



THE UNIVERSITY OF
MELBOURNE

Nossal Institute for
Global Health

Evaluation Report for DFAT-WHO water, sanitation and hygiene (WASH) Evaluation across the Asia Pacific 2018-2022. Final Report.

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ACRONYMS

AMR	Antimicrobial resistance
CO	Country Office
DFAT	Department of Foreign Affairs and Trade
GEDSI	Gender and Social Inclusion
HCF	Health care facilities
HQ	Headquarters
IPC	Infection Prevention and Control
JMP	Joint Monitoring Programme
KIAT	Indonesia Australia Partnerships for Infrastructure
KII	Key Informant Interview
MCH	Maternal Child Health
NGO	Non-government organisation
OECD	Organisation for Economic Cooperation and Development
RO	Regional Office
SDG	Sustainable Development Goals
SEAR	South and East Asia Region
SNV	SNV Netherlands Development Organisation
SQM	Square metres
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VfM	Value for Money
WASH	Water, sanitation and hygiene
WASH FIT	Water and sanitation for health facilities improvement tool
WHO	World Health Organization
WPR	Western Pacific Region
WSP	Water Safety Planning

Acknowledgements

This evaluation was conducted by the Nossal Institute for Global Health at the University of Melbourne. The evaluation was led by Alison Macintyre with technical oversight from Katherine Gilbert. WHO staff at all levels facilitated interview organisation. We would like to thank all those who provided time to be interviewed, particularly government and partner staff involved in the project.

Executive Summary

Introduction and background

The Australian Government's Department of Foreign Affairs and Trade (DFAT) supports WHO to strengthen WASH systems in the Asia Pacific. The program, Strengthening the quality and sustainability of water, sanitation and hygiene services, including in health care facilities, is being implemented in four countries in the Asia Pacific Region: Bhutan and Indonesia in the South East Asia Region (SEAR) and Vietnam and the Philippines in the Western Pacific Region (WPR). The program also supports capacity building, guidance development and leadership on surveillance and WASH in health care facilities (HCFs) at regional and global levels through WHO regional offices (SEARO and WPRO) and at headquarters. The program started in 2018 and will end in June 2023. The Objectives are:

1. Water Quality Surveillance and Management

Increased sustainable access to safely managed drinking-water through strengthened surveillance of water quality and risk management practices

2. WASH in health care facilities

Higher quality health care through improved access to safe and sustainable WASH services in health care facilities

This report is an evaluation of the DFAT-WHO WASH program in 2018-2022 and focuses primarily on two countries: Indonesia and the Philippines.

Evaluation Design and Methodology

The purpose of the evaluation was to assess the extent to which WHO achieved its intended outcomes for the project, with a focus on effectiveness and value for money (VfM). The evaluation was both summative and formative in design to assess effectiveness and VfM, and to assess ways in which learning from the evaluation could inform future program design. Effectiveness was defined in line with the OECD DAC Evaluation Criteria¹, and DFAT's VfM Principles² guided the VfM criteria.

A desk review of project documentation and secondary data (such as national policy documents) and key informant interviews were used to assess the evaluation criteria. Data sources and sample sizes are in the table below. Purposive sampling was used to select participants based on their responsibilities as related to the program.

Data sources and sample sizes

	Philippines	Indonesia	Regions	Global
1. Secondary data analysis				
Review of project documentation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of secondary data (i.e. policy documents, learning briefs etc)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Primary data collection				
KII with WHO staff	1 participant	2 participants	4 participants	5 participants
KII with government stakeholders	2 participants	6 participants	-	-

¹ OECD Evaluation Criteria.

<https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>

² DFAT's Value for Money Principles. <https://www.dfat.gov.au/aid/who-we-work-with/value-for-money-principles/Pages/value-for-money-principles>

KII with partners	-	3 participants	-	1 participant
KII with DFAT	-	2 participants	-	1 participant
TOTAL				27

The interview and secondary qualitative data were analysed using a framework analysis drawing on the evaluation questions and the outcome indicators, meaning that themes were identified under each evaluation question and indicator. As such, it combined an inductive and deductive approach. The data sources were corroborated as relevant to the evaluation question. Preliminary findings and recommendations were developed by the evaluation team, and a collaborative preliminary results workshop was used to discuss the team's preliminary findings with WHO headquarters. The reflections and responses were captured and included where relevant in the analysis.

Findings

Assessment against outcome indicators for WASH in HCF

OUTCOMES	Indicators	Result
National commitments are made to improve WASH in HCFs	National policies, standards, guidelines, strategies, plans and roadmaps addressing WASH in HCFs	STRONGLY MET
Capacity is developed among government staff to improve WASH in HCFs	National trainers who have, in turn, gone on to lead WASH FIT trainings	MET
WASH infrastructure and practices are improved in HCFs	HCFs that have improved WASH infrastructure and practices following implementation of the WASH FIT process	SOMEWHAT MET
Monitoring of WASH in HCFs is improved globally and nationally	WASH in HCF indicators incorporated into global and national monitoring mechanisms	MET
Partners commit to supporting WASH in HCFs	Evidence of partner commitments to WASH in HCFs	MET
GEDSI and climate are addressed in national WASH in HCF processes and tools	GEDSI and climate indicators in national WASH in HCF standards, processes and tools	MOSTLY MET

Assessment against outcome indicators for water quality surveillance and monitoring

OUTCOMES	Indicators	Result
Policy and regulatory drivers for surveillance are strengthened, including a greater focus on risk management	New or revised surveillance policies, standards and guidelines, incorporating sanitary inspections and/or WSP auditing	STRONGLY MET
Capacity is developed among government staff to carry out surveillance activities	Those trained have gone on to train others and/or have carried out surveillance in accordance with training	MET
Surveillance information management systems are strengthened	Evidence of changes / improvements to information management systems	MOSTLY MET
Surveillance practice drives corrective action and improvement	Improvement actions taken as a direct result of surveillance findings and recommendations	MOSTLY MET
Partners support surveillance activities	Evidence of partner support for surveillance	MET

Effectiveness

Key findings for the evaluation questions assessing effectiveness were:

- Strong evidence that program approaches have been adopted by governments in the Philippines and Indonesia.
- Across both countries, the predominant focus of the work and the change that was reported in documentation and in interviews was at the national level through policy change and government commitment across both technical areas. Some subnational progress is evident though at a smaller scale or at pilot levels.
- Several common and differing facilitators and barriers for each technical area were identified. Key enablers across both technical areas included: strong partner engagement, leveraging additional funding, and COVID-19 increasing attention to WASH. Key barriers included: sustainable financing, especially to address WASH service improvements; and limited subnational leadership and capacity for program delivery.
- The program approaches were appropriate for national level leadership, policy, regulation and monitoring outcomes. Program approaches may need adapting in the future to support sustainable institutionalization and implementation of policies and processes at the subnational and local levels.

Value for money

Key findings for the evaluation questions for Value for Money were:

- There is good evidence that WHO has been cost conscious in its partner and consultant selection processes.
- There is good evidence (from KII and project documentation data) that there are cost conscious processes in place to support quality delivery of program outcomes.
- There is good evidence that evidence and learning is used to inform program design and implementation though there are some areas which could be strengthened in future programming.
- There is some evidence that innovative approaches have been adopted for GEDSI and climate resilience in some contexts and for some program aspects.
- There is evidence to suggest the risks were managed well across the project though there are some areas that could be strengthened for future programming.

Recommendations

The evaluation evidence indicates clear progress has been made across both technical areas at all levels of the program implementation. Project documentation revealed all project activities and outputs were achieved and all outcome indicators were met though some more strongly than others. The following recommendations highlight areas for consideration for future DFAT-supported programming across the Asia Pacific and are designed to inform WHO support and practice more broadly.

1. DFAT support to WHO for WASH across the Asia Pacific region should continue, especially to support countries where leadership, policies, and processes are under development/in place in program focussed technical areas. In line with recommendation 4, WHO should continue to foster government leadership and support sustainability through directing efforts to support the operationalisation of policy and regulatory commitments. DFAT support to WHO for WASH across the Asia Pacific region should continue, especially to support countries where leadership, policies, and processes are under development/in place in program focussed technical areas. In line with recommendation 4, WHO should continue to foster government leadership and support sustainability through directing efforts to support the operationalisation of policy and regulatory commitments.

2. Future programs should explore how to integrate the WASH in HCF and water quality surveillance and management aspects of the program where relevant. This is not intended for all aspects of each of the technical areas, but could focus on the following areas: to more fully address water quality and related operation and maintenance at HCF; share monitoring data and relevant information between ministries that have respective responsibilities for WASH in HCF and water quality monitoring and surveillance where this is not occurring; and to develop higher level outcomes indicators for the program that integrate both areas to streamline reporting processes and capture relevant program points of intersection.
3. Future programs would benefit from adopting Gender and Social Inclusion (GEDSI) and climate resilience frameworks to systematically apply GEDSI and climate resilience consideration across all aspects of the program.
4. To the extent that resources allow and in collaboration with partners, build on progress of strengthening the enabling environment across both technical areas at the national level, and refocus technical support to include stronger attention to supporting national stewardship for the operationalisation of policies, which includes: strengthening regulatory capacity; strengthening coordination; incentivising subnational actors to comply and supporting their capacity to do so; supporting planning and budgeting processes at the subnational level; and strengthening monitoring and resulting action where needed.
5. Strengthen evidence and learning processes to capture evidence of what works where in greater detail to inform modifications and strengthening of national and local approaches, particularly regarding the operationalisation of existing policies and strategies at scale.
6. Explore opportunities to support other emerging areas of relevance to WASH across the two region and country contexts.

1. Introduction

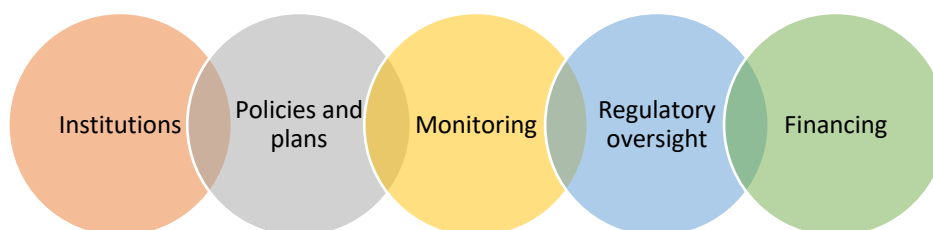
The Nossal Institute for Global Health ('the Nossal Institute') was appointed by the World Health Organization (WHO) to conduct an evaluation of the WHO-DFAT Water, Sanitation and Hygiene (WASH) Program 2018-2022 across the Asia Pacific region. The evaluation was designed to assess whether the Australian Government's Department of Foreign Affairs and Trade (DFAT) support for the WASH unit at WHO between 2018-2022 was effective and provided good value for money. The evaluation assessed what worked, how and for whom, and proposes recommendations for future programming. The lessons identified will be used to inform future design of the WHO WASH team's programs across the Asia Pacific region. The primary audiences for this evaluation are WHO Headquarters (HQ), Regional Offices (ROs), Country Offices (COs) and DFAT. The evaluation findings may also contribute to broader regional and global learning for the key technical areas to be evaluated: WASH in health care facilities (WASH in HCF) and water quality surveillance and management. The evaluation combined a summative and formative view, drawing lessons to inform the next programmatic phase and the potential adoption and scaling of the programme approaches in neighbouring countries across the region. The evaluation was conducted from November 2022–January 2023.

2. Background

The WHO-DFAT program contributes to improved access to safely managed WASH in HCFs and in households, sustainably and at a national scale, by strengthening the government systems that support WASH service delivery. The focus of the program has been to improve access to WASH in HCF and to strengthen water quality management and surveillance systems across four countries in the Asia Pacific region: Bhutan, Indonesia, Philippines, and Vietnam. Countries considered for inclusion were subject to the following criteria: demonstrated need based on the WASH situation in the country, strong political will, demonstrated capacity by WHO Country Office and country partners to implement, and potential to be a good practice example to neighbouring countries.

A systems approach has been adopted to implement all aspects of the project. While a "system" may be defined in different ways, in this application core elements include the extent to which countries develop and implement national policies and plans for WASH, conduct regular monitoring, regulate and take corrective action as needed, and coordinate these parallel processes with sufficient financial resources and support from strong national institutions. These WASH systems building blocks (Figure 1 below) align with the WHO-DFAT project's targets and outcome objectives, as defined in the project agreement.

Figure 1 Representation of the WASH system strengthening building blocks



The WHO-DFAT program also aims to influence the approaches taken by partners for a multiplicative effect – that is, to leverage financial and technical support from other partners/sources to contribute to WASH systems strengthening and the scale-up of effective technical interventions. The project also aims to support equitable participation in, and outcomes from, WASH interventions through explicit consideration of Gender and Social Inclusion (GEDSI) in WASH programming. The project also prioritizes contributions to climate resilience.

2.1 Description of WHO's WASH Program in the Asia Pacific

The DFAT-WHO WASH program was designed to focus on two key areas of WASH-related technical support: water quality management and surveillance and WASH in HCFs. The program focussed on supporting four countries in the Asia Pacific Region: Bhutan and Indonesia in the South East Asia Region (SEAR) and Vietnam and Philippines in the Western Pacific Region (WPR). The program also supported capacity building, guidance development and leadership on surveillance and WASH in HCFs at regional and global levels through WHO regional offices (SEARO and WPRO) and at headquarters. The program centres around two overall objectives across the two technical WASH areas.

The Objectives are:

1. Water Quality Surveillance and Management

Increased sustainable access to safely managed drinking-water through strengthened surveillance of water quality and risk management practices

2. WASH in health care facilities

Higher quality health care through improved access to safe and sustainable WASH services in health care facilities

As the program developed, a stronger focus on GEDSI and climate resilience was incorporated into the program's activities and reporting.

2.2 Scope of Evaluation

The evaluation covered both technical areas of the program: WASH in HCFs and water quality surveillance and management. The evaluation considered all three levels involved in the project, that is, global, regional and national, though the predominant focus was assessing outcomes at the country level. While the program was implemented across four countries, the evaluation focussed on two countries: Indonesia and the Philippines. Focusing the evaluation permitted greater assessment depth in these two countries, particularly within the timeframes and resources available for the evaluation. These two countries were selected to cover both WHO regions supported by the DFAT project: the South and East Asia Region (SEAR) and the Western Pacific Region (WPR). These two countries made considerable progress over the course of the project and can therefore offer insights into successful strategies for strong program engagement and uptake by government.

Several key outcomes and indicators were assessed in this evaluation for the focus technical areas and countries. They are found in Table 2 under Section 5.1 below. The outcomes and indicators consisted of seven outcomes for WASH in HCF and five for water quality surveillance and management.

2.3 Water quality surveillance and management

DFAT-WHO program of work has focused on water safety planning and water quality surveillance activities in the Asia Pacific region since 2005 and the 2018-2022 DFAT-WHO WASH program builds on the foundation of previous DFAT support. For this program cycle, the focus was on continuing water safety plan (WSP) implementation and strengthening water quality surveillance systems, including WSP auditing. Surveillance program assessments were conducted in each country at the outset of the project to support action planning for water quality surveillance strengthening. Following the situation assessments, policies, guidelines, regulations, stakeholder capacity and surveillance information systems have been progressively strengthened in both countries across program implementation.

To support roll out of stronger drinking water quality management and surveillance, training in countries and direct technical support has also been conducted. National training materials and curriculums have been developed and implemented, including for WSPs and associated auditing. While COVID-19 disrupted in-country visits, training continued in online formats at the country and regional level to maintain momentum for water quality management and surveillance.

At the regional level, water quality management and surveillance trainings both in person (prior to 2020) and online have been conducted across both SEAR and WPR to support capacity development, to increase national prioritisation of water quality surveillance, action planning and to facilitate learning exchanges across countries. One such learning exchange was conducted by WPRO in Boracay in 2019. In addition, training workshops have also been conducted on regional guidance developed by SEARO designed to support countries to strengthen national schemes for regulatory auditing of WSPs. WPRO representatives were also engaged in SEARO training sessions. Learnings from the target countries have informed global guidance documents and global learning on water quality surveillance and management.

At the global level, progress has also been made with multiple guidance documents developed across all years of program implementation. These include guidelines documents, technical manuals, training packages, tools for field practitioners and a report compiling data on global progress towards safely management drinking water and their associated policies and financing. The program has also supported the engagement of partners, though it was noted that none of the Water for Women partners were working specifically on surveillance in the project's focus countries. However, in Indonesia, WHO has partnered with KIAT, which is a DFAT supported project focused on safe drinking water supply. KIAT has been engaged with WHO work related to WSPs and associated auditing. Learning and evidence from the DFAT-WHO WASH program for water quality management and surveillance has been shared at regional and global fora including conferences, webinars and regional meetings.

In the most recent annual report, all main objectives for water quality management and surveillance were reported to be on track to be achieved in the two focus countries and at the global level.

2.4 WASH in health care facilities

WASH in HCF was introduced as a technical area during this program period (2018-2022). The WASH in health care facilities technical area has supported countries to strengthen planning, policies, guidelines, tools and capacity for WASH in health care facilities and in particular, work towards implementing the 8 practical steps for improving WASH in HCF. Initial planning built from assessment data that were either collected as part of the program or was already available in country.

In addition to the support above, the WHO-DFAT WASH program has worked to improve monitoring for WASH in HCF in both countries and supported country adoption and implementation of WHO/UNICEF's Water and Sanitation for health facilities improvement tool (WASH FIT). With partners in country, including government and other United Nations (UN) agencies/Non-Government Organisation (NGO) partners, WHO has supported the contextualisation, piloting and roll out of WASH FIT in selected health care facilities. Water quality surveillance has also been extended to health care facilities, in some instances.

At the regional level, both regions have led training workshops (online and in person) with target countries and other countries across the regions on WASH in HCF. In addition, both regions have conducted multi-country assessments on WASH in HCF (including data from target countries for this evaluation). Data and engagement with countries has been leveraged to advocate for greater leadership and action on WASH in HCF in both regions. SEAR has spearheaded the development of guidance on cross cutting areas for WASH in HCF, specifically gender and social inclusion and climate resilience.

At the global level, multiple guidance documents and tools have been developed to support countries to take action on WASH in HCF. In addition to guidance documents (which cover all relevant areas of WASH in HCF), global coordination with partners and advocacy efforts have supported several key global milestones during the program period. Two such examples are the World Health Assembly Resolution for WASH in health care facilities in 2019 and strengthened global tracking of progress towards the Resolution through a global country tracker that tracks countries' progress towards the Resolution. Both target countries in the program are engaged in the country tracker process. Learnings from the target countries and both SEAR and WPR have informed global guidance documents and global learning on WASH in HCF.

Underpinning all this work has been a focus on gender, equity and climate resilience with specific case studies and reporting capturing how the programs have been designed and have strengthened approaches to gender, equity and climate resilience. This has been reported most frequently for WASH in HCF.

While the COVID-19 pandemic prevented in country visits, attention was turned to COVID-19 technical support and guidance to support countries. The COVID-19 pandemic was reported to increase attention to WASH in countries and regions. While the project did experience some delays in Indonesia and the Philippines, momentum resumed, and the program's progress and plans continued with pivots to online training and support. A no cost extension was granted for the program into 2022.

In the most recent annual report, all main objectives for WASH in HCF were reported to be on track to be achieved in the two focus countries and at global level.

3. Evaluation purpose and objectives

3.1 Evaluation purpose and approach

The purpose of the evaluation was to assess the extent to which WHO achieved its intended outcomes for the project, with a focus on effectiveness and value for money (VfM). The evaluation was both summative and formative in design to assess effectiveness and VfM, and to assess ways in which learning from the evaluation could inform future program design. The scope of the evaluation is further described above (Section 2.2).

3.2 Evaluation principles

The following evaluation principles were adopted to guide the evaluation process.

Formative and summative: we looked back to assess the implementation of the program and the progress made to date, and looked forward with a view to identifying good, innovative practices that can be adopted and scaled up in the next program cycle.

Multisectoral: we are cognisant of the multisectoral nature of WASH policy and implementation, particularly for WASH in HCF. The evaluation team is made up of WASH and health experts to ensure expertise from both sectors is included in evaluation design executions and analysis. The stakeholders selected for interviews also spanned various ministries from across a range of disciplines.

Systems thinking focussed: given the systems strengthening focus of the programme of work, a systems thinking approach was taken to assessing and analysing the project outcomes, taking into account the interconnectivity of the project activities, outputs and outcomes.

4. Evaluation methodology

4.1 Evaluation questions

Two main criteria were adopted for the evaluation: effectiveness and VfM. Effectiveness was defined in line with the OECD DAC Evaluation Criteria³, and DFAT's VfM Principles⁴ guided the VfM criteria. Given the nature of the program design, scope of the evaluation and evidence available, not all of DFAT's VfM Principles were assessed, although each element (Economy, Efficiency, Effectiveness and Ethics) was addressed. The focus was: cost consciousness (#1 under Economy); evidence-based decision making (#3 under Efficiency); innovation (#7 under Effectiveness), and accountability (#8 under Ethics). See Appendix 1 and 2.

4.2 Data collection

Data sources and sample sizes are summarised in **Table 1** and elaborated upon below.

³ OECD Evaluation Criteria.

<https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>

⁴ DFAT's Value for Money Principles. <https://www.dfat.gov.au/aid/who-we-work-with/value-for-money-principles/Pages/value-for-money-principles>

Table 1 Data sources and sample sizes

	Philippines	Indonesia	Regions	Global
1. Secondary data analysis				
Review of project documentation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of secondary data (i.e. policy documents, learning briefs etc)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Primary data collection				
KII with WHO staff	1 participant	2 participants	4 participants	5 participants
KII with government stakeholders	2 participants	6 participants	-	-
KII with partners	-	3 participants	-	1 participant
KII with DFAT	-	2 participants	-	1 participant
	TOTAL			27

Desk review of project documentation. A review of DFAT-WHO WASH program documents, including those relating to the design, implementation, reporting and monitoring, was conducted. The purpose of this review was to understand the program design and the nature and extent of implementation and to investigate the GEDSI and climate considerations throughout the program. Project documentation was reviewed for the global and regional levels, as well as the two focus countries.

Desk review of additional secondary data. A review of secondary data was conducted to further provide context analysis and contribute data to assess effectiveness of the program against the program outcomes. Secondary data also contributed to assessing VfM. Documentation included national policy documents, as well as any broader health system evaluations, reports, grey and project documentation from national, regional and global WASH and health partners. Only documentation that was available in English was reviewed.

Key informant semi-structured enquiry (remote interviews): the evaluation team members conducted interviews remotely with the following groups:

- WHO staff in Geneva, the SEAR and WPR Offices and the country offices in Indonesia and the Philippines;
- DFAT staff in Canberra and the Indonesia Country Office;
- Staff from ministries relevant to the program (Ministry of Health, Ministry of Public Works, Ministry of Planning and Development);
- Partners supporting work in Indonesia; and
- One partner involved in global WASH in health care facilities efforts.

Purposive sampling was used to select participants based on their responsibilities as related to the program. WHO country staff supported with participant selection and with securing interviews but did not participate in interviews with external stakeholders. All interviews were conducted via Zoom or Teams and audio recorded. Each interview lasted for 1-1.5 hours and had up to 3 participants. The interviews were designed to capture a breadth of stakeholder perceptions of the program across the themes of effectiveness and VfM and across the two technical areas. Verbal consent was sought and given by all participants. A participant information sheet and consent guide are attached in Appendix 3 and semi-structured interview guides are attached in Appendix 4-6.

4.3 Data storage, analysis and validation

The analysis focussed on responding to the overall evaluation questions and outcome indicators outlined for assessment in this evaluation.

All interviews were conducted in English with the exception of one interview in Indonesia where real-time translation was supported by a WHO Indonesia communication staff member who was not involved in the project. All other interviews were conducted by one or two evaluation team members.

Each Key Informant Interview (KII) data was recorded and will be stored on a password protected system until the final evaluation report is completed. Notes were taken during interviews and transcripts were generated using online platform software (Teams or Zoom). Verbatim transcripts were not generated for interviews, rather a combination of interviewer notes and software generated transcripts were used for data analysis. Recordings were consulted to clarify or verify interview notes as needed.

The evaluation team analysed the interview and secondary qualitative data using a framework analysis drawing on the evaluation questions and the outcome indicators, meaning that themes were identified under each evaluation question and indicator. As such, it combined an inductive and deductive approach. The data sources were corroborated as relevant to the evaluation question.

Preliminary findings and recommendations were developed by the evaluation team, and a collaborative preliminary results workshop was used to discuss the team's preliminary findings with WHO headquarters. The reflections and responses were captured and included where relevant in the analysis.

4.4 Ethics and consent

Ethical approval was not sought for this evaluation. However, consent was sought at the start of each interview and participants were advised that they could withdraw their consent and data at any time of the evaluation process. No participants declined the interview. Interview data have been de-identified in the reporting with only the organisation and location of participants used to attribute quotes (e.g. WHO Geneva, WHO SEAR, Indonesia MoH etc).

4.5 Limitations and risks

Several limitations were identified when undertaking the evaluation. These are specified below alongside the mitigating methods put in place where relevant:

Depth: Given the breadth of the evaluation (global, regional and country levels, across 2 program areas: WASH in HCF and surveillance) and the limited time allocated to complete the evaluation, there are limitations to the depth that evaluation questions could address all components at all levels. To overcome this, some evaluation questions focussed predominantly at the country level.

Data availability: Value for Money was predominantly assessed based on KII data rather than on budgeting or financing data. Given the breadth and time allocated to complete the evaluation, it was agreed to focus on specific evaluation questions and KII data to address VfM. This limits the extent for which VfM can be assessed. Specific areas and evaluation questions were selected for the evaluation to best capture data through KIIs on VfM, rather than those which would rely heavily on budgeting and expenditure data.

Country data verification: This evaluation was limited to desk-based research approaches and no country visits were conducted to assess the evaluation questions. To overcome this, we sought

online interviews with diverse stakeholders in both countries and corroborated secondary data with interview data to support and verify the assessment of the evaluation questions. An initial findings workshop was conducted with WHO HQ staff involved to share and discuss findings. Where sufficient evidence was not available for a detailed assessment for some evaluation questions and indicators, this is noted in the report. In these instances, the lack of evidence stated is not to suggest that indicators were not met, rather that sufficient data were not available to make an assessment.

Attribution: Attribution was challenging given the catalytic nature of the program design and ways in which other funding streams were leveraged to support outcomes. Assessing elements for which DFAT support directly contributed to the outcomes and the role of partner contributions (technical and financial) was not possible due to the nature of partnership and joint action in the program approach.

5.0 Findings

5.1 Effectiveness

To assess effectiveness, both the outcome indicators and the effectiveness evaluation questions were assessed and are presented below.

Strongly met	Multiple data across both countries from documentation and KIIs that the indicator was met.
Met	Consistent data from both countries that provided evidence that the indicator was met.
Mostly met	Evidence was available that elements of the indicator were met, but fully achieving the indicator requires further systematic support.
Somewhat met	Components of the indicator were met but it was not consistently met for all aspects of the program or evidence suggested it was only partially met.

Table 2 Assessment against outcome indicators for WASH in HCF

OUTCOMES	Indicators	Result	Evidence	Considerations moving forward
National commitments are made to improve WASH in HCFs	<i>National policies, standards, guidelines, strategies, plans and roadmaps addressing WASH in HCFs</i>	STRONGLY MET	Both Indonesia and Philippines have developed, modified and finalised key national policy documents related to WASH in HCF and incorporated WASH within existing health strategies. Indonesia made commitments to achieving universal coverage of WASH in HCFs in primary health care centres and developed a costed roadmap to guide implementation.	Participants expressed that further work could support greater contextualisation and harmonisation of WASH in HCF with other policies and health areas (such as Antimicrobial Resistance (AMR)).
Capacity is developed among government staff to improve WASH in HCFs	<i>National trainers who have, in turn, gone on to lead WASH FIT trainings</i>	MET	Evidence that partner staff in Indonesia have been trained and gone on to train others on WASH FIT is strong with over 200 sites reported to be participating in WASH FIT processes in Indonesia. This exceeds the number of sites envisaged in the program. Evidence that government staff have been trained in the Philippines and supported ongoing training (including in Papua New Guinea).	The extent to which government staff have trained and engaged government staff at subnational levels in a systematic way is unclear. While an accredited national curriculum is under development in Indonesia for WASH FIT, there is limited evidence that there are systematic plans for training in place, targeted where needs are highest. Where training did occur, evidence suggested this occurred commonly in areas where other partners (such as UNICEF and SNV) had existing projects underway. Future programming could assess and support human resource planning and structure within the health system to systematically implement and refresh WASH FIT training.
WASH infrastructure and practices are improved in HCFs	<i>HCFs that have improved WASH infrastructure and practices following implementation of the WASH FIT process</i>	SOMEWHAT MET	Good evidence that WASH FIT training has been undertaken and WASH FIT processes implemented in HCFs exceeding numbers projected at project outset in both countries. Although there was some evidence that improvements to WASH infrastructure and practices were made following WASH FIT implementation, (e.g. in learning notes in Indonesia outlining improvements to the accessibility of WASH in HCF infrastructure and some procurement for health care waste technology for the COVID-19	To note, insufficient evidence was available to fully assess infrastructure and practice improvements rather than evidence showing no improvement. Future consideration should consider how best to track WASH FIT processes, associated improvements across sites to clearly gauge the extent to which infrastructure and practices are improved over time.

			response), the extent to which sustainable improvements and actions follow WASH FIT processes including infrastructure and behavioural improvements remains unclear. It was important to note that the program only aimed to pilot WASH FIT and the implementation of WASH FIT exceeded the planned number of sites. However, more data are needed to assess the extent to which this resulted in ongoing improvements to infrastructure and practices.	
Monitoring of WASH in HCFs is improved globally and nationally	<i>WASH in HCF indicators incorporated into global and national monitoring mechanisms</i>	MET	Good evidence that WASH in HCF monitoring has improved with several global WHO and UNICEF Joint Monitoring Programme (JMP) reports showing increased data availability across Sustainable Development Goals (SDG)-related indicators globally across the program period. Good evidence that both countries have embedded WASH in HCF-related indicators into existing national monitoring platforms. Both countries have also reported progress across the WHO-led country tracker for progress on WASH in HCF.	Extent to which this data are collected at scale, of high quality and used in decision making and the tracking of national commitments remains unclear. Future emphasis could focus on ensuring this data are collected, used and informs action at the country level.
Partners commit to supporting WASH in HCFs	<i>Evidence of partner commitments to WASH in HCFs</i>	MET	Good evidence to show government and non-government partners are engaged across all aspects of the program and align with WHO program approaches and guidance. Good evidence to suggest this is occurring in both countries and globally.	Continue to foster and strengthen relationships with partners in country and globally. Explore how to best align and support partners work at the subnational levels.
GEDSI and climate are addressed in national WASH in HCF processes and tools	<i>GEDSI and climate indicators in national WASH in HCF standards, processes and tools</i>	MOSTLY MET	Good evidence that some project aspects and documentation have addressed and incorporated GEDSI and climate considerations though this is not consistent across all aspects of the program in the two countries. Indonesia has good evidence of addressing GEDSI and take up of GEDSI approaches in the national roadmap and some WASH FIT implementation processes. Philippines has good evidence of incorporation and adapting WASH FIT and WASH in HCF activities in line with the overall	Good examples to draw on and systematize through future programming. Sharing of lessons between countries and contexts recognised as important to future implementation. To note, GEDSI and climate resilience were not a focus of the project from the outset but were integrated and developed across program implementation.

			Government's focus on Greening Health Care, which includes climate resilience and some GEDSI considerations. GEDSI and climate resilience not systematically or fully applied across all relevant policy documents, tools and processes in both countries. As such, indicator not fully met but progress overall well noted.	
WASH in HCFs is increasingly addressed by the health sector globally and nationally	<i>WASH is integrated in to relevant global and national health guidelines, strategies and action plans, including those on Maternal Child Health (MCH), Infection Prevention and Control (IPC) and AMR</i>	MET	Good evidence from both countries that WASH in HCF is embedded across health sector programs though some areas were highlighted from both countries that could be strengthened. Examples include where existing health sector priorities have incorporated WASH and where WASH in HCF approaches have adapted to align with other health sector priorities and approaches. Good evidence of global health sector strategies incorporating WASH in HCF though the extent to which DFAT support can be attributed to this is unclear.	Explore how best to integrate WASH in HCF approaches with relevant health programs and processes. Examples that interviewees provided for consideration included integrating WASH in HCF into existing quality of care mechanisms in countries; into IPC documentation, particularly guidelines; into disaster risk-reduction and for AMR national action plans and subsequent action.

Table 3 Assessment against outcome indicators for water quality surveillance and monitoring

OUTCOMES	Indicators	Result	Evidence	Looking forward
Policy and regulatory drivers for surveillance are strengthened, including a greater focus on risk management	<i>New or revised surveillance policies, standards and guidelines, incorporating sanitary inspections and/or WSP auditing</i>	STRONGLY MET	There is strong evidence that Indonesia and Philippines have developed, modified and finalised key national policy documents related to water quality surveillance and management, including integrating modified sanitary inspections and WSP auditing. There is good evidence that global documentation and guidance on water quality surveillance and monitoring has informed the program, as well as been informed by the program.	Continue to modify national policies, including strengthening the GEDSI and climate resilience aspects consistently across all relevant policies, tools and guidelines. Further support the operationalisation of policies and approaches at the subnational and local levels.
Capacity is developed among government staff to carry out surveillance activities	<i>Those trained have gone on to train others and/or have carried out surveillance in accordance with training</i>	MET	Good evidence of government and partner staff being trained and capacity developed on surveillance and WSPs/WSP auditing, including a cadre of master trainers in both countries who have delivered trainings. Numbers reached exceeded project projection in part due to online delivery of training due to COVID-19. There was not sufficient evidence available for the evaluation to fully assess the extent to which capacity was built through training though some before and after training survey data indicate some improvement in knowledge. This does not indicate that capacity wasn't built, just that evidence wasn't available to verify the extent of capacity developed.	Further and continued support has been requested for capacity building, including support from international consultants and for learning exchange with other countries, including Australia, to strengthen WSP processes and capacity. Further evaluation is required to assess the extent to which online processes supported capacity building compared to hybrid or face to face training, with some participants fully benefited from online training processes.
Surveillance information management systems are strengthened	<i>Evidence of changes / improvements to information management systems</i>	MOSTLY MET	There is evidence to show that tools related to surveillance have changed over the project period, including the modification/creation of surveillance information systems in both countries. While several aspects of surveillance information systems have been improved across the program, evidence on the operationalisation of the surveillance information systems goal, future programming could focus on supporting indicated this is limited to some sites and pilot areas. While the program didn't set out to fully operationalise the strengthened systems, further support will be required to fully achieve this outcome. Evidence indicates	Further support is required to realise the full operationalisation and institutionalisation of surveillance information systems, including data sharing across ministries and the sustainable procurement and availability of equipment for surveillance and laboratory capacity and costs to foster surveillance data at scale. While this is a longer-term goal, future programming could focus on supporting operationalisation of tools and strengthening participation, incentivisation and engagement of all relevant stakeholders.

			that challenges remain in fully engaging all relevant water suppliers and ongoing financial and infrastructure (laboratory capacity and materials) barriers to water quality testing.	
Surveillance practice drives corrective action and improvement	<i>Improvement actions taken as a direct result of surveillance findings and recommendations</i>	MOSTLY MET	Documentation and KIIs produced some evidence that the enabling environment for surveillance practice had been strengthened but evidence on the extent to which this had resulted in corrective action consistently is limited. The project set out to only support pilot surveillance and corrective action processes and this was met in terms of reach at pilot scales. Site visits and field evidence would have strengthened the assessment of this indicator.	Policy and enabling environment improvements need additional support, including laboratory capacity and financing to sustainably bring surveillance to scale. Support may also be required to effectively utilise data to inform and prioritise improvements.
Partners support surveillance activities	<i>Evidence of partner support for surveillance</i>	MET	Good evidence in both countries and at the global level that partners are involved in surveillance activities and the generation of surveillance documents and guidance.	Continue to strengthen partnerships at the country level across government ministries, across levels of government (national and subnational), and the private sector.

5.2 Evaluation questions for Effectiveness

5.2.1 To what extent were the program outcomes achieved across Philippines, Indonesia and at the regional/global level?

a) To what extent have the program approaches been adopted by governments?

Summary: *Strong evidence that program approaches have been adopted by governments in the Philippines and Indonesia.*

There is evidence from document review and KIIs across the two focus countries that program approaches have been adopted by governments, both for WASH in HCF and water quality surveillance and management. The predominant focus of WHO's support has been at the national level and several new and modified policies, guidelines, roadmaps, tools and monitoring mechanisms have been developed.

For WASH in HCF, both countries have integrated WASH in HCF indicators into national monitoring systems and have developed roadmaps for implementation of WASH in HCF. In Indonesia, the government has committed to achieving universal access to WASH in health care facilities in all primary health care facilities. Philippines government has also developed standards and integrated several aspects of WASH into the national strategy for Green Health Care facilities. The Green Health Care Facilities standards are mandated for all health care facilities above 10,000 square metres (sqm). COVID-19 was identified in both countries as a catalyst for increased action on WASH in HCF.

For water quality surveillance and management, there has been a history of engagement in the Philippines on supporting policies and strategies related to water quality surveillance and management prior to this project cycle. The project further built on this foundation including the development of guidelines and policies on drinking water quality surveillance and water safety plan monitoring and audit processes. KII data indicated that ministry partners welcomed WHO's efforts to align their technical support with government processes and provide technical support to ensure Philippines processes were consistent with global standards and recommendations. Indonesia also saw development and finalisation of several seminal policy documents, including a Decree on drinking water quality surveillance. These documents covered multiple aspects of water quality, WSPs and surveillance, including WSP auditing. In line with the Decree, Indonesia also has an agreed national roadmap in place. KII data from partners indicated that WHO's support was valuable in supporting high quality technical input into relevant policies, advocating for strengthened policies and providing technical support in capacity building processes with government staff.

"WHO Indonesia have provided good support in regards to water quality surveillance and very, very well supported us with lessons from other countries and we received support for implementation and technical implementation such as strengthening our standards and other technical matters so we can draw conclusions on what to do in the field. WHO has been very supportive I hope our partnership will continue" Ministry of Health, Indonesia

b) How, where and for whom was change achieved most effectively?

Summary: *Across both countries, the predominant focus of the work and the change that was reported in documentation and in interviews was at the national level through policy change and government commitment across both technical areas. Some subnational progress is evident though at a smaller scale or at pilot levels.*

As highlighted in part a) above, a predominant focus of WHO's support across the program cycle was to support strengthened national policies, guidelines, tools and approaches and there is good evidence that these policy changes supported national level ministries and partners, and to some extent, subnational government and partners to increase political will and drive WASH improvements across both technical areas. It is important to note that the extent of operationalisation of policies, strategies, tools and guidelines for WASH in HCF and water quality surveillance and management was designed to be at the pilot phase level or in a phased process starting in some subnational areas with plans to expand over future years.

Data availability was a challenge to fully assessing the extent to which change was realised at the subnational level, particularly for whom (considering gender and social inclusion aspects); for which specific areas of WASH (water, sanitation, hygiene, environmental cleaning and health care waste management) at the health care facility level; and the level of engagement and extent of capacity strengthening of stakeholders and institutions/organisations (such as laboratories and local water providers) at subnational and local levels. It is important to emphasise that this does not necessarily indicate that no change occurred, but rather the data available for the evaluation were not sufficient to reliably assess this change.

Capacity building was central to WASH in HCF (for WASH FIT most specifically) and for water quality surveillance and management. There is good evidence that capacity strengthening activities with government staff and partners were undertaken. KII data indicated that those who had participated in the training processes reported that training was targeted appropriately and was well received. Partners involved varied across technical areas and countries but included implementing partners such as UNICEF and SNV in Indonesia for WASH in HCF, and water utility partners and local government agencies for water quality surveillance and water safety planning. The reach of training exceeded what was planned for water quality surveillance and management, in part due to the switch to online delivery in response to COVID-19 restrictions. Training is ongoing for WASH in HCF with both countries undergoing processes of contextualising WASH FIT processes further in line with government strategies, standards and the local context. The reach of WASH FIT training, particularly in Indonesia, exceeded initial targets through support of other partners (such as UNICEF and SNV) embedding WASH FIT into their programs.

Additional funds were frequently leveraged to support subnational operationalisation of both technical areas, although the extent to which DFAT funds supported operationalisation is difficult to determine with the data available. The extent to which domestic financing from government was utilised is also unclear though there are several examples of government financing commitments including in the Philippines where it was reported that budget has been allocated for Greening Health Care facilities (which includes WASH in HCF) and costed roadmaps are in place for WASH in HCF in Indonesia.

Gender and social inclusion approaches have been adopted in some areas of the program, particularly in Indonesia for WASH in HCF. GEDSI has been embedded into some policy documentation, tools and GEDSI processes such as including disabled people's organisations and gender groups in WASH FIT processes. No clear project framework or explicit project indicators exist for routinely tracking and assessing the project outcomes related to gender and social inclusion across the project and both technical areas as a whole. The absence of this data made determining who the program reached, specifically vulnerable groups, at health care facility and local communities difficult.

c) What were the underlying barriers and facilitators of the program's effectiveness, including replication and scale-up of the surveillance and WASH in HCF aspects of the program at the country level?

Summary: Several common and differing facilitators and barriers for each technical area were identified. Key enablers across both technical areas included: strong partner engagement, leveraging additional funding, and COVID-19 increasing attention to WASH. Key barriers included: sustainable financing, especially to address WASH service improvements; and limited subnational leadership and capacity for program delivery.

While some common barriers and facilitators emerged from KII data across the program as a whole, these differed according to the technical area. There were similarities identified within technical areas across each country and the data below are presented for each technical area in line with this finding.

WASH in health care facilities

COVID-19 as a catalyst and enabler for raising attention to and action on WASH in HCF at the country and global levels was consistently reported across KIIs. COVID-19 was reported to have driven national awareness on WASH in HCF, particularly to support infection prevention and control but also to manage health care waste during COVID-19. Data indicate the pandemic also accelerated activity at the global level, partly to support COVID-19 specific guidance for WASH, but also tools such as a modified WASH FIT process for rapid assessment of facilities during COVID-19. In addition to the pandemic, other enablers that were identified included: WASH in HCF falls primarily under the domain of the ministries of health which is WHO's main in country partner and requires less coordination with other ministries than other WASH-related areas; the 2019 World Health Assembly Resolution of WASH in health care facilities and the associated country tracker; engagement of partners at the global and country levels, including the ability to leverage additional funds for the roll out of WASH FIT.

Fewer barriers than enablers emerged for WASH in HCF but several barriers were highlighted, particularly with a focus on longer term roll out of WASH FIT at scale. Barriers related to sustainably scaling up and delivering quality WASH services and practices in health care facilities emerging from KIIs included: sustainable financing to address WASH services improvement, maintenance and upgrades at the facility level; integrating WASH in HCF within and aligned with other health priorities (e.g. Green Health Care Facilities in the Philippines, quality of care mechanisms in Indonesia); and, understanding the quality of WASH FIT implementation due to limited site visits for data verification and to develop deeper learning to inform future roll out.

Water quality surveillance and management

One key enabler frequently reported for water quality surveillance and management was the ongoing project continuity of DFAT and WHO supporting the area of work in the focus countries and more broadly across the region and globally. The continuity of support, particularly in the Philippines, has allowed continual policy strengthening over time and supported both countries to update and modify strategies and guidelines in line with up-to-date global guidance. Having WHO global guidance available was highlighted as an enabler to strengthening national policies. WHO's support for coordination and engagement across relevant ministries and partners was commonly recognised among participants as an enabler to progress on water quality surveillance and the implementation of WSPs. It was noted that this may need to be modified in the future to include stronger partnership and engagement of local level government structures and those ministries responsible for local level governance and budgeting such as the Ministry of Home affairs in Indonesia. In addition, the engagement of other partners and funding (such as KIAT (Indonesia

Australia Partnerships for Infrastructure) and USAID in Indonesia) facilitated operationalisation of WHO-supported policies and WHO also engaged these partners in capacity building and coordination efforts.

Barriers identified included lack of sustainable financing at many levels for water quality surveillance, corrective actions and WSPs at scale. For example, in Indonesia, guidelines exist for who is responsible for funding surveillance or WSP actions but there are barriers to this funding being allocated and realised. Some participants acknowledged that in some settings, particularly in Indonesia, that barriers to progressing policy change and operationalising guidance can emerge with WHO's main partner in country being the Ministry of Health. Responsibilities for water quality surveillance operationalisation, including local level governance and planning at the subnational level, sit across multiple ministries and involve different partners across varying levels of government jurisdictions. This requires WHO to coordinate and/or partner with multiple government departments/ministries that are beyond existing MoH relationships. In addition, it was noted that in the Philippines, recent restructures within in the MoH could pose challenges for the sustainability of existing WASH programming.

5.2.2 How appropriate were the program's strategies to promote the sustainability of changes?

Summary: *The program approaches were appropriate for national level leadership, policy, regulation and monitoring outcomes. Program approaches may need adapting in the future to support sustainable institutionalization and implementation of policies and processes at the subnational and local levels.*

In line with evaluation question under 7.2.1a, it was widely acknowledged among KII participants that WHO effectively works with government across a range of ministries and supports WASH in HCF and water quality surveillance efforts in line with government priorities and systems. This acknowledgement was highlighted as a key aspect of WHO's approach that supports sustainability. While this was commonly recognised as key to sustainability within KIIs at the national level and to support the development of national guidelines, regulation, process and roadmaps, the institutionalisation and operationalisation of these policies and approaches were recognised as not fully in place across WASH and related health systems.

To assess the extent to which the program addressed sustainability from a systems perspective, data from this evaluation have been analysed in line with the WASH system building blocks that the project focussed on as described in Section 2 Figure 1. To note, the systems building blocks in the table below are components adapted from the IRC WASH systems building blocks⁵. Not all the building blocks as outlined by the IRC document are highlighted below; these are those which were a focus of the DFAT-WHO WASH program. While a top line analysis has been done for each of the building blocks here, it is critical to highlight that these are not stand-alone blocks. The block and their elements are interconnected within the system. There are also four other critical blocks not assessed: infrastructure; water resource management; learning and adaptation and planning.

Table 4 Progress according to relevant systems building blocks for WASH

Systems Building Block	WASH in HCF	Water Quality Surveillance
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⁵ Huston, A, Moriarty, PB. Understanding the WASH system and its building blocks: building strong WASH systems for the SDGs. Working Paper, 2018. IRC: The Hague.

Institutions	Capacity building of government staff recognised, as was coordination among partners and government, particularly at the national level.	Capacity building among government and partners recognised, though further support is needed to reach building capacity at scale. WHO's support for coordination well recognised. For future programming, greater attention could focus to support subnational coordination and action, including the engagement of additional areas of government with subnational responsibilities.
Policies and Plans	Good evidence that policies and plans were strengthened, implementation and accountability to plans will require future support. For both technical areas demonstrated commitment from government at the national level and some subnational areas. Policies progress discussed here is also relevant to regulatory oversight building block below.	
Monitoring	Indicators for WASH in HCF built into national monitoring mechanisms in both countries during the program period. Quality and use of data at national level yet to be determined.	Water quality surveillance systems were strengthened, with a particular focus on the documentation including policies, tools and guidelines and to some extent routine surveillance in some areas. Surveillance at scale and corrective actions is yet to be fully realised.
Regulatory oversight	There is some evidence that WASH in HCF exists within regulatory and/or accreditation processes in both countries. For HCFs over 10,000 sqm, standards (including for WASH) must be met in the Philippines and this is enforced by law. WASH indicators form part of accreditation processes in Indonesia. The extent to which either are enforced is unclear.	Progress was made in the Philippines to build on the national WSP policy and incrementally develop supportive policy relating to WSP auditing (WSPs are mandatory) and to guide stronger surveillance oversight in line with the new policy on drinking water quality surveillance. WSP auditing processes have occurred in some cities. In Indonesia, the National Decree on drinking water quality surveillance was updated outlining which parameter water providers need to test and report on, and also requiring WSPs and WSP auditing (as part of surveillance). Efforts should continue to fully operationalise regulation and WSP auditing processes in both countries.
Financing	While some policy documents for WASH in HCF (such as the costed roadmap in Indonesia and Greening Health Care Facilities standard in Philippines) and for water quality surveillance and management outline costs, have a budget line or outline responsibilities for financing, there is little evidence that sustainable financing mechanisms are in place across both technical areas, particularly to support subnational level implementation. Subnational implementation processes, particularly for WASH in HCF are commonly supported by partners and their associated funding.	

The table above highlights that there is evidence that WHO has supporting strengthening of several of the system building blocks for WASH. It was not possible to assess the extent to which this support enhanced the functioning of the system as a whole but future analysis could explore the ways in which WHO's work supports the strengthening of dynamic systems, moving beyond just assessing building blocks but also how the building blocks interact and interconnect to support the system.

Several KII participants reported that the extent to which water quality surveillance and management and WASH in HCF policy change cascaded to local level outcomes was limited. While it must be noted that subnational implementation was only planned to reach pilot levels during this program cycle, WHO's role in supporting local level implementation at scale and strengthening systems at local levels for both technical areas was highlighted as a key consideration in future programming plans. Of particular note, was to further explore the way in which small scale water suppliers at local and community levels can be engaged in surveillance and water safety planning.

5.3 Value for Money

5.3.1 How have decision making processes for implementation been cost conscious?

a) To what extent has partner selection been cost conscious through adopting competitive processes?

Summary: *There is good evidence that WHO has been cost conscious in its partner and consultant selection processes.*

It is important to note that a review of costs or any financing data from the program were not analysed to assess VfM in this evaluation given the scope and time available to conduct the evaluation. Data available to the evaluation team for assessing this evaluation question are drawn from KII data from WHO staff. All interviewees expressed that WHO internal processes were sufficient to support competitive bidding processes to select consultants and partners across the project. Participants universally felt that these processes supported cost consciousness through facilitating WHO to select partners and consultants who provided quality contributions with cost minimisation processes in place in line with WHO costing requirements.

b. Which processes were adopted to design & adapt program activities & plans to be cost conscious and deliver quality program outcomes?

Summary: *There is good evidence (from KII and project documentation data) that there are cost conscious processes in place to support quality delivery of program outcomes.*

As with 7.3.1a above, data were limited to KIIs with WHO staff and project reporting documentation to assess this evaluation question. Overall, participants felt that cost conscious processes were consistently applied across the project. Examples of cost consciousness included: consistently leveraging funding from other sources and partners to support implementation and operationalization of strategies for WASH in HCF and water quality surveillance and management; repurposing project funding when progress was not being achieved in one context to support expanding project work in contexts where program delivery could be strategically accelerated; increasing program reach through developing online learning tools and courses for WASH in HCF and water quality surveillance and management which supported cost savings across the project;

leveraging data and learning from small scale implementation at low cost, to drive national level policy adaptation and strengthening which supports implementation at scale; and utilizing experience and learning from DFAT-supported countries to directly support progress in similar technical areas in other countries in the Asia Pacific region and beyond.

Specific examples were highlighted for cost consciousness across several interviews. One learning exchange example provided by a KII participant highlighted the potential of master trainers from a DFAT-supported country to support other countries in the region to take up WASH FIT processes in their country context (learning exchange from the Philippines to Papua New Guinea). While the final report of this learning exchange was not complete for review for this evaluation, the quote below from a KII highlights how such learning may be useful in minimizing costs (including time taken to contextualize tools to different settings).

“But it was a really successful experience because it showed that the master trainer really had grasped the different aspects of it and would be able to do this training in all contexts, not only in the Philippines but in the region. But also, that the investment in the manuals for the Philippines wouldn't need that much tweaking to be applicable in other situations as well. So, I think because what they tried to do in the Philippines was that they simplified the manual a little bit because the global manual is really very complex and onerous and so they tried to simplify it a bit and that also really, really worked in the context of Papua New Guinea”

KII WHO regional office

Other examples included: how advocacy was used to supported funding going towards systems building blocks rather than infrastructure implementation alone; the utilisation of online training platforms and processes during COVID-19, especially capitalising on increased attention to WASH resulting in greater reach of training programs than expected; and processes by which government partner plans are reviewed and discussed to ensure quality and cost consciousness.

There were some concerns raised about the extent to which quality could be assessed for cost consciousness across water quality surveillance and WASH in HCF. This was not specifically highlighted to suggest implementation was not of quality, rather that several participants did not reliably have data available to assess the quality of all program aspects, predominantly due to COVID-19 restrictions. Areas that were highlighted that quality could be explored further were:

- COVID-19 restrictions have meant there have been limited site visits to understand the extent and quality of WASH improvements at health care facilities in both countries;
- While some before and after assessments were done of capacity building exercise delivered under the water quality surveillance and WSP aspects of the program, understanding the extent to which online sessions improved capacity of attendees was reported as limited and some KII participants acknowledged that it is not known the extent to which online training can adequately replace face-to-face training with hands on components on site.

5.3.2 To what extent has evidence and learning been used to inform program design and implementation at the country level?

Summary: *There is good evidence that evidence and learning is used to inform program design and implementation though there are some areas which could be strengthened in future programming.*

Project documentation and KII data demonstrated that program planning and design were based on contextually specific data. Situation assessments were conducted in each country for water quality surveillance and management and existing data were utilised or collected to inform WASH in HCF planning. In addition, throughout program implementation, learning and evidence was generated

through learning notes, learning events and to some extent sites visits, though this was limited due to COVID-19. KII data indicate that learning generated from the program was utilised strongly regionally and globally as examples, particularly for WASH in HCF progress.

Learning generated from DFAT supported countries has been used to inform programming in other countries in the region directly (through expert knowledge exchange) and more broadly through regional learning and sharing and through capturing learning documents/videos that are shared through global level platforms and documentation. One example where learning was generated from, is highlighted in Box X, which spotlights the GEDSI efforts WHO has support for WASH in HCF in Indonesia. Videos, learning briefs and programming documentation from this work have been used to influence other actors' practice, supported uptake of GEDSI elements in some national policy and informed WASH FIT 2.0. Implementation data from both countries were used to inform WASH FIT updates (including climate resilience learning from the Philippines and GEDSI from Indonesia) and WSP manual and small systems guidelines (currently under development).

While there was strong evidence and learning generated in some areas, KII data indicated that some participants expressed interest in further understanding how the operationalization of policies and tools were effective at local levels and to develop a deeper understanding of the longer-term outcomes and impacts of WHO's work over time. A more systematic and academic approach to evidence generation and learning could be applied to future programs to address this. It was acknowledged that WHO has limited human resources (when compared to other development partners such as UNICEF who have dedicated knowledge and learning teams) and that partnering with others to collect evidence and generate learning products may be required. Other areas raised where evidence and learning could be strengthened were: to generate evidence to understand how to better integrate the two program technical areas and to share data and knowledge between these technical areas (particularly shared across different ministries); that greater academic research and publications could be incorporated into the program and strengthen evidence available for learning and advocacy; that evidence generated could feed back into improving and updating WHO's Essential Environmental Health Standards in Health Care; and that learning materials such as videos and online learning courses that were developed during COVID-19 could be expanded.

5.3.3. To what extent have innovative approaches been adopted to integrate GEDSI and climate resilience into programming, monitoring, funding and decision-making?

Summary: *There is some evidence that innovative approaches have been adopted for GEDSI and climate resilience in some contexts and for some program aspects.*

There were several examples highlighted in documentation and KII data regarding GEDSI and climate resilience innovations at global, regional and country levels. It must be noted that no specific measure for 'innovation' has been applied, rather examples that were provided or noted by documentation or KII data as innovations to existing programming approaches or guidance were considered 'innovative' in this evaluation.

Evidence in both KII data and documentation demonstrated that global level documentation has been strengthened in relation to GEDSI and climate resilience, especially for WASH in HCF. This included the updated WASH FIT tools to consider GEDSI and climate resilience, the guide for equitable water safety planning, inclusion of GEDSI considerations in Sanitary Inspection forms, the upcoming revised Volume 3 small water supply guidance, and the integration of equity and climate messaging into the revised WSP manual. KII data suggested that WHO-DFAT program innovations in Indonesia (GEDSI) and the Philippines (climate resilience) informed the updated WASH FIT tool.

The SEAR Office also had evidence of a strong focus on climate resilience and GEDSI producing a GEDSI toolkit for WASH in HCF and running training on climate resilient WASH in HCF and WSPs. The SEAR has also developed a star rating mechanism for climate resilient HCFs.

Overall, there is good evidence to indicate the GEDSI and climate resilience innovations contributed to programming. However, the evidence for monitoring is limited. No systematic approach was applied to GEDSI and climate resilience across the program (including during program design) and there is little data available to demonstrate innovations in monitoring regarding these two aspects.

There are examples of how gender, and to some extent social inclusion, have been adopted in WASH in HCF policy and implementation in Indonesia, including during processes for WASH FIT through engaging community organisations, women's and disabled people's organisations. The GEDSI WASH in HCF innovations are further explored in the Spotlight Box below. However, the scale of implementation and institutionalisation is modest. It is noted there are plans in progress to strengthen this at scale. Climate resilience considerations have been strong in the Philippines, though this in part was attributed to high level government leadership and prioritization of climate resilience rather than a WHO-led process. As such, data indicate WHO is tailoring their support to address climate resilience in the Philippines in line with national priorities and policies to maximise reach and outcomes and, learning is informing other programming in the region and globally.

Some evidence of climate resilience and GEDSI integration into water quality surveillance and management emerged though some participants noted this could be strengthened, particularly to support governments to navigate climate related data and meaningfully use it to inform water quality surveillance and management.

Regarding the extent to which GEDSI and climate resilience innovation were evident for funding and decision-making, only a few examples emerged. Learning documents and videos from Indonesia demonstrated how local level leaders were involved and engaging in GEDSI processes for WASH in HCF and funds were dedicated to improve infrastructure to support people with limited mobility. From a funding perspective, there is a budget line for greening health care facilities in Philippines though this has been government-led rather than WHO driven but is supportive of embedding stronger climate considerations into WASH in HCF.

While global strategies for WHO (WHO's Global Program of Work and the WHO WASH strategy) contain strong commitment to gender and social inclusion and climate, there was little evidence of a consistent framework for GEDSI and climate across program design and implementation to support consistency and monitoring of program outcomes in these areas.

Figure 2 Spotlight innovation: Addressing gender and social inclusion for WASH in HCF in Indonesia

Data from the evaluation indicated that WHO Indonesia has led several innovative approaches to strengthen gender and social inclusion within their WASH in HCF support. WHO's support has contributed to strengthening GEDSI components in the National Roadmap for WASH in HCF. The Roadmap explicitly sets out strategies for addressing gender considerations, particularly for: women around childbirth; the female workforce at HCF; the needs of vulnerable groups (people with disability, older people, children, patients with injury or severe illness, and minority groups); and to ensure all facilities are accessible and usable by all, including sanitation facilities. These primarily fall into 2 of the 7 strategies outlined in the roadmap:

- Strategy 4: Inclusive and sustainable improvement in WASH facilities and infrastructure and waste management*
- *Strategy 5: Engagement of communities in the improvement of WASH and waste management services at public health centre*

While a foundation was set before the DFAT-WHO WASH Program 2018-2022 through existing government policies and decrees outlining the need to consider gender and accessible infrastructure for sustainable development, WHO identified a need to further understand what would be required to ensure GEDSI was actioned at all levels of WASH in HCF (policy to implementation). This was catalysed by the GEDSI emphasis in the WHA 72.7 Resolution for WASH in health care facilities and guided by the WHO's 13th General Programme of Work's focus on mainstreaming GEDSI in WHO programs and support. In collaboration with WHO Indonesia's gender focal point, the WHO WASH team in Indonesia led a series of focus group discussions with stakeholders including gender and disability groups, health facility staff and policy makers at the national level. Recommendations were used to inform the WASH in HCF Roadmap development. The GEDSI aspects of the Roadmap are comprehensive; they consider not only inclusive infrastructure but also outline the need for:

- The involvement of GEDSI stakeholders in policy and guideline development;
- GEDSI training is given to the health workforce at all levels;
- Studies on the specific needs of vulnerable groups to inform implementation;
- Meaningful engagement of vulnerable groups within all aspects of implementation (planning, monitoring, implementation and evaluation); and
- Advocacy that continues to ensure these needs are reflected in indicators for accreditation of primary health care.

The Roadmap has only recently been developed and has not yet been fully rolled out. This evaluation found evidence that in parallel to the Roadmap development, WHO supported WASH in HCF implementation and capacity building activities with a strong GEDSI focus, in line with the GEDSI strategies outlined in the Roadmap. Several learning products indicated that in East Nusa Tenggara and the Lampung Province in Sumatra, the local leadership championed GEDSI and involved organisations for disabled people in planning activities, the local health workforce received GEDSI training within their broader WASH FIT training and that WASH FIT implementation has resulted in upgrades and modifications to infrastructure, such as widening doors and improving ramp access to building and toilets, for it to be more accessible. Representatives from vulnerable groups were also engaged in the WASH FIT improvement plan development and fed into the costed Roadmap development. Evaluation interview data indicated the GEDSI work was well received by the Ministry of Health and they recognise the need to address GEDSI in the implementation of the Roadmap.

To note, this evaluation was unable to assess the extent to which GEDSI was consistently considered across all WASH FIT implementation and further research could help to understand the effectiveness of GEDSI implementation in future programming. Yet the evaluation data suggest that WHO Indonesia's innovations in GEDSI for WASH in HCF create a foundation for more systematic and well evaluated GEDSI efforts in future WASH in HCF support.

5.3.4. To what extent have processes to assess and manage risk and ensure accountability been adopted throughout the project to support the delivery of project outcomes?

Summary: *There is evidence to suggest the risks were managed well across the project though there are some areas that could be strengthened for future programming.*

There was no formal risk register analysed in this evaluation. The assessment of risk management processes was conducted based on KII data and relevant project reporting documentation. KII data revealed, from both partner and WHO staff, that almost all perceived that risks were managed well, including throughout the COVID-19 pandemic. Internal WHO reporting (in addition to formal project reporting to DFAT) also highlighted effective risk management processes and decision making. This included noting where progress was off-track and how it could be addressed.

Key to supporting risk management was communication. Several KII participants at all levels (between WHO country offices and government partners, between WHO offices at country, regional and global levels and between WHO and DFAT) highlighted that communication was central to managing risks throughout the project. This was noted for all types of risks that were raised including internal program risks, and external risks, such as COVID-19.

External partners expressed that WHO was flexible and responsive to risks, including challenges facing government partners such as staff turnover and changes in the prioritization and approval of policies and guidelines. Examples of effective risk management included WHO amplifying advocacy to higher level government when progress slowed or the political prioritization of program areas diminished. WHO was also able to adapt funding mechanisms to support delivery of the program during COVID-19 when government partners had competing priorities addressing COVID-19 needs.

Most data indicated that future improvements could be best targeted at internal program risks. While WHO involvement at all levels promotes coordinated decision-making and aligned technical assistance, an agreed protocol for more streamlined project management with the objective of minimizing the involvement of all WHO levels in certain processes, would allow for more efficient implementation and responses to risks. One suggestion was to better integrate the two technical areas of the programs and have joint indicators where possible. In addition to streamlining reporting, some participants noted that there could be stronger engagement with DFAT at the country level in program reporting, review and strategy.

6. Recommendations

The evaluation evidence indicates clear progress has been made across both technical areas at all levels of the program implementation. Project documentation revealed all project activities and outputs were achieved and all outcome indicators were met though some more strongly than others. The program has successfully engaged partners at all levels and fostered coordination that, if continued, will be essential to scaling up operationalisation of the strategies and policies that were developed during the 2018-2022 program.

While clear progress has been demonstrated across all program areas, consideration could be given to the following areas in future programming:

- More clearly align strategy and relationship between the two program areas as well as explore how progress and learning can contribute to DFAT's broader programming;

- Clearer articulation of GEDSI and climate resilience across program design and reporting; provide greater support to national level stewardship to support strong subnational implementation (i.e. implementation of national policies);
- Explore how the program can support related emerging issues such as those raised in interviews including antimicrobial resistance, disaster risk reduction and response and other relevant challenges in the regions;
- Streamline reporting to focus on a priority set of progress and outcome indicators, including to capture outcomes related to subnational and local level implementation; and,
- Strengthen learning and capturing of evidence to support understanding broader impact over time.

The following recommendations highlight areas for consideration for future DFAT-supported programming across the Asia Pacific and are designed to inform WHO support and practice more broadly.

- 1. DFAT support to WHO for WASH across the Asia Pacific region should continue, especially to support countries where leadership, policies, and processes are under development/in place in program focussed technical areas. In line with recommendation 4, WHO should continue to foster government leadership and support sustainability through directing efforts to support the operationalisation of policy and regulatory commitments.**

The evaluation data provided evidence that DFAT-supported WHO WASH programs can generate learning and capacity which can inform, influence and drive action on WASH in surrounding countries. Country selection processes were raised as an important factor for program success and focussing on settings where there is momentum and political will can foster effective programming and generate evidence that can contribute to broader impact on WASH services across the region. Clear progress has been shown in this evaluation in strengthening government policies, regulatory processes, monitoring and tools in both technical areas. Capitalising on this progress and extending program efforts and associated learning on operationalisation of these efforts could continue countries progress towards achieving SDG 6.1 and 6.2 as well as contribute to broader region progress in these areas.

- 2. Future programs should explore how to integrate the WASH in HCF and water quality surveillance and management aspects of the program where relevant. This is not intended for all aspects of each of the technical areas, but could focus on the following areas: to more fully address water quality and related operation and maintenance at HCF; share monitoring data and relevant information between ministries that have respective responsibilities for WASH in HCF and water quality monitoring and surveillance where this is not occurring; and to develop higher level outcomes indicators for the program that integrate both areas to streamline reporting processes and capture relevant program points of intersection.**

Inception and design processes should explore ways in which to best streamline and develop indicators across the two technical areas and agree high level indicators that support meaningful tracking of project outputs and outcomes. KII data indicated a demand for greater data sharing among ministries with responsibilities for each technical area so they could incorporate relevant information into their planning and operations. There were only ad hoc examples of where water quality surveillance and management and WASH in HCF efforts occurred concurrently. To support safely managed water supplies at health care facilities (e.g. in line with Indonesia's efforts to support more advanced WASH related targets at HCFs and Philippines Greening Health Care facilities policy which outlines WSPs as well as WASH FIT process for HCFs), future programming should explore how

to best streamline and operationalise more integrated approaches at HCFs. Well-designed learning components should be utilised to understand which aspects could be better integrated and how this may effectively be done.

3. Future programs would benefit from adopting Gender and Social Inclusion (GESDI) and climate resilience frameworks to systematically apply GESDI and climate resilience consideration across all aspects of the program.

Strong examples of GESDI were implemented in aspects of the WHO-WASH program, particularly in Indonesia as is highlight in Box X, and more recently, through the development of GESDI Toolkit by the SEAR Office. However, GESDI and climate resilience were not systematically embedded across the whole program and as such, gaps remain where these areas could be strengthened for both technical areas and countries. Such examples can be built upon and applied in a systematic way across future program cycles, supporting more consistent and systematic uptake of GESDI and climate policies, processes and indicators by governments. GESDI assessments should be conducted in each context at the program inception stage and used to inform program activities, indicators and monitoring. Similarly, examples of integrating climate resilience have emerged from the Philippines and there is willingness from participants to expand this approach across both WASH in HCF and water quality surveillance in both countries. Utilising articulated frameworks for GESDI and climate resilience could support clearer monitoring of program outcomes for diverse stakeholders and support more clearly understanding the extent to which the program reaches and benefits all. Complementary financing, especially for climate resilience, may also be explored to support greater scale of operationalisation of the support provided by WHO. This has occurred to some extent with Philippines, where financing has been allocation for greening health care facilities, including WASH in HCF, and further opportunities could be sought to complement the DFAT-WHO program's efforts and drive operationalisation at scale in countries.

4. To the extent that resources allow and in collaboration with partners, build on progress of strengthening the enabling environment across both technical areas at the national level, and refocus technical support to include stronger attention to supporting national stewardship for the operationalisation of policies, which includes: strengthening regulatory capacity; strengthening coordination; incentivising subnational actors to comply and supporting their capacity to do so; supporting planning and budgeting processes at the subnational level; and strengthening monitoring and resulting action where needed.

Explore how future programming could support operationalisation of existing policies at scale and how WHO can support this within their mandate, leverage existing and new partnerships to do so, as well as capture learning to inform national policy updates and reform. This support should continue to adopt and deepen the systems strengthening approach adopted during the 2018-2022 program. Areas that emerged from the evaluation include: strengthening subnational government leadership and action, including coordination among relevant actors and government ministries; support operationalisation of guidelines for small community water supplies; and to support planning and budgeting processes for WASH FIT implementation. For WASH FIT, future programming should consider how to capture progress more systematically on WASH FIT implementation, the extent to which it drives sustainable and ongoing improvements to services and behaviours.

5. Strengthen evidence and learning processes to capture evidence of what works where in greater detail to inform modifications and strengthening of national and local approaches, particularly regarding the operationalisation of existing policies and strategies at scale.

As the WHO human resource capacity is limited at all levels of the program (global, regional and country levels), explore how to leverage partnerships or engage in new ones with local/international research organizations or consultants to more systematically capture implementation knowledge for the purpose of strengthening the enabling environment and adapting existing processes. Extending learning exchanges to share expertise from DFAT-WHO support countries to other countries and also to draw on existing expertise in the region (for example from Australia as was done in Indonesia) could also strengthen evidence informed programming.

6. Explore opportunities to support other emerging areas of relevance to WASH across the two region and country contexts.

During inception processes if future funding is supported, assess which emerging areas might be relevant and feasible to pursue that would support strengthening WASH, health and disaster preparedness and response for all across the Asia Pacific region.

Appendix 1 - Evaluation focus areas within DFAT's VfM principles framework

Highlighted in the table below are the four focus areas assessed for VfM under each major area according to DFAT's VfM principle framework. Those highlighted in yellow were assessed in this evaluation.

Economy	Efficiency	Effectiveness	Ethics
1. Cost consciousness	3. Evidence based decision making	5. Performance and Risk Management	8. Accountability and transparency
2. Encouraging competition	4. Proportionality	6. Results Focus	
		7. Experimentation and innovation	

Appendix 2 - Evaluation questions and data source used in the evaluation

Criteria	Evaluation Questions	Basis of assessment	Data Source
EFFECTIVENESS	1. To what extent were the program outcomes achieved across Philippines, Indonesia and at the regional/global level? a. To what extent have the program approaches been adopted by governments? b. How, where and for whom was change achieved most effectively? c. What were the underlying barriers and facilitators of the program's effectiveness, including replication and scale-up of the surveillance and WASH in HCF aspects of the program at the country level?	Achievement of outcome targets /Stakeholder perceptions	Policy and document analysis/KII with global, regional and country staff/KIIs with stakeholders and partners
	2. How appropriate were the program's strategies to promote the sustainability of changes?	Stakeholder perceptions/Alignment with ongoing government strategies	Policy and document analysis/KII with global, regional and country staff/KIIs with government staff
VALUE FOR MONEY	3. How have decision making processes for implementation been cost conscious? a. To what extent has partner selection been cost conscious through adopting competitive processes? b. Which processes were adopted to design and adapt program activities and plans to be cost conscious and deliver quality program outcomes?	Stakeholder perceptions/Alignment of documentation with competitive processes outlined at WHO	Internal WHO policy and document analysis/KII with global, regional and country WHO staff
	4. To what extent has evidence and learning been used to inform program design and implementation at the country level? (Indonesia and Philippines focus)	Stakeholder perceptions/Alignment of program and policy documentation with current guidance and evidence and assessments undertaken	Policy and document analysis/national and regional surveillance and HCF assessments/KII with global, regional and country staff/KIIs with

			stakeholders and partners
	5.To what extent have innovative approaches been adopted to integrate GEDSI and climate resilience into programming, monitoring, funding and decision-making?	Stakeholder perceptions/Reporting documentation/Government document alignment with GEDSI and climate	Policy and document analysis/KII with global, regional and country staff/KIIs with government staff
	6.To what extent have processes to assess and manage risk and ensure accountability been adopted throughout the project to support the delivery of project outcomes?	Stakeholder perceptions/internal WHO documentation	Internal WHO policy and document analysis/KII with global, regional and country WHO staff/government and DFAT KIIs

Appendix 3 – Information sheet and consent guide

Information Sheet

Date: - November 2022

Full Project Title: Evaluation of the WHO-DFAT WASH support in the Asia-Pacific region 2018-2022.

Principal Investigators: Katherine Gilbert¹ and Alison Macintyre¹

Affiliations:

¹The Nossal Institute, University of Melbourne, Australia

Dear Sir/Madam,

You are invited to take part in an evaluation study assessing the DFAT-WHO Water, Sanitation and Hygiene program across the Asia Pacific region from 2018-2022.

What is the background of the study?

The WHO WASH team is reviewing its DFAT-supported program across the Asia Pacific region. The team is interested to understand the barriers and enablers related to WASH in health care facilities and water quality surveillance strengthening in your country. We are exploring what has worked where, why and for whom.

What is the objective of this research?

The objectives of this evaluation are to examine the effectiveness and value for money for DFAT's investments in WHO's WASH program across the Asia Pacific region from 2018-2022. The results from this evaluation may also inform future program design and investments in WASH across the region.

How was I identified and why am I being invited to participate in this research?

You have been selected because of your role as a key person in your organization and having participated in program activities.

What will happen in this research?

Participation in this project will involve attending an interview where participants will be asked to talk about your experience of working with the program interventions and overall progress on WASH within your country/region. The interview will last between approximately 60 minutes. If you agree, we will audio record the interview. Your name will be replaced on all documents and records by an ID number to maintain your anonymity.

Are there any risks to me?

There are no risks involved in your participation in this study. Your name will not be associated with what you have to say in the workshop/interview and the data will only be available to me and my supervisors.

What are the benefits of participating in the study?

You may benefit from a deeper understanding and reflection on WHO's WASH program and WASH in the Asia Pacific region. Moreover, you will contribute to public health research and also assist in developing and implementing a systems approach to WASH in your country/region.

How will my privacy be protected?

The records of this study will be kept private and stored on password protected, secured computer drives at the Nossal Institute, University of Melbourne. In any report we publish, we will not include information that would make it possible to identify you in any way. You are free to withdraw from the interview at any time without obligation. You can ask us to withdraw any information you give us up until the time that the final report is written. Information on individuals who declined to be interviewed will not be shared or provided to your employer or other parties.

What opportunity do I have to consider this invitation?

If you wish to participate in this study, please indicate your willingness to me within a week of receiving the invitation. Declining to participate will not affect your relationship with WHO, DFAT or your employer. There is no compensation or other monetary inducement for your participation.

What do I do if I have any concerns about this study?

Any concerns regarding any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact any of the research team:

- 1) Alison Macintyre of the University of Melbourne - alison.macintyre@unimelb.edu.au
- 2) Katherine Gilbert of the University of Melbourne - katherine.gilbert@unimelb.edu.au

Consent Guide

Date: November 2022

Full Project Title: Evaluation of the DFAT-WHO WASH program across the Asia Pacific 2018-2022.

Declaration by the participant

- I understand I am being asked to provide consent to participate in this research study.
- I have read the Participant Information Sheet, or someone has read it to me in a language that I understand.
- I understand the purposes, study tasks and risks of the research described in the study.
- I understand that the research team will audio record the interviews; and I agree to be recorded for this purpose.
- I provide my consent for the information that you provide to be used for the purpose of this research study only.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I freely agree to participate in this research study as described and understand that I am free to withdraw at any time during the study and withdrawal will not affect my relationship with any of the named organisations and/or research team members.

Appendix 4. KII guide for country government staff and partners

Briefing to participants will be sent via email invitation for the interview. The information will be specific to their role and area of technical expertise. It will include –

- Purpose of evaluation - to understand the extent to which the DFAT-WHO WASH program achieved its outcomes across the project
- Highlight that the evaluation is focussing on effectiveness and Value for Money (cost consciousness and risk management). It will stipulate the focus technical areas of WASH in health care facilities and water quality surveillance and management. It will highlight which countries are the focus. This will be tailored for the ministries/partners involved.
- Highlight that it is summative (looking back at what worked, where, how and for whom) and formative (what could be considered for future programs and investments)
- Outline consent process, recording process and opportunity for questions
- Information sheet will be attached.

Aims	Questions
Introduction	<p>We are evaluating WHO's WASH program across the Asia Pacific region, with a focus on Indonesia and the Philippines. We are evaluating two key technical areas WHO has supported from 2018-2022. They include:</p> <ul style="list-style-type: none"> • WASH in health care facilities. • Water Quality Management and Surveillance. <p>We will focus on understanding how you have been involved, the extent to which these technical areas have progressed in your setting and the role WHO has played to support progress.</p>
Demographic questions	<p>Gender: Degree: Profession: Role: Number of years in this role:</p>
Effectiveness	<p>Could you tell us about the government/relevant ministry's main strategies to improving WASH? Probe: WASH in HCF, WQM&S specifically</p> <p>Could you tell us about your involvement with WHO's WASH technical support and program?</p> <p>Are you familiar with WHO's support to WASH in health care facilities? If yes</p> <ul style="list-style-type: none"> • Can you comment on the extent to which WHO's support has improved WASH in health care facilities? Probe: re national commitments for WASH in HCF, guidelines, monitoring, capacity of ministry staff, facility improvements and technical assistance. ○ Can you describe the outcomes of this support (both positive and negative) WASH in health care facilities? Probe: policy documentation, commitments, HR, facility supplies and infrastructure, coordination, capacity of relevant workforce?

- How has this changed occurred? Probe: technical support, evidence generation, greater leadership, greater awareness, political will, guidance, coordination, capacity, investment, facility-led action
- How, where and for whom was change achieved most effectively? Probe – GEDSI considerations
- Were there any unexpected outcomes? If so, what, where and for whom?
- How did COVID-19 affect the program and to what extent did it influence the project outcomes and activities?

How has the WHO support on WASH in health care facilities influenced health sector priorities, programs and activities?

Can you describe how health and WASH partners in your country are engaged in WASH in health care facility strategies? To what extent has the WHO program influenced this?

Are you familiar with WHO's support to water quality management and surveillance? If yes -

- Can you comment on the extent to which WHO's support has improved water quality surveillance and monitoring? In which areas in particular? Probe: policy, regulatory and standards support, training of staff and partners, monitoring and information systems, improvement actions on WQM&S.
- Can you describe the outcomes of WHO's support (both positive and negative) on water quality management and surveillance?
Probe: policy, regulatory and standards support, training of staff and partners, monitoring and information systems, improvement actions on WQM&S.
- How has this changed occurred? Probe: technical support, evidence and data generation, coordination, development and implementation of policies/regulations/standards, government and partner staff capacity, availability of data
 - How, where and for whom was change achieved most effectively? Probe GEDSI considerations
 - Were there any unexpected outcomes? If so, what, where and for whom?
 - How did COVID-19 affect the program and to what extent did it influence the project outcomes and activities?

How has the WHO support influenced water quality and surveillance approaches and corrective actions?

Can you describe how partners in your country are engaged in water quality surveillance and monitoring? To what extent has the WHO program influenced this?

Please explain what the underlying barriers and facilitators of the program's effectiveness were. Probe: WASH in HCF, WQM&S

To what extent does WHO's program align with the government strategies related to WASH and health?

	<p>To what extent do you consider the changes to WASH in health care facilities as being institutionalised? What else needs to happen?</p> <p>To what extent do you consider the changes to water quality management and surveillance as being institutionalised? What else needs to happen?</p>
Value for Money	<p>To what extent do you consider that the project design incorporated existing evidence on the technical areas and existing context and WASH/health systems? Could you describe what evidence and learning has been generated from the WHO WASH program? How has it been used to inform program design and planning?</p> <p>Can you explain how the program ensures it is accessible and inclusive for ALL groups at risk in Indonesia/Philippines? Probe: WASH in HCF and WQM&S. Have any innovations emerged to support the inclusiveness of the program?</p> <p>Can you explain how the program ensures it considers climate resilience in Indonesia/Philippines? Probe: WASH in HCF and WQM&S. Have any innovations emerged to support the climate resilience as part of the WHO program?</p> <p>How have you identified risks to the implementation of this work? How have these been communicated with WHO? How has WHO supported understanding and managing risks that have emerged across the program period? What has worked well? What changes would you make to these processes in the future?</p>
	Any further comments or thoughts?

Appendix 5. KII guide for WHO interviews

Briefing to participants will be sent via email invitation for the interview. The information will be specific to their role and area of technical expertise. It will include –

- Purpose of evaluation - to understand the extent to which the DFAT-WHO WASH program achieved its outcomes across the project
- Highlight that the evaluation is focussing on effectiveness and Value for Money (cost consciousness and risk management). It will stipulate the focus technical areas of WASH in health care facilities and water quality surveillance and management. It will highlight which countries are the focus, specific to the region of focus if regional WHO.
- Highlight that it is summative (looking back at what worked, where, how and for whom) and formative (what could be considered for future programs and investments)
- Outline consent process, recording process and opportunity for questions
- Information sheet will be attached.

Aims	Questions
Introduction	<p>We are evaluating the DFAT-supported WHO WASH program across the Asia Pacific region, with a focus on Indonesia and the Philippines. We are evaluating two key technical areas WHO has supported from 2018-2022. They include:</p> <ul style="list-style-type: none"> • WASH in health care facilities. • Water Quality Management and Surveillance. <p>We will focus on understanding how you have been involved, the extent to which these technical areas have progressed, how the program has taken account of value for money and the role WHO has played to support progress.</p>
Demographic questions	<p>Gender:</p> <p>Degree:</p> <p>Role:</p> <p>Number of years in this role:</p>
Effectiveness	<p>Could you tell me about your involvement in supporting the DFAT-WHO WASH program in the Asia Pacific region?</p> <p>To what extent and how do you think the DFAT-support approach to WASH in health care facilities been most effective? Probe: global, regional, country levels. Why? What could be done to improve the effectiveness of this approach?</p> <p>To what extent and how do you think the DFAT-support approach to water quality management and surveillance been most effective? Probe: global, regional, country levels. Why? What could be done to improve the effectiveness of this approach?</p> <p>What do you see as the major enablers and constraints to improving WASH in health care facilities and WQM&S in each of the countries? Why? Can you give examples? How has the program responded to these?</p> <p>Were there any unexpected outcomes? If so, what, where and for whom?</p>

	<p>How did COVID-19 affect the program and to what extent did it influence the project outcomes and activities?</p> <p>To what extent have partners been engaged in the program? Where has this worked best? Probe: global, regional and country levels.</p> <p>What strategies is the program using to ensure the sustainability of changes at the national and subnational level? What are the risks with this approach? How could these risks be addressed?</p> <p>To what extent does WHO's program align with the government, regional and global strategies related to WASH and health?</p> <p>To what extent do you consider the changes to WASH in health care facilities as being institutionalised? What else needs to happen?</p> <p>To what extent do you consider the changes to water quality management and surveillance as being institutionalised? What else needs to happen?</p>
Value for Money	<p>How has WHO considered cost consciousness throughout program design and implementation? Probe: global, regional and country levels.</p> <p>Can you describe how has this been adopted for partner selection processes? Probe: competitiveness process and its implementation.</p> <p>How have the costs of program activities and priorities been considered across the project? Can you describe the effect that cost-related decisions have had on project outcomes? Can you describe the process for making cost-related decision across the program?</p> <p>Could you describe what evidence and learning has been generated from the WHO WASH program? How has it been used to inform program design and planning? How could the generation and use of evidence be improved in program design and implementation?</p> <p>Can you explain how the program ensures it is accessible and inclusive for ALL groups? In which aspects of the program has this been implemented Probe: WASH in HCF and WQM&S.</p> <p>Have any innovations emerged to support the inclusiveness of the program?</p> <p>Can you explain how the program ensures it considers climate resilience in Indonesia/Philippines? Probe: WASH in HCF and WQM&S.</p> <p>Have any innovations emerged to support the climate resilience as part of the WHO program?</p> <p>How has WHO supported understanding and managing risks that have emerged across the program period? Probe: global, regional and country levels.</p> <p>Can you describe the process for assessing and responding to risks? What has worked well? What changes would you make to these processes in the future?</p>
	Any further comments or thoughts?

Appendix 6. KII guide for DFAT staff

Briefing to participants will be sent via email invitation for the interview. The information will be specific to their role and area of technical expertise. It will include –

- Purpose of evaluation - to understand the extent to which the DFAT-WHO WASH program achieved its outcomes across the project
- Highlight that the evaluation is focussing on effectiveness and Value for Money (cost consciousness and risk management). It will stipulate the focus technical areas of WASH in health care facilities and water quality surveillance and management. It will highlight which countries are the focus, specific to the region of focus if regional WHO.
- Highlight that it is summative (looking back at what worked, where, how and for whom) and formative (what could be considered for future programs and investments)
- Outline consent process, recording process and opportunity for questions
- Information sheet will be attached.

Aims	Questions
Introduction	<p>We are evaluating the DFAT-supported WHO WASH program across the Asia Pacific region, with a focus on Indonesia and the Philippines. We are evaluating two key technical areas WHO has supported from 2018-2022. They include:</p> <ul style="list-style-type: none"> • WASH in health care facilities. • Water Quality Management and Surveillance. <p>We will focus on understanding how you have been involved, the extent to which these technical areas have progressed, how the program has taken account of value for money and the role WHO has played to support progress.</p>
Demographic questions	<p>Gender:</p> <p>Degree:</p> <p>Role:</p> <p>Number of years in this role:</p>
Effectiveness	<p>Could you tell me about your involvement in supporting the DFAT-WHO WASH program in the Asia Pacific region?</p> <p>To what extent and how do you think the DFAT-support approach to WHO's WASH in health care facilities work been most effective? Probe: global, regional, country levels. Why? What could be done to improve the effectiveness of this approach?</p> <p>To what extent and how do you think the DFAT-supported approach to WHO's water quality management and surveillance program been most effective? Probe: global, regional, country levels. Why? What could be done to improve the effectiveness of this approach?</p> <p>What do you see as the major enablers and constraints to improving WASH in health care facilities and WQM&S in each of the countries? Why? Can you give examples?</p> <p>Were there any unexpected outcomes? If so, what, where and for whom?</p>

	<p>How did COVID-19 affect the program and to what extent did it influence the project outcomes and activities?</p> <p>To what extent has WHO's WASH program in the region supported partners engagement in the program? Where has this worked best? What opportunities exist to improve partner engagement? Probe: global, regional and country levels.</p> <p>To what extent do you think the strategies the program is using to ensure the sustainability of changes at the national and subnational level are effective? What are the risks with the current approaches? How could these risks be addressed?</p> <p>To what extent do you consider the changes to WASH in health care facilities as being institutionalised? What else needs to happen?</p> <p>To what extent do you consider the changes to water quality management and surveillance as being institutionalised? What else needs to happen?</p>
Value for Money	<p>To what extent do you consider WHO has considered cost consciousness throughout program design and implementation? Probe: global, regional and country levels.</p> <p>Could you describe how evidence and learning has been generated from the WHO WASH program? How has it influenced and/or informed work of DFAT and its partners in the region? W</p> <p>To what extent do you consider the program has addressed gender and social inclusion at the country, regional and global levels? Probe: WASH in HCF and WQM&S. Are you aware of any innovations that emerged to support the inclusiveness of the program?</p> <p>To what extent do you consider the program ensures it considers climate resilience in at the country, regional and global levels? Probe: WASH in HCF and WQM&S. Are you aware of any innovations that emerged to support climate resilience as part of the WHO program?</p> <p>How has WHO supported understanding and managing risks that have emerged across the program period? Probe: global, regional and country levels. Can you describe the process for communicating and responding to risks with DFAT? What has worked well? What changes would you make to these processes in the future?</p>
	Any further comments or thoughts?