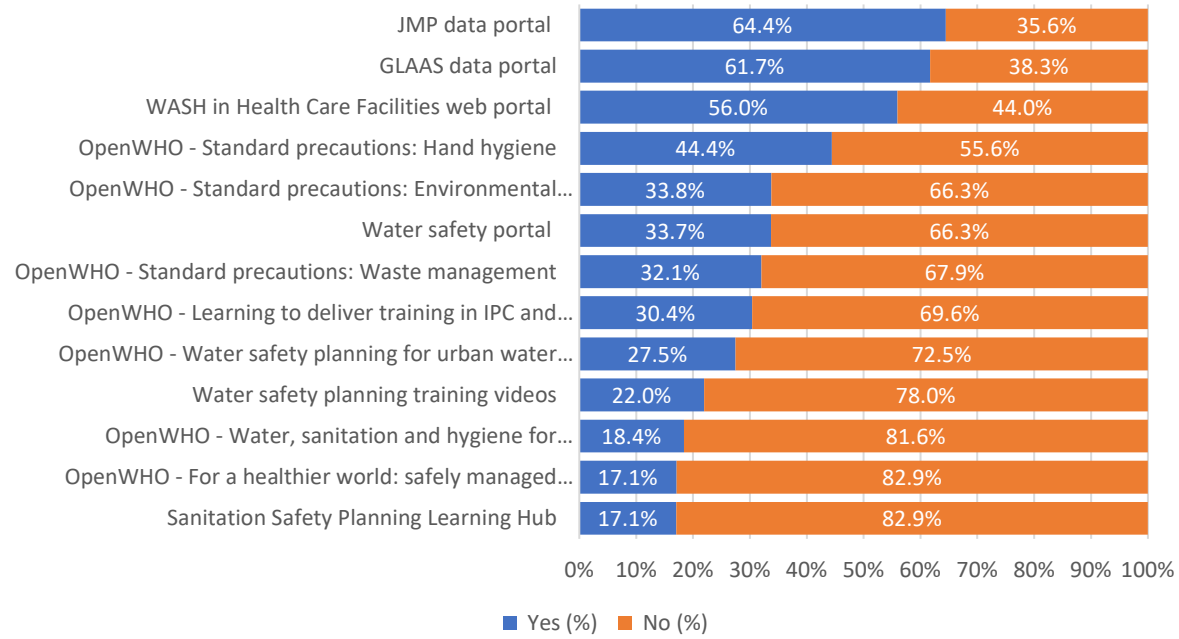
[29] KII.

Fig. 15. WHO respondent accessing online training or information hubs



Source: Evaluation survey capturing the views of WHO (103 respondents).

Fig. 16. Non-WHO respondents accessing online training or information hubs

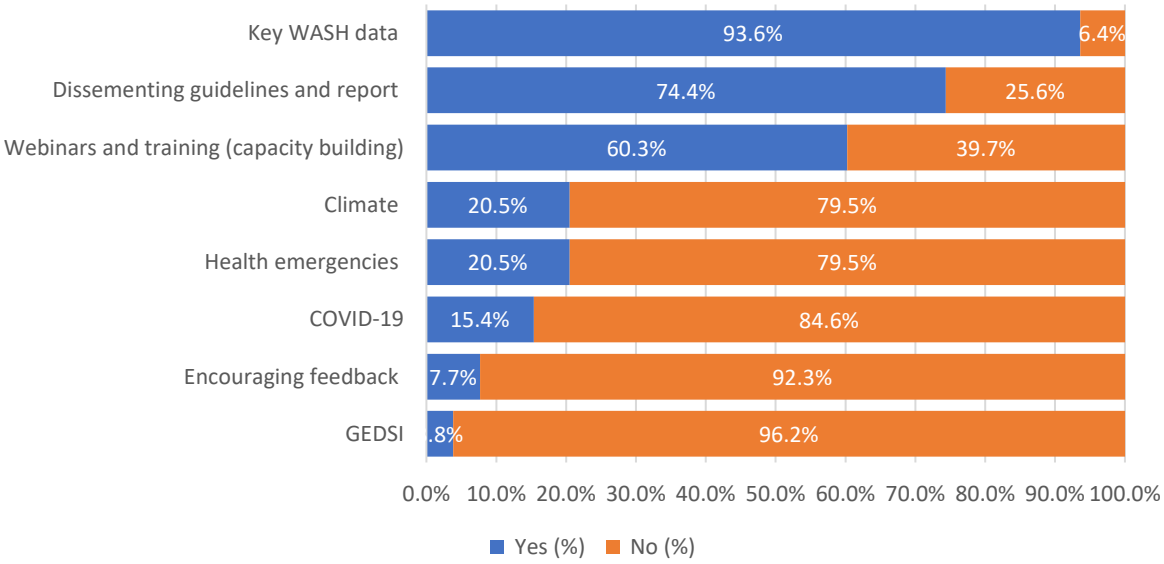


Source: Evaluation survey capturing the views of WHO (105 respondents).

More specific activities related to advocacy and communication are WASH newsletters focussing on WHO's own activities, which were introduced prior to the WASH Strategy. Analysis of newsletters from June 2021 to March 2024 demonstrates the promotion and dissemination of information on a number of topics (Fig. 17),

such as key WASH data, WASH webinars and capacity-building, and guidelines and reports. However, the newsletters have less focus on covering other topics such as GEDSI, climate change and other health topics (Ebola, AMR, NTDs).

Fig. 17. Frequency with which topics are covered in WASH newsletters (2021–2024)



Source: Evaluation analysis of 78 WHO WASH newsletters from June 2021 to March 2024.

Finding 5.2. Some existing advocacy and communication practices could be improved in terms of timeliness and practical application. Guidelines and other documents are translated into various languages – with delays, however. In 2021, this issue was noted as an action point during the WSH team annual meeting: to improve the translation of documents through engaging with academia and collaborating centres *(41)*. At the same meeting, a number of other action points around advocacy were also noted, such as to develop an advocacy package to raise awareness at country and WHO representative level around WASH and health linkages; to organize a channel for sharing information and publications across regions and countries; to develop guidelines for promoting publications for actions at each level; and to prepare a list of global WASH events and related "learning events". WSH has indicated that multiple actions were subsequently taken including, amongst other things: development of a country office support package; introduction of self-paced learning modules; and bespoke webinars with UNICEF and other partners. Regional summits, rarely convened, offer another modality/platform bringing together both the technical and political side and are considered to be more impactful than global events *(98)*.

Findings 5.3 Internal advocacy and communication (about WASH) could be strengthened across WHO more broadly. A specific (rhetorical) question raised by one external respondent was "Is WHO purely a health organization or are they broader?" The respondent went on to mention that the WASH sector could do more in terms of reaching out and integrating beyond its core components *(98)*. Other respondents also mentioned that there was still some uncertainty as to whether WASH was within the mandate of WHO. This highlights a need, and in turn provides an opportunity, to communicate about WASH in a way that emphasizes its role as a foundational element of any society, with strong linkages to health. As reported by the findings under EQ 3, WSH receives a limited allocation of WHO core funding, despite documents demonstrating the integral link of WASH and health *(83)*, which suggests that internal advocacy and communication within WHO are still needed,

especially among WHO representatives and regional directors/directors of programme management who have decentralized power to influence budget allocation at country and regional levels .

Finding 5.4. There has been a strong training and capacity-building focus, particularly in recent years across a number of thematic areas, countries and regions and via new approaches. There is a renewed focus on training and communications with the recent recruitment of a consultant to focus specifically on these aspects as well as cross-cutting work. As reported above, new online portals are in existence which provide not only an opportunity for advocacy and communication, but also a modality/platform for training and capacity development. However, there is limited consolidated analysis of the extent of activities related to capacity-building at regional or country level, including the nuanced needs.

> "Where there is continued need for work and engagement with country level is helping countries understand the more detailed nuances of the guidelines, and what is the difference between a guideline and a standard and how do you adopt standards in your country. That is different country to country, not something you can do from Geneva, but something you can support on country level."
>
> KI respondent

Another relatively recently activated modality for training is the Open WHO courses. The online learning platform was initially launched in 2017 by the Learning and Capacity Development Unit in the WHO Health Emergencies Programme *(99)*, yet exploring options for an agreed platform for e-learning training modules (including Open WHO) was raised as an action for follow-up at the WSH virtual retreat in February 2021 *(41)*. Members of the WSH team have also contributed to the development of courses such as Hand Hygiene, Cleaning and Disinfection and Waste Management. In September 2024 a further two courses were also in the process of being launched: Water and Sanitation for Health Facility Improvement Tool (WASH FIT) for improved quality of care; and WASH and antimicrobial resistance in the environment. This gives the unit six distinct courses and allows for the creation of a dedicated WASH Channel on the platform, which in itself supports enhanced visibility. The other WASH-specific courses include those on sanitation safety planning, WASH and NTDs, WASH and GEDSI in HCFs, and urban water safety planning.

Whilst the responses to the online survey suggest a limited number accessing the courses (see Fig. 15 and Fig. 16), the Open WHO data analytics suggests a different picture (Table 19). It is worth noting that in most cases the professional affiliation reported in Open WHO is either student, medical organization, volunteer, health ministry professional or non-governmental organization (i.e., non-WHO), with minimal participation of WHO staff.
The top three most accessed Open WHO courses[30] are closely aligned across both WHO and non-WHO respondents (see Box 7).

Box 7. Top 3 prioritized thematic areas since 2018

WHO respondents
1. Drinking water quality and safety
2. WASH and waste management in health care settings
3. Hand hygiene

Non-WHO respondents
1. Drinking water quality and safety
2. Hand hygiene
3. WASH and waste management in health care settings

Source: Evaluation survey question 6

[30] **WHO prioritized** "Learning to deliver training in IPC and environmental cleaning for health care facilities in low-and-middle-income countries" (40%); "Standard precautions: hand hygiene" (37%) and "Standard precautions: environmental cleaning and disinfection'"(33%), whereas **non-WHO prioritized** "Standard precautions: hand hygiene" (44%) and

Table 19. Data analytics for a selection of three Open WHO courses

Open WHO course (June 2024)		Enrolments	Activity	Certificates
For a healthier world: safely managed sanitation (as of 17 June 2024)				
Course started	18 November 2022	5 416	4 235 (78%)	2 061 (38% / 49%)
Top 5 country users	India (16%), China (10%), Nigeria (7%), Philippines (7%), Egypt (6%)			
Top 5 professional affiliations	Student, medical organization, other, volunteer, health ministry or health professional, i.e., clinician, nurse, midwife or pharmacist			
Water, sanitation and hygiene for the prevention and care of neglected tropical diseases (as of 17 June 2024)				
Course started	22 September 2023	8 513	6 951 (82%)	4 096 (48% / 59%)
Top 5 country users	India (15%), Nigeria (9%), Kenya (7%), China (6%), Ethiopia (6%)			
Top 5 professional affiliations	Student, medical organization, other, health ministry or health professional, i.e., clinician, nurse, midwife or pharmacist, non-governmental organization.			
Water safety planning for urban water supply systems: an introduction (as of 17 June 2024)				
Course started	29 September 2023	5 386	4 265 (79%)	1 953 (36% / 46%)
Top 5 country users	China (16%), India (14%), Kenya (6%), Philippines (6%), Nigeria (4%)			
Top 5 professional affiliations	Student, other, medical organization, volunteer, non-governmental organization			
Mainstreaming of gender equality, disability and social inclusion in WASH in health-care-facilities (as of 25 June 2024)				
Course started	14 March 2024	3 023	2 372 (78%)	1 030 (34% / 43%)
Top 5 country users	India (15%), Nigeria (7%), Ethiopia (7%), United States (6%), Kenya (5%)			
Top 5 professional affiliations	Student, medical organization, other, non-governmental organization, volunteer.			

"Standard precautions: environmental cleaning and disinfection' (34%) and "Standard precautions: waste management" (32%).

Finding 5.5: KIIs and survey respondents suggest continued demand for training. Despite the significant amount of training already conducted, a demand for more training remains.[31] This includes webinars/online workshops on specific topics such as small water supply guidelines, although given this is a newish topic it is not surprising that neither training nor a training package have been delivered as yet *(100)*. Another area of requested support is capacity-building and awareness on climate-resilient WSP and sanitation safety planning.[32] It was also expressed by informants that follow-up training is needed particularly in relation to guidance documents, which are regularly updated. Other stakeholders commented on the need for more support from WHO to interpret guidelines locally and to choose the most reliable and relevant source from the many standards and guidelines that now exist on the Internet. It was daunting for non-academically minded people to identify the most useful resources – what is necessary versus what is nice to know.

4.5.2. EQ 5.2: To what extent have WASH approaches and tools promoted via the Strategy been embedded in national strategies and systems as well as in the strategies and approaches of major development partners?

This subquestion specifically considers the integration of WHO guidance into sector strategies, policies, regulations and guidelines and the use of WASH monitoring. The evidence presented here is based on data tracked and reported by WHO, the evaluation survey and on anecdotal evidence from KIIs and country case studies.

Table 20. Summary of key findings related to EQ 5.2

Summary of key findings related to EQ 5.2	Strength of evidence rating
Finding 5.6: WHO tracks integration of key WASH standards and guidance into policy and national targets; their achievement at country level is largely outside WSH's control and uncertainty pertains as to where WHO's role in implementation of guidance ends.	Strong
Finding 5.7: The evaluation survey reports good levels of knowledge and use of key WSH global knowledge products by government and partners.	Strong / moderate[33]
Finding 5.8: In-country support is crucial for the contextualization of WHO WASH guidance and its implementation, but resources are insufficient to provide this in many contexts.	Strong

Finding 5.6: WHO tracks integration of key WASH standards and guidance into policy and national targets; their achievement at country level is largely outside WSH's control and uncertainty pertains as to where WHO's role in implementation of guidance ends. This tracking is done via outcome indicators (see Table 21). For sanitation and WASH in HCF, the ambition extends beyond "integration" to "implementation", as discussed in Finding 1.6 – Relevance). For all outcomes except water safety planning, milestones were last set for 2021. WHO reporting shows that, by 2022, most milestones had been met or surpassed, except for WASH in HCF.

[31] KIIs and online survey.
[32] KIIs.
[33] The quality of evidence was judged to be moderate because the survey findings are likely to have a positive bias based on the self-selection of respondents and countries who are more likely to have worked on WASH.

Table 21. WSH logframe tracking of milestones related to country level uptake of standards and guidance

Thematic area	Logframe indicator	2021 Milestone	2022 Progress
Drinking water	Number of countries with water safety planning policies (using risk-based approaches).	68 countries	90 countries[34]
	Number of countries with national targets in alignment with SDG criteria for safe management of drinking water.	70 countries	78 countries
Sanitation and wastewater	Number of countries that are implementing WHO sanitation guidelines and/or sanitation safety planning (using risk-based approaches).	47 countries	56 countries
	Number of countries with national targets in alignment with SDG criteria for safe management of excreta along the sanitation chain.	34 countries	36 countries
Other health programmes	Number of countries that are implementing national standards and other elements of the WHA resolution on WASH in HCF.	90 countries	73 countries

Source: Logframe results 2023, unless otherwise indicated.

The reasons for different levels of ambition are not clearly articulated in the Strategy, and global targets have not been translated into regional or country targets (see Finding 1.4 – Relevance), due to the decentralized nature of WHO. This means that WSH has very little direct leverage over the pursuit of outcome targets beyond the use of dedicated donor funding in specific countries and may explain why targets do not span across the whole Strategy implementation period.

There is a lack of clarity as to where WHO's role and responsibilities end in supporting the uptake of global norms, standards, guidelines and monitoring at the country level. The reworked WASH strategy's ToC defines WHO's sphere of control in terms of "disseminating" guidelines, "awareness creation" for WASH in health, making evidence "publicly accessible" and providing "technical support" to countries on the uptake of guidance, monitoring and the development of WASH policies and targets. Findings 1.5 and 1.6 note that the Strategy's ambition does, for some thematic areas, move into an "implementation" role, e.g., to "implement national WASH in HCF packages" as cited in Table 7. Finding 4.2 indicates that non-WHO stakeholders see WHO's role at the country level to include support for implementing guidance and an advocacy role related to sector policies, strategies, regulation finance and coordination. There is also evidence that WHO collaborates with partners to extend support to implementation across thematic areas. Overall, the extent of WHO's mandate is not fully clarified at the country level.

Finding 5.7: The evaluation survey reports good levels of knowledge and use of key WSH global knowledge products by government and partners. Table 22 presents the levels of knowledge and use for key guidance, practical tools, WASH monitoring data and technical briefs for government and partners in a descending order. There are good overall levels of knowledge and use of key WHO products. The top product is JMP data (67%), followed by WHO's guidelines for drinking-water quality (65%), and GLAAS (60%). Guidance and tools with the lowest levels of knowledge and use are topics that could be classified as niche topics, e.g., microplastics in

[34] Internal WHO KII data refer to the last data point being 2017 and point out that further uptake has not been systematically tracked since. Drinking-water quality auditing might, in future, be enforced through regulation.

drinking water (10%) and the WASH and NTD strategy (9%), which on the other hand has the largest number of enrollees among the Open WHO courses.

There is also evidence from WHO annual reports, KIIs and documentation review that WHO partners make use of WHO normative guidance and evidence for their programming. Several funding partners with a large portfolio of in-country sector work, including USAID, referred to the regular use of JMP and GLAAS data to guide their programming. Other informants also referred to the use of WHO data for programming. As previously stated, UNICEF extensively uses WHO's normative guidance. The reported collaborative efforts of WHO in engaging a range of implementing partners and across various initiatives (see Finding 4.6) to develop and disseminate norms and guidance supports partner uptake and use of this guidance.

Table 22. Knowledge and use of key guidance, tools and monitoring by government and in-country partners

Type of document	Document	Know and use (%)
Monitoring	WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) reports (Households, Schools, Health Care Facilities or Wastewater Treatment)	67.3%
Normative guidance and guidelines	Guidelines for drinking-water quality	65.1%
Monitoring	GLAAS report	60.4%
Practical tools	WASH FIT: A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities	54.4%
Practical tools	Water safety planning manual	50.5%
Normative guidance and guidelines	Guidelines on sanitation and health	47.5%
Normative guidance and guidelines	Developing drinking-water quality regulations and standards	40.2%
Practical tools	Sanitation safety planning manual	34.3%
Normative guidance and guidelines	Guidance for climate-resilient and environmentally sustainable health care facilities	26.7%
Normative guidance and guidelines	Lead in drinking water – health risks, monitoring and corrective actions	25.7%
Reports and technical briefs	State of the World series (Sanitation, Drinking-water or Hand Hygiene)	25.2%
Monitoring	Integrating water quality testing into household surveys	24.7%
Reports and technical briefs	Global analysis of health care waste in the context of COVID-19	24.7%
Reports and technical briefs	Technical brief on water, sanitation, hygiene and wastewater management to prevent infections and reduce the spread of antimicrobial resistance	24.5%
Reports and	Environmental surveillance for SARS-CoV-2 to complement	23.1%

Type of document	Document	Know and use (%)
technical briefs	other public health surveillance	
Monitoring	Burden of disease attributable to unsafe drinking-water, sanitation and hygiene: 2019 update	19.6%
Practical tools	WASH and health working together: a "how to" guide for neglected tropical disease programmes	19.0%
Strategies	Addressing climate change: supplement to the WHO water, sanitation and hygiene strategy 2018–2025	17.3%
Reports and technical briefs	Health, safety and dignity of sanitation workers	16.7%
Monitoring	Reflecting on TrackFin 2012–2020	15.1%
Reports and technical briefs	Microplastics in drinking water	9.6%
Strategies	Ending the neglect to attain the sustainable development goals. A global strategy on water, sanitation and hygiene to combat neglected tropical diseases 2021–2030	8.8%

Finding 5.8: In-country support is crucial for the contextualization of WHO WASH guidance and its implementation, but resources are insufficient to provide this in many contexts. The complexity of some guidance can be an obstacle to its implementation, and this highlights the importance of a local WHO presence to help contextualize and/or simplify guidance for local use. Guidelines must be translated and contextualized at the country level to ensure that they are understandable, locally relevant and usable. WHO's role to "disseminate standards and guidelines" as described in the Strategy could be construed as including the necessary local adaptation of normative guidance. However, there are not always the resources within WHO or other partner organizations at the country level to do this. This also applies to updates of normative guidance, as explained by an internal KII.

> One of the biggest challenges is that however great your documents at a global level are, unless you've got people to help translate that to a national level, and support, and hand hold, …unless you have worked in the country, unless you have the time and the patience, and the relationships, it is very difficult to do that.

Respondents at the country level confirm the important role that in-country support plays in facilitating the contextualization of WASH standards into policies and their implementation. In Ukraine, the active support of WHO regional and country WHO staff to the health ministry was described as crucial for advancing a "difficult policy dialogue" across sectors to integrate water quality standards into national policies.

WSH Unit staff highlighted that they face increasing demands from the country level for advice on how to implement the various tools and approaches which recognize WHO itself cannot fund or oversee implementation. Declining staff levels and competing priorities were cited as key obstacles to effectively supporting implementation in practice.

Even if formal adoption of WHO tools and guidelines occurs, this does not necessarily lead to their implementation at scale. Apart from WHO's own resource constraints, governments may adopt WHO tools and approaches but then fail to implement them at scale due to a lack of funds, bearing in mind that some aspects of WASH – not least WASH in HCF – have major funding implications. In addition, the rapid turnover of

senior managers in government agencies necessitates continuous advocacy, orientation and training as new postholders may be unaware of tools and approaches promoted in recent years or unconvinced of the case for using them. Both factors were found to be at play in the Ethiopia case study where the pre-2018 momentum on water safety planning had been lost, despite the adoption of a national framework and guidelines and the incorporation of WSP into the national One WASH Programme.

4.5.3. ToC summary analysis for EQ5 – Sustainability

The ToC assumptions for Sustainability partially hold true, as assessed in Box 8.

Box 8. Theory of change assessment for EQ 5 – Sustainability

The following assumptions in the ToC relate to sustainability:
(5A) Political interest and willingness to work on and prioritize WASH
Assessment: This assumption may hold true in some country contexts but is not likely to hold true across most countries. Survey respondents identified "increasing political will and commitment to WASH in government" as the top priority for progressing WASH at the country level.

(5B) Partners are integrating WHO normative work/guidelines in their programming approaches
Assessment: While it is impossible to assess this comprehensively though the scope of this evaluation, the assumption likely holds true for key documents, based on documentation in WHO WASH annual reports, survey responses, meetings with donors and from KIIs.

5 CONCLUSIONS

5.1 Relevance

Summary conclusion: Access to safe WASH services is highly relevant to global needs and critical to promoting and protecting health, especially given that global progress on WASH is falling behind. WHO's WASH work is well aligned to country needs and is appreciated. WASH normative guidance and tools are invaluable outputs of the Strategy and inform implementation at scale by others. WHO has maintained its relevance through global efforts to improve WASH, including through the UN. However, WHO will need to further leverage its core strengths in normative, monitoring and technical work and, importantly, broaden the focus of the next Strategy to incorporate wider WASH issues (including climate change, water resources, emergencies), linkages with PHC-oriented health systems, alignment with GPW14 and the UN System-wide Strategy for Water and Sanitation *(79)* and define the role and accountability of country offices in implementing the Strategy. GEDSI needs to be prominent in the next Strategy to reflect the goals of GPW14 and the UN System-wide Strategy for Water and Sanitation.

Conclusion 1: WASH and the WHO engagement in the sector are highly relevant to country needs and critical to health outcomes. However, the Strategy itself focuses on global level activities. The WASH Strategy is a starting point from which WHO has adapted and incorporated new topics and approaches. However, the related targets and logframe mainly define efforts at the global level. Although the draft GPW14 gives greater recognition to WASH than GPW13, its use of WASH access indicators is not well aligned with the Strategy, given that WHO does not improve WASH access directly. The next WASH Strategy has become more important

with increased attention to WASH under the GPW14 and in light of the UN System-wide Strategy for Water and Sanitation, the run-up to the SDG 2030 deadline and the degree to which WASH progress has fallen behind.

Conclusion 2: The WASH Strategy does not align well with GPW13 to promote GEDSI. While important normative issues such as gender, equity and human rights are part of WHO's work, they could be addressed more comprehensively. This is especially true for areas like disability and the social inclusion of marginalized groups, including informal settlers, displaced people and those living in fragile or conflict-affected regions, as well as areas impacted by climate change. Within WHO, the focus on GEDSI is not particularly strong, and there is no dedicated advocate or leader for these issues within the WSH Unit.

5.2. Effectiveness

Summary conclusion: The Strategy has been implemented successfully and has proven realistic in its ambitions given the huge constraints under which the WASH function operates within WHO, including the relatively low prioritization given to WASH within the organization; the impact of COVID-19 and other emergencies; and declining WASH funding within WHO and staffing at country level. A critical question is whether the next Strategy can establish a framework for action at the country level, rather than serving as a menu of thematic options for country offices to select from. The current Strategy primarily focuses on the role of the WSH Unit at the global level. For such an action-orientated framework to be effective, however, it would require the presence of dedicated WASH staff within WHO country teams.

Conclusion 3: The quantity and quality of normative output is impressive given the rigorous process involved in its development. There are increasing demands on the WSH Unit for more guidance on how to implement the various tools and approaches promoted. The WSH Unit achieves this through extensive use of online platforms that provide orientation, training and guidance; collaboration with numerous external experts and advisory groups in the development of normative guidance; and strategic partnerships with a range of global and regional organizations which help the WSH Unit extend its reach. Additionally, guidance has been expanded and updated, especially in relation to climate change. The WSH Unit has also been instrumental in securing the integration of WASH into other core global health strategies and programmes.

Conclusion 4: WHO's "convening power" in WASH is evident at the global level, with the WSH Unit playing a pivotal role in shaping sector strategy and securing global commitments. At the country level, however, WHO tends to have a lower profile in the WASH sector than other international development agencies, including UNICEF. The decline in WASH funding and staffing makes it increasingly difficult for WHO to play its intended role in WASH advocacy and technical support at this level and has implications for the implementation of GPW14, which aims to "promote, provide and protect health and well-being".

5.3 Efficiency

Summary conclusion: Cooperation across the WSH Unit and improving collaboration across the three levels of the Organization have contributed to the efficient use of limited human and financial resources to implement the Strategy and yield results. There is potential for further efficiency gains if core funding is improved to

enable optimal allocation of staff across the PIAs and objectives at the country level are made clearer and aligned with GPW14.

Conclusion 5: The limited level of core funding combined with the high proportion of donor funding compromises the efficiency of Strategy implementation. In evaluating the Strategy's objectives, it is evident that each PIA at all levels faces constraints in both financial and human resource capacity. This is evidenced by an estimated 1–2% of the global flexible budget being allocated to WSH, coupled with declining donor funds over the Strategy period. In many cases, the human resource deficit is being addressed through consultants, which on the one hand responds to fluctuations in funding, but on the other hand does not allow for retained institutional capacity or improved capability.

Conclusion 6: There is a clear need to establish a results framework, an improved resource mobilization strategy and a narrative-based financial report to demonstrate an appropriate balance in the allocation of resources across priority areas. Currently, the priority thematic areas do not align with the available resource levels. This discrepancy is further compounded by unpredictable funding due to complex internal processes and negotiations with donors.

Conclusion 7: WHO has sought to make the best use of its limited human and financial resources through cooperation across the WSH Unit and collaboration with other units within the ECH Department and beyond (including other WHO departments, UN partners and external partners). Mechanisms have been introduced or scaled up to improve closer collaboration and coordination, which has translated into high satisfaction levels of support felt by regions and countries. However, direct communication between headquarters and countries, although appreciated by countries, increases the burden and threatens the efficiency of headquarters work, given the limited human resources at that level.

5.4 Coherence

Summary conclusion: WHO has a clear global mandate on WASH and health and successfully fulfils its leadership role within the global WASH architecture, supported by effective collaboration. However, at the regional and country levels, WHO's decentralized structure, coupled with human and financial resource gaps, prevents it from fulfilling its mandate effectively and maximizing collaboration. Strengthening specific implementation partnerships could help to fill these gaps.

Conclusion 8: WHO has a clear mandate for WASH and health, which it fulfils well at the global level. However, this does not translate into consistent support at the country level. WHO's mandate at global level is clear and undisputed. WHO sets directions for WASH and health globally, which others follow while collaborating on implementation with WHO. There is an expectation by external WASH stakeholders that WHO's global mandate also extends to the country level, but a lack of strategic inclusion of WASH in country collaboration strategies and financial and human resources hinders WHO's ability to take on this role in many country contexts.

Conclusion 9: Despite strong collaboration at global level, with UNICEF, there is room for further strengthening of partnerships and clarifying WHO mandates at regional and country level. WHO is a strong collaborator in WASH at the global level, playing a pivotal role in setting directions for the sector via evidence, convening and effective collaboration, especially with UNICEF and across most global stakeholder groups.

WHO could further strengthen partnerships at the regional and country level, including with UNICEF, to complement its lack of sufficient human and financial resources and avoid mandate confusion.

Conclusion 10: WHO's strong technical collaboration on WASH and health does not yet fully translate into effective disease prevention and control via sustainable access to water supply and sanitation services in disease hotspot areas. WHO has effectively contributed to WASH and health collaboration under specific initiatives, such as NTDs, AMR and the Global Task Force on Cholera Control, but could play a more pro-active role in terms of bringing WASH stakeholders onboard in specific disease spaces. There is untapped potential with other key implementers, in particular the World Bank and regional development banks, which could help WHO further advance key topics closely related to its mandate, e.g., support to infrastructure prioritization for disease prevention and control and in the area of regulation.

5.5 Sustainability

Summary conclusion: WHO has scaled up advocacy, communication and capacity development initiatives to support sustainable health gains. There is strong awareness and good levels of use of key WSH knowledge products, which suggests that, in principle, Strategy implementation promotes sustainability. Despite the strong and renewed focus on training and capacity development, continued demand for training exists at country level. The extent to which WHO is mandated to embed Strategy content into national and partner systems and approaches remains vague. To further support the contextualization and implementation of its guidance and monitoring at country level, WHO should clarify its competitive advantage and revise its approach to capacity-building, advocacy and communication in light of current resource constraints.

Conclusion 11: The Strategy outlines various activities and mechanisms within its thematic areas aimed at supporting advocacy, communication, capacity and capability development. These efforts are designed to foster an enabling environment for sustainable health gains. Over time, new tools and approaches have been introduced to scale up advocacy and communication activities across all three levels. However, some existing tools could benefit from improvements in their timeliness and application. To ensure sustainability of the WSH Unit's achievements within WHO, advocacy and communication aspects could be further strengthened. This should focus on increasing the visibility of WSH initiatives and highlighting the integrated nature of WASH across WHO's global mandate.

Conclusion 12: WHO plays a vital role in contextualizing global guidance. However, it is necessary to clarify and communicate the extent of the agency's role in supporting its progressive implementation at country level, particularly given human and financial resource constraints. WHO and its partners play a crucial role in supporting the contextualization of WHO norms and standards and their progressive implementation. Survey responses indicate that there is a good level of knowledge and use of WHO key knowledge products at country level. However, the boundaries of WHO's role in terms of implementing global guidance at country level remain unclear. WHO human and financial resource constraints at the national level mean that, in many country contexts, WHO is unable to fulfil a substantial technical support function on a continuous basis, let alone a lead role.

6 RECOMMENDATIONS

Recommendation 1 – Develop a new WASH strategy based on WHO established core areas of work in WASH (including setting standards, guidelines, strengthening WASH systems at country level, monitoring, and promoting evidence-based policy and research), while integrating newly identified priority areas where WHO contributions add significant value (e.g. climate change resilience, WASH in emergencies including cholera, AMR, PHC, infection prevention and control, vector-borne diseases, cholera, NTDs and GEDSI). The new Strategy should enhance intersectoral engagement and be aligned with both internal and external strategies of key WASH actors (including UNICEF), primarily GPW14 and the UN System-wide Strategy for Water and Sanitation.

Timeframe: Next six months. Action: WHO

Rationale

The new WASH strategy should build on recognized core areas of strengths, established expertise, processes and relationships of WHO in WASH that have demonstrated effectiveness. These include Guideline development, normative standard-setting, monitoring, tools and implementation frameworks, and leadership. At the same time, GPW14, the SDG 6 Global Acceleration Framework and the UN System-wide Water and Sanitation Strategy highlight global WASH and health trends. Drivers of these trends include accelerated climate change, water scarcity and water pollution, human migration and displacement, growing inequities within and between countries and the growing number of crises and emergencies – all of which impact access to safe WASH services. The UN System-wide Water and Sanitation Strategy places emphasis inter-agency and sector-wide collaborative priority actions to meet the water and sanitation needs of developing countries, including least developed countries, small island developing States and countries with other special circumstances. WHO's agenda for UHC and Leaving No One Behind are strong drivers for engaging with GEDSI, climate resilient WASH and WASH in emergencies and integrating with other health programmes to maximize the impact of WASH. WASH in turn is significantly influenced by water resources management and the broader "big water" sector, in terms of WASH service sustainability. Furthermore, climate change finance will become more dominant in the WASH sector and under GPW14, presenting opportunities for WHO but also requiring WHO to be ready to respond. There is expressed demand for information and guidance on these issues from stakeholders.

The new strategy should be informed by the following points.

- It should sustain areas that underpin WHO's authority in WASH such as setting international standards and guidelines while monitoring progress towards national and international WASH targets, using data-driven approaches and research to inform decision-making and guiding policies, identifying priorities and targeting the most vulnerable populations effectively and strengthening of WASH systems at country level, including developing the capabilities of government institutions (e.g. WASH regulators), in a coordinated manner with partners.

- It should connect with entry points of the UN System-wide Water and Sanitation Strategy, including:
    - Entry Point 2 (enhancing country engagement by leveraging whole-of-UN support and mobilizing stakeholders and partnerships for water and sanitation);

  - Entry Point 3 (aligning UN system support to integrate water and sanitation issues across sectors and mainstreaming them into intergovernmental processes); and
  - Entry Point 4 (accelerating progress and transformational change by unifying UN system support through the SDG 6 global accelerators of financing, data and information, capacity development, innovation and governance).

- It should use the drive towards PHC-orientated health systems highlighted in GPW14 as an overarching framework in WHO to link WASH activities conducted at all levels of WHO and step up intersectoral coordination. This includes themes that are increasingly mainstreamed by WASH (e.g., climate resilience, WASH in emergencies, including cholera, as well as GEDSI) within WHO ECH and with other health programmes, such as AMR, vector-borne diseases, cholera, NTDs and health system resilience.

- It should position WASH strategically for its role in building resilience to climate change as the Climate Change team transitions from a technical unit to a mainstreaming role across WHO under GPW14, particularly in health systems and facilities. This includes developing guidelines, supporting climate-adaptive infrastructure such as in HCFs, informing communities to enable climate-resilient WASH practices and supporting the adaptation of relevant WASH guidance to specific diseases and contexts (e.g., emergencies, cholera).

- It should increase the engagement of WASH in Emergencies with the health emergencies programme by adapting WASH tools to emergencies and, where appropriate, supporting the transitioning of emergency WASH to a development focus and clarifying roles, undertaking joint assessments, participating in taskforces, joint research, integrating guidance and adapted WASH tools into health emergencies (e.g. WASH FIT, Water Safety Planning (WSP) and water quality testing, sanitation safety planning, hygiene guidance, etc.).

- It should build upon existing efforts to prioritize GEDSI in WASH into thematic guidance materials and monitoring and support country-level implementation such as policy development and capacity-building – ideally reinforced by a focal point/champion for GEDSI at ECH Department level.

Recommendation 2 – To implement the new strategy, develop an operational plan anchored in the GPW14. This plan should be accompanied by a results (monitoring and evaluation) framework that outlines clear accountabilities and defines specific roles for headquarters, regional and country offices.

Timeframe: Next 12 months. Action: WHO

Rationale

The next Strategy should be anchored in the GPW14, aligned to WASH and WASH-related outputs and outcomes and supported by a results framework to monitor progress in the next WASH Strategy implementation. Defining specific target geographies would help delineate the role of regional and country offices in developing and implementing regional and country level strategies, such as providing guidance on adapting global Strategy components to country needs and ensuring alignment with national WASH strategies and plans. For country offices, it should go beyond providing a menu of technical subjects within WASH and provide guidance on the development of country-level strategies and plans interlinked with the WASH strategy

and GPW14.

Going forward, WHO should:

- Connect the future WASH strategy to GPW outcomes and outputs and develop a results framework (logframe) based on a ToC that aligns with and clearly contributes to GPW14 and provides a sound basis for tracking progress in strategy implementation;
- Develop common monitoring WASH-related indicators linked to GPW14 indicators on GEDSI, climate resilience, climate and health, maternal and child health, primary health care/UHC, vector-borne diseases and other disease-specific programmes with other WHO units and departments;
- Ensure that WASH activities are included as much as is feasible in the GPW14 operational, budgeting and country support processes and plans;
- Articulate clear global, regional and country-level roles, capitalizing on the strength of each level, and provide guidance on how to adapt relevant strategy components to country needs so that country offices can ensure elements are included in national plans; also consider developing regional ECH strategies with a clear focus on WASH;
- Involve country offices in strategy development via regional offices (Directors of Programme Management, WASH Regional Advisers [RAs]) and consider prioritizing specific target geographies related to disease burden and populations; and
- Ensure that country cooperation strategies include indicators related to GPW14 and the WASH Strategy, remembering that GPW indicators are aligned with SDG indicators.

Recommendation 3 – To position the WHO WASH programme of work more strategically within and beyond WHO, expand and capitalize on internal and external partnerships, leveraging and strengthening awareness and understanding of its utility. This will also support joint advocacy and fundraising efforts.

Timeframe: Next twelve months - Action: WHO (across its three levels) and in collaboration with UNICEF, development banks, global health initiatives and partnerships with other key implementation stakeholders.

Rationale

WHO's role in the WASH sector is central to achieving health goals and SDG targets and addressing the cross-cutting nature of healthy environments and preventive health measures. Yet while WHO's leadership in setting global guidelines, norms and standards for sanitation and drinking-water quality and global monitoring (as co-custodian for several SDG 6 indicators) is well acknowledged, WASH is often overshadowed by higher-profile health issues, particularly at the country level. There is an urgent need to integrate WASH more visibly and substantively across WHO's health programmes, building on the links between health and WASH as advocated in GPW14, and develop a compelling argument for WASH with adequate resource allocation. Within the UN

system, WHO is positioned as a leading player on WASH and health, developing strong global partnerships amongst most stakeholder groups to implement its Strategy. WHO requires strong partnerships at all levels to support the dissemination and implementation of key standards, guidance and monitoring at the country level; however, collaboration is less well defined at regional and country levels and not yet fully exploited with development banks.

- WHO should draw on WHO health and economic research and data and build on the links between health and WASH laid out by GPW14 and in WHO's WASH Primer for Health Professionals to continue to advocate for increased investment in WASH. Messaging should highlight WHO's unique contribution and value for money in achieving the goals of GPW14 and the role of WASH in other major areas of work (e.g. climate change, emergencies and cholera, AMR); the high burden of disease due to poor WASH; the demand for WHO's normative and monitoring information; the pivotal roles of health sectors and ministries of health in integrating WASH into health programmes; the risks of non/disengagement; and the counterfactual impact with a reduced WHO focus on WASH.

- WHO should use the development of the next WASH strategy to consult and raise awareness, clearly articulating WHO's role in WASH, the areas of strategic priority for the next strategy period and links with health. It should increase understanding of WHO's WASH mandate, assets and associated efforts and reach out to WHO regional directors, directors of programme management and WHO representatives leading country offices; and advance WASH for health, such as through the development of regional strategies, peer to peer exchange or the development of induction courses to new staff to include WASH basics, WHO's scope of WASH work and country office responsibilities for WASH. WHO should consult Members States and continue to build upon existing visibility and presence in major conferences and other fora as a key entry point for future funding opportunities.

- WHO should define necessary resources to deliver the new Strategy, including the regional and country levels within GPW14 biennial budget, and ensure that WASH is reflected in biennial workplans.

- It should carry out a donor/stakeholder mapping exercise (considering regional strategies for PHC-orientated health systems) to capture existing and new relationships/partners and funding opportunities such as global health initiatives, philanthropy, private sector, the Global Financing Facility at the World Bank, UHC-partnership, Global Fund (malaria) and feed into the resource mobilization strategy. It should expand joint mobilization of funding with existing partnership approaches, such as those with UNICEF, and with other key implementation partners at regional and country level.

- WHO should develop a practical resource mobilization sub strategy and workplan that identifies funding sources, including development banks, global health initiatives and partnerships with other key implementation stakeholders, to support delivery against the Strategy. Emphasis should include funding to establish minimum WASH capabilities in country offices, with corresponding regional and headquarters support, and ensuring a baseline level of WASH support where it is most needed.

- WHO should engage with department/division senior leadership to include WASH in WHO's proposed "core predictable country presence" focused on "empowering and transforming" country offices to "drive impact" at regional and headquarters level. This should include sufficient ECH personnel with

relevant qualifications, including WASH, as a detailed component of their job descriptions to respond efficiently to country and regional demand for normative guidance while also continuing WASH-health integration efforts as envisaged under GPW14.

- WHO should capitalize fully on partnerships to increase efficiencies and effectiveness and ensure that WHO continues to play a catalytic role within the UN architecture related to SDGs (specifically SDG 6) and the UN System-wide Strategy for Water and Sanitation. It should strengthen existing partnerships, explore new collaborations (particularly with development banks and regional actors) and clarify mandates with key partners like UNICEF at the regional and country levels.

- WHO should accelerate engagement with development banks on strategic areas of collaboration, e.g., regulation, identification of priorities for infrastructure investment (based on spatial analysis of the WASH-related disease burden and marginalized population segments) and enhanced collaboration in fragile and conflict-affected areas transitioning to sustainability.

Recommendation 4 – Enhance the sustainability of WHO's WASH and health interventions at the country level by working with key partners to develop strategies and foster country-level partnerships that progressively integrate WASH standards, guidance and tools into national policies and regulatory frameworks. Additionally, clarify WHO's comparative advantage vis a vis other stakeholders and partners.

Timeframe: Next 12 months - Action: WHO (across its three levels) and in collaboration with UNICEF and other key partners

Rationale

While sustainability also depends on available funding for WASH, the next Strategy needs to clarify WHO's comparative advantages in terms of supporting the adaptation, dissemination and implementation of standards and guidance at country level, how to assess activities to be phased out and work with key implementation partners (such as UNICEF) and country level to identify effective transition strategies and support their implementation. To this end, WHO should:

- support efforts to clarify responsibilities and comparative advantages with UNICEF and other key partners at regional/country level and clarify WHO's role in supporting the adaptation, dissemination and implementation of standards and guidance at country level, i.e., with the dissemination of guidance for some technical areas in the Strategy logframe, while it moves into implementation for others (e.g., WASH in HCF, Sanitation Safety Planning);

- work with key implementing partners (e.g., UNICEF) to support the adaptation and implementation of WHO's normative guidance and monitoring at country level and specific country-level technical assistance and advocacy;

- take stock of capacity and capability development to identify gaps, what worked well and what did not, define which activities are being phased in and out based on assessments of relevance and need and develop a coherent approach to resourcing and delivery at country level;

- support exploration of options for country-level partnerships including collaborating with national training/research institutions for national level capacity-building and ensuring the operationalization of national policies and regulatory frameworks at the local level;
- continue transitioning away from primary data collection for GLAAS, towards a joint programme with UNICEF, similar to JMP, contextualized within the broader ToC and Align to Accelerate initiatives with UNICEF and the World Bank; and

- plan for technical assistance to country level where there are identified human resources gaps, e.g., through the use of consultant pools, potentially via regional offices.

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