

Report of the Independent Evaluation of WHO's COVID-19 Response in Ukraine

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Acronyms

ACT	Access to COVID-19 Tools
CERF	United Nations Central Emergency Relief Fund
CoM	Cabinet of Ministers of Ukraine
COVID-19	2019 novel coronavirus disease (also 2019-nCoV)
CPRP	Country Preparedness and Response Plan
CSO	Civil society organisation
DPA	Department of Political and Peacebuilding Affairs
DTRA	The Defence Threat Reduction Agency
ECA	Eastern Conflict Area
EIDSS	Electronic Integrated Disease Surveillance System
EPR	emergency preparedness and response
EPW	WHO's European Programme of Work
EQ	Evaluation question
ERG	Evaluation Reference Group
ERP	Emergency Response Plan
ETAGE	European Technical Advisory Group of Experts on Immunization
EURO	Regional Office for Europe
FGD	Focus group discussion
GCA	Government-controlled area
GDPR	General Data Protection Regulation
GER	Gender, equity, and human rights
GoU	Government of Ukraine
GPW13	The Thirteenth General Programme of Work (2019-2023) of WHO
HRMMU	United Nations Human Rights Monitoring Mission in Ukraine
HRP	Humanitarian Response Plan
IHR	International Health Regulations (2005)
IMST	Incident Management Support Team
INGO	International non-governmental organisation
IP	Implementing partner
IPC	Infection Prevention and Control
JEE	Joint external evaluation
KII	Key informant interview
KMDA	Kyiv City State Administration
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of health
NGCA	Non-government controlled area

NGO	Non-governmental organisation
NHSU	National Health Service of Ukraine
NITAG	National Immunization Technical Advisory Group
NDVP	National Deployment Plan for Vaccination
OLC	Oblast Laboratory Centre
PHC	Public Health Centre
PHEIC	Public Health Emergency of International Concern
PHSM	Public health and social measures
PIP	Pandemic Influenza Preparedness plan
PoE	Point of Entry
PPE	Personal Protection Equipment
SAGE	WHO Strategic Advisory Group of Experts on Immunization
SOP	Standard operating procedure
SPRP	Strategic Preparedness and Response Plan
TB	Tuberculosis
ToC	Theory of Change
TTX	Table-top exercise
UNCT	United Nations Country Team
UNEG	United Nations Evaluation Group
UPHC	Public Health Centre of the Ministry of Health of Ukraine
WCO	WHO Country Office
WHE	WHO Health Emergencies Programme
WHO EURO	WHO Regional Office for Europe
WHO EVL	WHO Evaluation Office
WHO HQ	WHO headquarters
WPRO	Regional Office for the Western Pacific
WR	WHO Representative

Executive Summary

INTRODUCTION

Purpose and scope. This report presents the findings, analysis and recommendations of the independent evaluation of WHO's COVID-19 response in Ukraine. This evaluation was commissioned by the WHO Country Office (WCO) in Ukraine to provide an independent, objective, and systematic assessment of WHO's preparedness for and response to COVID-19 in Ukraine. The evaluation addresses the Country Office's strategy, interventions, operations, performance, and results to date, as well as its engagement and coordination with partners towards these same ends. The WHO Evaluation Office managed the evaluation and contracted an independent evaluation firm to conduct it.

The evaluation aims to critically appraise WHO's contributions to the COVID-19 response in Ukraine, bearing in mind that these efforts were conducted in addition to continuing humanitarian aid in the Eastern Conflict Areas (ECAs). The evaluation's primary timeframe was from early 2020 (the start of the COVID-19 response) to December 2021 (the end of data collection). However, it also examined key pre-COVID-19 preparedness measures that were in place in early 2020 in terms of supporting/inhibiting WHO's mobilisation and support efforts.

Intended audience. The principal users of the evaluation are WHO senior management (e.g., WHO Representative in Ukraine, WHO Regional Director for Europe, WHO Health Emergencies Programme (WHE), Director-General), WHO staff directly involved in the COVID-19 response in Ukraine, and heads of other WCOs responding to the pandemic. Other users include WHO partners at the regional, global, and country levels, including the Ministry of Health (MoH) and other government ministries, United Nations Country Team (UNCT) partners, non-governmental organisations (NGOs), civil society organisations (CSOs), implementing partners (IPs), donors, and other relevant stakeholders.

METHODOLOGY

Evaluation approach. The evaluation was conducted between September 2021 and April 2022 in four distinct phases: (1) preparation and inception, (2) data collection, (3) analysis, and (4) reporting. Each phase included a set of evaluation activities and deliverables guided and approved by the WHO Evaluation Office (WHO EVL) at Headquarters (HQ) and with input from the Evaluation Reference Group (ERG). To conform with the OECD DAC Quality Standards for Development Evaluation and the Norms and Standards of the United Nations Evaluation Group (UNEG), the evaluation adopted a theory-based, utilisation-focused, participatory approach, including the lens of gender, equity, and human rights. The evaluation developed an implied Theory of Change (ToC) that was approved by WHO during the inception phase.

Data collection and analysis. The key lines of inquiry covered by the evaluation are framed according to with the main evaluation questions (EQs) as put forward in the terms of reference, which were further elaborated in sub-questions in an evaluation matrix to guide data collection and analysis. Participatory data collection secured key stakeholders' views, while gender, equity, and human rights lenses were used in analysing data devoting attention to different social determinants of vulnerability to COVID-19 infection and access to prevention and care.

The evaluation collected varied perspectives on EQs through interviewing 86 informants representing 42 agencies and organisations, including the WHO staff working directly on the COVID-19 response in Ukraine, Government of Ukraine (GoU) representatives from health and other sectors, donors, UN agencies, CSOs, IPs, international non-governmental organisations (INGOs), members of the Health Cluster, healthcare providers, private sector actors, and other partners. In addition, to obtain perspectives from the field, seventeen focus group discussions (FGDs) were held in a face-to-face setting in Dnipropetrovsk, Kyiv, Odesa, and Poltava, as well as in an online setting in Chernivtsi, Donetsk, Luhansk, Mariupol, and Severodonetsk. FGDs involved 87 representatives

of health workers from COVID-19 designated hospitals, primary health care facilities/hospitals, labs, HIV service providers, and detention facilities, as well as providers of services for pilots on outreach and contact tracing. Finally, perception survey data received from 39 key stakeholders has been used to substantiate and triangulate the KII and FGD findings.

The findings were complemented by results of a desk study of secondary sources (over 50 key documents) including WHO global frameworks, strategies, workplans, budgets, agreements with the GoU, WHO/EURO strategies and guidance, national policies and strategies, COVID-19 related dashboards, situation analyses, government statistics and data produced by UN agencies, and others.

Limitations. Given that fact-finding and analysis for this report were completed prior to the Russian military offensive in Ukraine on 24th February 2022, many of the accomplishments highlighted in this report may have subsequently been negated. As a result, it is necessary to reassess country-specific recommendations in light of the radically changed circumstances across Ukraine. Other limitations that affected data collection are: (a) limited participation of external stakeholders, notably fewer than planned from key government institutions and none from the private sector; (b) limited data on the experience of the affected population; (c) limited systematic data available before August 2021 concerning details of the 28 awards/projects contributing to the overall objectives of the WCO response, which hampered comprehensive analysis of higher-level results; and (d) limited granularity of findings collected remotely, which restricts the depth of analysis for the evaluation findings, conclusions, and recommendations. Despite these limitations, the evaluation still managed to obtain a reasonably complete and fair insight into the operations and results of the WCO response.

COUNTRY AND OPERATIONAL CONTEXT

Country context. Ukraine has been one of the most severely affected countries in the European region in terms of the number of confirmed COVID-19 cases and deaths due to COVID-19. The country has been affected by several COVID-19 waves and was ranked ninth in the region concerning the number of confirmed cases at the beginning of the evaluation, with 2,370,425 cases as of 23rd September 2021. Moreover, a protracted humanitarian situation in the conflict-affected Donbas region of Ukraine has been exacerbated by the COVID-19 pandemic.

With the first case detected on 29th February 2020, the pandemic hit Ukraine in the middle of the healthcare system reform, while the protracted COVID-19 crisis proceeded in parallel with frequent changes in high-level political leadership in the country. Since the beginning of the COVID-19 outbreak in March 2020, the MoH has been headed by four different ministers, while two Prime Ministers, two Deputy Prime Ministers, and three Ministers of Foreign Affairs have moved in and out of offices.

WHO programming in Ukraine. Prior to the COVID-19 outbreak and since 2015, WCO Ukraine has been supporting the MoH in developing its governance capacity to lead the process of health system transformation and building modern institutions. Health reforms have continued to take place concurrently with the initiation and implementation of the COVID-19 response. In addition, prior to the COVID-19 pandemic, a third of Ukraine WCO's work was focused on health emergencies (e.g., ECA) and two-thirds on development related to health systems and disease programmes. In this regard, the Office assisted the GoU in responding to several other communicable disease outbreaks including the world's second-largest measles outbreak, as well as diphtheria, and – most recently – polio outbreaks. Moreover, since 2014, in addition to its normative role, WHO has led and coordinated the health strand of the international humanitarian response to 3.4 million people – one-third of whom are elderly – in Donetsk and Luhansk oblasts in non-government-controlled areas (NGCAs).

In 2020-2021, WHO spent more than US\$30 million as part of its significant financial and human resource mobilisation efforts for COVID-19 response operations in Ukraine. The Country Office organised most of its work on

the COVID-19 response through more than 28 awards/grants, and following Ukraine's Country Preparedness and Response Plan (CPRP) pillars.

EVALUATION FINDINGS

The findings of the evaluation are presented for each of the four main EQs and associated sub-questions on the evaluation criteria of relevance, effectiveness, efficiency, impact, coherence, as well as explanatory factors of WHO's COVID-19 response in Ukraine.

Relevance, Appropriateness

Evaluation question 1: How well aligned has WHO's support to the COVID-19 response in Ukraine been with the stated needs of the government, the specific needs of the affected population, and WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies?

Key finding 1: The WHO COVID-19 response was in line with the needs of the GoU and aligned with its strategies/policies that refer to the needs of affected populations. Among the key documents illustrating this alignment is the CPRP. In addition to basing its response on WHO global guidance for COVID-19 (as set out in the Strategic Preparedness and Response Plan) as the pandemic evolved, WCO Ukraine continued to rely on WHO global guidance, e.g., on developing a national deployment and vaccination plan for COVID-19 vaccines and ACT.

Key finding 2: Throughout the COVID-19 response, WHO and other UN agencies have promoted an improved focus on vulnerable groups' needs and supported its analysis.

Key finding 3: As the pandemic progressed, WCO Ukraine continued using WHO and UN instruments to align, review, and improve national frameworks: CPRP, humanitarian response plan (HRP), and the national deployment and vaccination plan (NDVP). Throughout the pandemic, WCO Ukraine supported – independently and in collaboration with other UN agencies – data collection, analysis, and reporting on needs, doing so proactively in several areas.

Key finding 4: WCO Ukraine kept upscaling and adapting their services based on their own and UN organisations' analysis of emerging needs, anticipating GoU requests, which is seen as a key strength of the response throughout the pandemic.

Effectiveness, Impact, Coverage

Evaluation question 2: What results has WHO's support to the COVID-19 response in Ukraine produced?

Evaluation question 3: To what extent have WHO's interventions reached all segments of the affected population, including the most vulnerable?

Key finding 1: The effectiveness of WCO Ukraine's initial response to COVID-19 was limited due to Ukraine's imbalanced capacities for implementing the International Health Regulations (2005) (IHR) and several ongoing structural changes internal to WHO in 2019. However, as one of the WHO's priority countries in the European region, having staff with an emergency mindset and dedicated procedures in place before the COVID-19 pandemic, WCO Ukraine could swiftly mobilise and engage effectively in the response.

Key finding 2: WCO Ukraine achieved its targets for deliverables in respect of all 28 separate financial contributions worth over US\$ 38 million that were obtained during the period from March 2020 to November 2021. Progress has been excellent/good in all ten CPRP pillars, with main achievements in five out of ten pillars (1, 3, 5, 6, and 7). The reasons for this progress include a combination of relevant strategies and agile action.

Key finding 3: WHO – in collaboration with other UN agencies – has worked to promote an improved focus on the needs of vulnerable groups, using vulnerability assessments to specifically inform the roll-out of vaccinations (pillar 10) and recommendations to improve case management (pillar 7). As a result, vaccination efforts in Ukraine have been largely informed by vulnerability assessments resulting in increased vaccination coverage of vulnerable groups, although some have been left behind. WHO has also supported safeguarding equitable access to COVID-19 prevention and care, where coverage remains a challenge.

Key finding 4: The health and peace aspects in conflict areas were important and WHO was effective in providing technical and neutral mediation services. WCO Ukraine was able to increase its funding for the humanitarian response as part of the COVID-19 response, sustain its already expanded operation in the NGCAs and in GCAs.

Key finding 5: WCO Ukraine developed a systematic monitoring tool for the complete COVID-19 response, which was deployed in early 2021 and monitored budget utilisation throughout the response. WCO Ukraine as a whole, and the Incident Management Support Team (IMST) in particular, have been undertaking regular monitoring visits and/or technical assessments applying the WHO global or regional guidance from the outset of the response and acting on the monitoring data obtained.

Efficiency, Coordination, Coherence

Evaluation question 4: How successfully has WHO harnessed the resources at its disposal (including financial, human, physical, intellectual, organisational, and political capital, as well as partnership) to achieve maximum results in the COVID-19 response in Ukraine in the timeliest and most efficient manner possible?

Key finding 1: To respond to the COVID-19 pandemic in Ukraine and provide support in a timely, well-prioritised manner, WCO Ukraine was quick and effective in mobilising both human resources (increasing from 13 to 74 staff by August 2021) and financial resources (over US\$ 38 million as noted earlier) through efforts of the WHO team at all levels (global, regional, and country).

Key finding 2: WHO achieved cost-effectiveness in procurement by forging long-term agreements with local private companies, employing a two-tier approach (i.e., selective purchase through the global procurement system and locally), and developing and launching an electronic supply management system to optimise the cost-quality ratio of goods purchased for the response.

Key finding 3: Throughout the pandemic, the WHO response in Ukraine has benefited from good working relationships across all levels of WHO.

Key finding 4: WCO Ukraine used its political capital by coordinating with government and development partners including the UN. Some partners would like to see more collaboration to advance work on vaccine uptake.

Key finding 5: WHO's comparative advantages are high-level health sector technical expertise and its role as a trusted broker, while its limited visibility at the sub-national level in Ukraine is considered a weakness.

Explanatory factors

Evaluation question 5: What have been the main internal and external factors influencing WHO's ability to respond in the most relevant, effective, efficient, and equitable manner possible?

Key finding 1: The major internal factors that supported the response include the reputation of WHO, strong leadership within WCO Ukraine, the increased availability of experienced national staff, the effective mobilisation of human and financial resources by different levels of WHO, staff management practices and the clear delineation of roles and responsibilities within WCO Ukraine. Inhibiting internal factors included delays caused by centralised WHO processes of the Global Service Centre in Kuala Lumpur for the recruitment of human resources and lengthy processes for the procurement and shipment of goods.

Key finding 2: External factors that supported the WHO response included having a strong national counterpart moving to a high leadership position in-country. External inhibiting factors include recurrent changes in national counterpart agencies, disruptions caused by ongoing reforms, vaccine hesitancy and global shortages and challenges to supply chains.

Key finding 3: WCO Ukraine as a whole and the IMST team (pillars 3, 5, 6, 7, 8 and 10) have been monitoring and adjusting their performance in an agile manner to adapt to emerging needs.

CONCLUSIONS

PREPAREDNESS

WHO's Thirteenth General Programme of Work (GPW13) defines, as one of its three targets, that one billion more people should be better protected from health emergencies by 2023¹. Work towards that target has been underway for some time but COVID-19 has highlighted weaknesses in global pandemic preparedness. That fact was recognised by the 74th World Health Assembly in May 2021 which noted that "the COVID-19 pandemic has revealed serious shortcomings in preparedness for, timely and effective prevention and detection of, as well as response, to potential health emergencies".²

Achievements by WHO in Ukraine thus need to be considered against the backdrop of acknowledged global weaknesses. In that context, the evaluation suggests that WCO Ukraine's preparedness was strong. The WCO had been actively engaged in the humanitarian response in the ECA for a number of years. Hence, the staff had a good understanding of many relevant issues and a number of key procedures were in place by the end of 2019. Those capabilities helped to ensure that additional financial and other resources to address the challenges of COVID-19 were quickly mobilised and that systems and processes could be rapidly modified (or established) to underpin the response itself.

The evaluation confirmed that human factors were also an essential component of preparedness. The fact that staff at the country level had well-established mechanisms to access expert professional knowledge and resources quickly and confidently, both nationally and internationally, from within and beyond WHO has also been a key strength from a preparedness perspective.

The WCO team had also built up good political capital which proved to be a major asset and reflected a history of close collaboration, built on strong interpersonal relationships, between senior leaders in WCO on the one hand and both elected representatives and senior public servants in the Government of Ukraine on the other. The part played by national staff in facilitating effective work across relevant national public agencies was particularly notable as an important factor underpinning preparedness while strong ties among WHO staff at the country, Regional, and Headquarters helped to ensure there was a sound basis for cooperation as the pandemic unfolded.

There were, nevertheless, some issues that were not entirely helpful to be prepared at the country level. Specifically, Ukraine had been struggling to implement all aspects of the International Health Regulations (2005), there had been several personnel changes at senior levels among counterparts in the Government of Ukraine, and the period immediately prior to COVID-19 arriving in Ukraine had seen a number of changes in Country Office staffing and office accommodation.

In summary, the evaluation has concluded that a combination of context (several years' experience of emergency response), capability (in the form of technical knowledge from within and beyond the whole of WHO) and collaboration (across the levels of WHO and with relevant government counterparts) meant that the Ukraine Country Office was relatively well-prepared for COVID-19.

¹ The WHO Executive Board has subsequently approved that the term of GPW13 be extended to 2025.

² WHA Resolution WHA74.7, at page 22 Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA74-REC1/A74_REC1-en.pdf#page=1 [Accessed 4 April 2022]

RESPONSE

The WHO response was large in scale (covering a country that is both the seventh most populous and second largest in Europe), long in duration (almost two years covered by the evaluation and continuing thereafter) and diverse in its reach (encompassing urban, rural, and remote communities and areas which have faced several years of ongoing conflict).

In respect of COVID-19-related mortality and morbidity, the cumulative confirmed case rate in Ukraine was about three-quarters of the EURO average but the cumulative mortality rate was 15 per cent higher. Since those data may not be statistically robust and reflect many factors other than the part played by WHO in Ukraine, they should not be afforded undue weight in any assessment of the Country Office's response.

A more direct reflection of the response is provided by the evaluation's assessment of progress as "excellent" for five (16 per cent) and "good" for 21 (66 per cent) of 32 pillar-specific response objectives³.

There was generally good alignment between the response and the needs of the government and affected populations. That alignment reflected the quality of pre-existing relationships at individual and institutional levels, investment in establishing robust plans at the outset (and subsequently adjusting them as required), a strong focus on the collection and use of data to monitor progress and guide decision-making, and high levels of trust and mutual respect.

Collaboration with other UN agencies was effective in ensuring there was an improved focus on understanding and addressing the needs of vulnerable groups at all stages of the response.

Agility alongside clear role delineation on the part of the WCO leadership team coupled with creativity in establishing and modifying "fit-for-purpose" systems and operating procedures, most notably in respect of procurement, ensured that the response evolved quickly as needs and circumstances changed. As a result, preconceptions among some partners that WHO was overly bureaucratic and slow to react were largely overcome.

The Country Office, often with strong support from Regional and HQ levels, was also able to quickly identify and capitalise on a wide variety of funding opportunities and subsequently put resources obtained to effective use. Targets for deliverables were achieved in respect of all 28 separate awards that were obtained during the period from March 2020 to November 2021 and a remarkably high overall absorption rate of 98 per cent was achieved.

Procurement was central to the response at all stages. There were some occasions when procurement of consumables or other goods was considered to have been slow but that was perhaps inevitable given the scale of the procurement undertaken and the situation that prevailed globally in the early months of the pandemic when supply chains were under stress. Overall, the evaluation has found that procurement – including the focus on the quality of goods and probity of processes – was an important strength in the response.

While some stakeholders perceived that WHO's response to COVID-19 has limited visibility in some regional levels within the country, many others commented very positively on the achievements in relation to vaccination and delivery of hospital-based care across the whole of Ukraine.

The only weakness that appears to have been of significant concern to a number of stakeholders was a perceived inability on the part of WHO to address the issue (and consequences) of vaccine hesitancy among the Ukrainian population. However, the evaluation team also notes that for the SPRP vaccination pillar, as part of the shared responsibility among partners, WHO's focus of work was with the healthcare workers while the risk communication and community engagement to the wider population was with UNICEF.

³ There was only one pillar-specific response objective where progress was judged to have been "limited": "Enhance the mechanisms for the timely exchange of public health information with neighbouring countries"

In respect of WHO's COVID-19 response in Ukraine, the evaluation has concluded that the WCO, with support from GoU, other partners and WHO, was able to perform very well.

RECOMMENDATIONS

Recommendations reflect the prescribed timeframe for this evaluation (early 2020 to December 2021), and those directed to the Country Office reflect the country context, findings and conclusions at the time of the evaluation. However, the war and rapidly changing humanitarian situation in the country necessitate urgent attention to adapt the COVID-19 response given the changed environment and response capacities within the country, as well as within the region given many refugees. It is noted that the findings and recommendations provide useful lessons and insights for other WHO Country Offices, Regional Offices and HQ in their COVID-19 responses, noting the need to tailor to respective contexts.

COUNTRY-LEVEL RECOMMENDATIONS

Recommendation

Recommendation 1: Taking into account the rapidly changing humanitarian crisis situation in the country, the WHO Country Office in Ukraine should incorporate successful interventions and management practices of the COVID-19 response, and COVID-19 as a major communicable disease risk, into short, medium and long term strategic plans for humanitarian response.

Rationale: The country context, including the humanitarian situation and public health capacity, has been drastically changing since late January 2022. While the humanitarian response is the need of the hour, the WHO Country Office should incorporate COVID-19 response in its humanitarian response plans and update Emergency Response Plan (ERP) accordingly.

Recommendation 2: The WHO Country Office in Ukraine should continue and build on its current COVID-19 response strategy and approach to pandemic preparedness, and to further strengthen by:

- implementing a process to review/refine the Country Office strategy and programme taking account of, and accommodating, the evolution of the current pandemic and changes in internal/external institutional or operating environments; and,
- improving understanding of, attention to and incorporation of the needs of vulnerable groups and gender considerations in the context of the current humanitarian crisis in programme design, partner selection, targeting, protection and addressing access barriers.

Rationale: The findings and experiences documented in the current evaluation suggest a need to continue the strategic and operational pillars of the COVID-19 preparedness and response capacities, programmes and processes at the country level in Ukraine.

Recommendation 3: The WHO Ukraine Country Office should further scale-up efforts to address vaccine hesitancy for all vaccine-preventable diseases, including its negative impacts, by:

- working further to understand and tackle the underlying factors that result in poor vaccine uptake;
- continuing and, where possible, enhancing collaboration across the UN family and with civil society to build on outcomes of the behavioural studies/research on drivers of vaccine hesitancy;
- sustaining advocacy with the Government of Ukraine and relevant stakeholders on vaccine access in all areas of Ukraine, including ECA; and,

- adapting learnings and technical expertise from across WHO to develop locally appropriate measures to generate increased demand for vaccination including, where relevant, closer working with local media organisations and civil society.

Recommendation 4: The WHO Ukraine Country Office should plan now to ensure that progress in strengthening its national staff capacities is maintained to meet the changing demands of the pandemic response, including by:

- ensuring that career development and/or performance plans for relevant national staff set out clear growth opportunities which can support their taking on greater responsibilities (based on the staff appraisal results)⁴;
- gradually introducing mid-level national staff to greater and more varied opportunities to take on higher-profile roles including representation of WHO in policy dialogue with senior-level counterparts in government and other agencies across a broad range of health-related issues; and,
- reviewing human resource policies and practices to ensure that changes introduced for strengthening national staff capacities are sustained.

Rationale: A majority of WHO Ukraine Country Office key staff members, including national staff, worked directly on COVID-19 response in the last two years (given the need and funding available) and continue playing an important role in supporting effective work across national and international agencies.

Recommendation 5: The WHO Ukraine Country Office should begin early planning for the 'new normal' post-pandemic, strategically adjusting its current level of support for Ukraine's health system in the medium to long-term. Early planning will be needed to ensure a well-managed transition that allows the Country Office to focus clearly on WHO's priorities as set out in GPW13 and other documents, prioritising:

- ongoing targeted support for humanitarian efforts and provision of technical support;
- putting institutional capacity building for Ukraine's programme of health reform at the centre of future plans; and,
- support for performing other core functions, such as: providing leadership on matters critical to health; engaging in partnerships where joint action is needed; shaping the research agenda; stimulating the generation, translation and dissemination of knowledge; setting norms and standards, and promoting and monitoring their implementation; articulating ethical and evidence-based policy options; providing technical support, catalysing change, and building sustainable institutional capacity; and, monitoring the health situation and assessing health trends.

Recommendation 6: The WHO Ukraine Country Office should systematise further organisation, prioritisation of, and reporting on WHO's operations at country level. Actions include to:

- align targets specified in various awards to CRPR pillars;
- explicitly prioritise work on certain Pillars (e.g., Pillars 3, 5, 6, 7, and 10, and making Pillar 1, beyond CPRP, a part of the mid-term strategic plan (2022-2023)) and on strengthening the health system in long-term strategic plans;

⁴ Echoed in talent retaining efforts of WHO such as targeted efforts through career counselling, mentorship and leadership pathway programmes to build the capacities of female staff members at junior levels to prepare them for higher-level managerial position. Source: WHO. 2021. *Human resources: annual report, Report by the Director-General*. [online] Available at: <https://apps.who.int/gb/eb-wha/pdf_files/WHA74/A74_25-en.pdf> [Accessed 13 April 2022]

- emphasise and further develop tracking of outcome-level results (i.e., beyond deliverables, scope of support provided, activity-based quarterly reports), and scale up internal systems to spotlight these achievements;
- track and report on Country Office achievements for greater visibility and fundraising to sustain/increase the scale of WHO operations at the country level;
- continue to advocate with donors on the funding requirements for WHO's COVID-19 response throughout the country; and,
- adapt monitoring and evaluation systems and reporting into humanitarian response, including COVID-19, plans.

REGIONAL/GLOBAL-LEVEL RECOMMENDATIONS

The experience gained, and achievements made, by the WHO Ukraine Country Office over the past two years inform several good practices and several recommendations that are of potentially wider relevance for WHO in other Country Offices, Regional Offices and Headquarters.

Recommendation

Recommendation 7: All WHO Regional and Country Offices should be required to arrange for (and fund) relevant staff to participate in regular functional simulation exercises to understand and practice the role of the National IHR Focal Point, with learnings from such exercises disseminated widely and incorporated into preparedness planning at all levels of the Organisation.

Rationale: Simulation exercises have been carried out by WPRO (Exercise Crystal) since 2008 and, more recently, by EURO (Exercise JADE). A number of benefits were realised by the Ukraine Country Office because of its participation in Exercise Jade in 2019.⁵

Recommendation 8: HQ and Regional Offices, in consultation with Country Offices, should establish clear “escalation” paths to permit greater flexibility in administrative processes during emergencies, including:

- use of “fast track” procurement and human resource recruitment processes which minimise process steps to achieve rapid responses when justified by specific operational criteria in health emergencies.

Rationale: During a fast-evolving situation such as the COVID-19 pandemic, the Ukraine Country Office frequently sought a high degree of responsiveness and rapid turnaround of requests in the areas of procurement and staff recruitment. Nevertheless, delays were experienced, despite the best efforts of HQ and other, centralised “back-office” functions.

Recommendation 9: Heads of Country Offices should be encouraged and supported to redouble efforts to break down siloed thinking and action, and foster synergies between programmes at the country level.

Heads of Country Offices should be encouraged to:

- maximize synergies across GPW13 and Country Office programme strategic priorities and programmes, and that these are not inhibited by structural or cultural barriers; and,
- promote a Country Office Business Model highlighting a multi-skilled team with Head of Country Office and Incident Manager leadership, along with identified staff/roles for information management, clinical expertise, operations/logistics, monitoring and evaluation, and as appropriate global health cluster co-ordination at technical level.

⁵ Participation in such exercises is already “recommended” as an annual activity for all EURO Country Offices

***Rationale:** The COVID-19 response created opportunities for synergies to be realised between Country Office work in humanitarian response, health reform, and pandemic response. Synergies among WHO's three strategic priorities are also highlighted in GPW13.*

Recommendation 10: Review the nature and extent of decision-making authority that is delegated to Heads of Country Offices with attention to allowing them greater agility and well-considered risk-taking.

***Rationale:** A notable feature of the response in Ukraine was the extent to which staff - led by the WHO Representative (WR) - were able to adapt approaches as demands changed and, in doing so, were not unduly restricted by established practice. Examples noted include new approaches to procurement and moves to capitalise rapidly on funding opportunities. The Country Office leadership team demonstrated a mature approach to taking and managing risks which ensured that responses were tailored closely to the needs of the Government, other partners, and the community. External stakeholders noted with approval the contrast with what can be perceived as a risk-averse and overly bureaucratic culture within WHO.*

Recommendation 11: WHO Country Offices, Regional Offices and Headquarters should increase investment in data and analytics, with a particular focus on forecasting, including to:

- further develop, use and refine country-centred planning systems, including multiple dashboards for monitoring and reporting progress as well as forecasting emerging pandemic hotspots and needs for goods and services; and,
- take advantage of established expertise in related fields and adopt leading-edge analytical techniques to support forecasting of needs and priorities and planning.

***Rationale:** The Ukraine Country Office's success in developing multiple dashboards to monitor and fine-tune the response to COVID-19 was viewed as a key strength. Crucially, data were not solely focused on reporting and evaluating progress retrospectively, but they were also used to forecast the trajectory of the pandemic and project future needs for goods and services.*

Recommendation 12: HQ, with support from Regional Offices, should take steps now to ensure that lessons learned from COVID-19 are captured and made available to support future preparedness and response. Suggested approaches could include:

- developing a specific community of practice across the Organization to systematically capture and translate lessons;
- using text analytics and artificial intelligence to mine diverse data sources.
- deploy the knowledge thus acquired in formal training situations (such as simulations – see recommendation 7), to guide planning or, on a more *ad hoc* basis, to respond to specific requests for advice or assistance from across WHO or from the Member States.

***Rationale:** There may be a natural tendency to delay the capture of institutional knowledge until the pandemic has passed (or diminished significantly in scale and scope). Doing so may, however, result in much valuable knowledge being lost as memories fade and priorities shift. Measures should be taken as soon as possible to capture, record and provide structured access to lessons learned from the pandemic.*

1 Introduction

As the first known evaluation of a single WHO country office (WCO) support to the COVID-19 response, this evaluation has been commissioned by the WCO Ukraine to provide an independent, objective, and systematic assessment of WHO's preparedness for and response to COVID-19 in Ukraine, including its strategy, interventions, operations, performance, and results to date, as well as its engagement and coordination with partners toward these same ends. The evaluation set out to document successes, challenges, and best practices and provide lessons learned and recommendations for future use by WHO and its partners to inform policy and decision-making at country, regional and global levels.

This report presents the findings, analysis, and recommendations of the independent evaluation of WHO's COVID-19 response in Ukraine. The evaluation purpose, objectives, scope, and evaluation questions are outlined in section 1. Section 2 elaborates on the methodology, including the evaluation phases, approach, ethical considerations, and limitations. An overview of the country and operational context is provided in section 3. Findings for each of the evaluation questions (EQs) are detailed in section 4. Conclusions and recommendations are presented in section 5. Annexes to the report comprise part II of the draft report.

It has to be noted that fact-finding and analysis for this report were completed prior to the Russian military offensive in Ukraine on 24th February 2022. Many of the accomplishments highlighted in this report may have subsequently been negated. As a result, it is necessary to reassess country-specific recommendations in light of the radically changed circumstances across Ukraine.

1.1 Purpose and objectives

The primary purpose of this evaluation is “to provide an independent, objective and systematic assessment of WHO's preparedness for and response to COVID-19 in Ukraine, including its strategy, interventions, operations, performance and results to date, as well as its engagement and coordination with partners toward these same ends”.⁶

In pursuing this purpose, the evaluation is intended to serve both learning and accountability objectives. The evaluation offers WHO and its partners an opportunity to learn from what has worked (less) well and why, to ensure that the organisation continues to play a major role in the response for the foreseeable future and to navigate a wide range of challenges in its operating environment. The evaluation is also an accountability tool to provide external stakeholders (e.g., governing bodies, Member States, donors, partners) and WHO management itself with an objective, impartial perspective on how adeptly WHO has managed the financial and other contributions to the COVID-19 effort, what it has (not) been able to accomplish, as well as crucial insights into the key factors – both internal to WHO and external to the organisation in its operating environment – that have enabled positive outcomes and hindered it from achieving more and/or better results.

The principal users of the evaluation are the WHO senior management (e.g., WHO Representative in Ukraine, WHO Regional Director for Europe, WHO Health Emergencies Programme (WHE), Director-General), the WHO staff directly involved in the COVID-19 response in Ukraine, and heads of other WCOs responding to the pandemic. Other users include WHO partners at the regional, global, and country levels (e.g., Ministry of Health and other governmental ministries, United Nations Country Team (UNCT) partners, non-governmental organisations (NGOs), civil society organisations (CSOs), implementing partners (IPs), donors, and other relevant stakeholders).

⁶ WHO (2021, September). Independent Evaluation of WHO's COVID-19 Response in Ukraine Terms of Reference Final.

1.2 Scope

The evaluation aims to critically appraise WHO's contributions to the COVID-19 response in Ukraine, bearing in mind that these efforts were conducted in addition to continuing humanitarian aid in the Eastern Conflict Area (ECA). The evaluation's primary timeframe is from early 2020 (the start of the COVID-19 response) to December 2021 (the end of data collection). However, it also examined key pre-COVID-19 preparedness measures that were in place in early 2020 to support/inhibit WHO's mobilisation and support efforts.

1.3 Evaluation questions

The key lines of inquiry covered by the evaluation are framed in line with the main evaluation questions (EQs) as put forward in the terms of reference (Annex 1). The evaluation study has set out these questions in the evaluation matrix (Annex 2), detailing sub-questions, indicating the specific evaluation methodologies to address each evaluation topic, and providing a set of measurable performance indicators/standards of performance against which the attainment of results is assessed. The matrix has been used as a guide to collect and analyse the data.

In the reporting phase, to ensure a more straightforward narration of reporting findings, some evaluation questions have been combined and re-grouped. Most notably, EQ2 (effectiveness, impact) has been combined with EQ3 (coverage, equity) and EQ5.3 (performance monitoring) has been split in two to reflect the purpose: (a) monitoring and learning from (a lack of) achievements and (b) internal functioning. Table 1 reflects these revisions.

Table 1 Evaluation questions and sub-questions per criteria

EQ1 Relevance/Appropriateness: How well aligned has WHO's support to the COVID-19 response in Ukraine been with the stated needs of the government, the specific needs of the affected population, and WHO's broad approach to humanitarian action and health emergencies in light of WHO's 13 th General Programme of Work (GPW13) and the SDGs, as well as its normative guidance on health emergencies?	
Rel.1	How well aligned has WHO's COVID-19 response been with the needs of the Government, the affected population, and WHO's broad approach to humanitarian action and health emergencies? (EQ1.2)
Rel.2	To what extent has WHO's COVID-19 response been explicitly informed by an analysis of the most salient dimensions of heightened (or differential) vulnerability across specific sub-populations e.g., along gender, geographical, social, or other meaningful lines? (EQ1.3)
Rel.3	How consistently and systematically has WHO undertaken reliable ongoing monitoring and situation analysis as a means of assessing needs and adapting its response accordingly? (EQ1.4) How well has WHO adapted its response to changing needs and conditions? (EQ2.3)
EQ2 Effectiveness, Impact: What results has WHO's support to the COVID-19 response in Ukraine produced?	
EQ3: Coverage, Equity: To what extent have interventions reached all segments of the affected population, including the most vulnerable?	
Eff.1	What preparedness measures were in place at the onset of COVID-19, what was WHO's role in establishing these preparedness measures, and how adequate were these measures as a means of bracing the country for COVID-19? (previously EQ1.1)
Eff.2	To what extent have planned objectives and outcomes been achieved by WHO's COVID-19 response in relation to the WHO's response plan? (previously EQ2.1)
Eff.3	What overall level of coverage has been achieved through WHO support to the response? (previously EQ3.1) Have there been any differential results in response effectiveness across various sub-populations ? (previously EQ2.4) To what extent has WHO's interventions reached the most vulnerable groups ? (EQ3.3) What overall level of coverage has been achieved through WHO support geographically? (previously EQ3.4) What – if any – outstanding coverage gaps remain? (previously EQ3.5)

- Eff.4 How has the WCO's **humanitarian response** (or support for health sector reform) been affected by the virus? (previously EQ3.2)
- Eff.5 To what extent has WHO's COVID-19 response in Ukraine produced **unintended outcomes** (positive or negative) and how has it managed these while adapting to the "new reality" of a prolonged response? (previously EQ2.2)
- Eff.6 To what extent has **WHO monitored its performance in delivering results** and the factors affecting it, learned from this information and knowledge and fed these sources of learning into its ongoing response? (previously EQ5.3)

EQ4 Efficiency, Coordination, Coherence: How successfully has WHO harnessed the resources at its disposal (including financial, human, physical, intellectual, organisational, and political capital as well as a partnership) to achieve maximum results in the COVID-19 response in Ukraine in the timeliest and most efficient manner possible?

- Coh.1 How rapidly was WHO able to **mobilise, scale up, and provide support in a timely**, well-prioritised manner? (previously EQ4.1)
- Coh.2 To what extent have key financing vehicles incentivised a **One WHO and One UN approach** as intended? (EQ4.3)
- Coh.3 Given the inputs invested in preparedness and response efforts and the results achieved to date, how **cost-effective** has WHO's COVID-19 work in Ukraine been over time? (previously EQ4.4)
- Coh.4 How well has the organisation worked as **One WHO** to harness its collective financial, human, physical, intellectual, organisational, and political capital to achieve results in an efficient, linked-up manner across all three levels of the organisation? (previously EQ4.2)
- Coh.5 How effectively has **WHO partnered with other entities at the global, regional, and country levels** to achieve results in the most relevant, effective, and efficient manner possible? (EQ4.5) What have been the comparative advantages and weaknesses of WHO and other key response partners in preparedness, response, and coordination? (previously EQ4.6)

EQ 5 Explanatory Factors: What have been the main internal and external factors influencing WHO's ability to respond in the most relevant effective efficient and equitable manner possible?

- Expl.1 What have been the main **internal factors enabling and inhibiting** WHO's ability to respond in the most relevant manner possible? (previously EQ5.1)
- Expl.2 What have been the main **external factors enabling and inhibiting** WHO's ability to respond in the most effective manner possible? (previously EQ5.2)
- Expl.3 To what extent has **WHO monitored its performance in terms of internal functioning**, learned from this information and knowledge and fed these sources of learning into improving its own performance? (previously EQ5.3)

2 Methodology

2.1 Evaluation phases

The evaluation was conducted between September 2021 and April 2022 in four distinct phases: (1) preparation and inception, (2) data collection, (3) analysis, and (4) reporting (Table 2). Each phase included a set of evaluation activities and deliverables guided and approved by the WHO Evaluation Office (WHO EVL) at HQ and with input from the Evaluation Reference Group (ERG).

Table 2 Deliverables and activities per evaluation phase

Phase 1 Preparation and Inception	Preliminary desk review and key informant interviews, design of methodology and tools, drafting inception report, addressing comments from WHO EVL and Evaluation Reference Group, presentation of inception report to WHO EVL and ERG, finalisation of the inception report.
Sept - Oct 2021	Deliverable: Inception report in line with UNEG and WHO evaluation guidance
Phase 2 Data collection	Initial round of interviews/Kyiv visit, finalise and test tools, identify and complete the list of respondents and/or government. and non-governmental institutes and other(s) for interviews/discussions, complete collection of documents for review, conduct key informant interviews (KIIs) or small group discussion (SGD), organise site visits, conduct focus group discussions (FGDs), translate, pilot, and launch online survey, in-depth desk review, data collation/prepare for analysis
Oct - Dec 2021	
Phase 3 Data analysis	Data synthesis and triangulation, secondary analysis, hosting a collaborative sensemaking workshop to validate and enrich findings
Jan - Feb 2022	
Phase 4 Reporting	First draft of the final report, WHO/ERG feedback on the first draft of the final report, adjustment of the report and finalisation of the evaluation report
Feb - April 2022	Deliverables: Draft report in line with UNEG and WHO evaluation guidance Final report in line with UNEG and WHO evaluation guidance

2.2 Evaluation approach

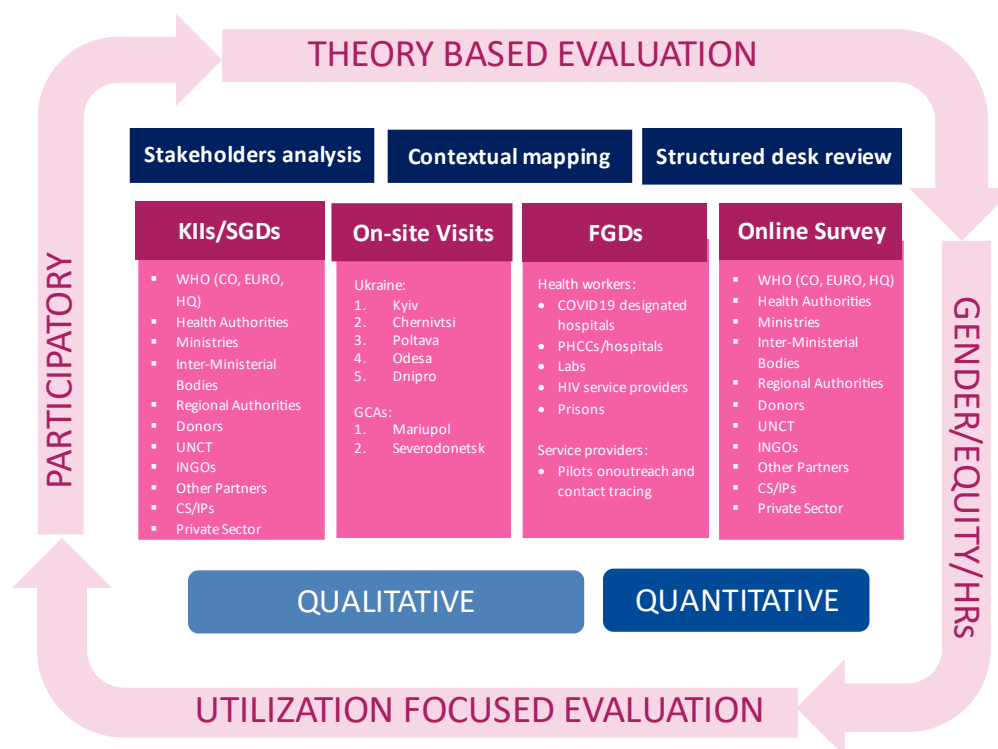
To conform with the OECD DAC Quality Standards for Development Evaluation and the Norms and Standards of the United Nations Evaluation Group (UNEG), the evaluation adopted a theory-based⁷, utilisation-focused, participatory approach using the lenses of gender, equity, and human rights (Figure 1).

The evaluation applied a theory-based approach by developing an implied Theory of Change (ToC)⁸ to illustrate how the WCO Ukraine's COVID-19 response is connected to the country-specific and organisation-wide frameworks and objectives (see section 3.2 and Figure 4). A participatory approach was demonstrated by securing key stakeholders' inputs for the design and implementation of the evaluation, while the fact that the evaluation is designed for and by its intended end-users ensured its utilisation focus. Finally, the evaluation has applied gender, equity, and human rights (GER) lens in collecting and analysing data devoting attention to gender, age, and other social determinants of social vulnerability to COVID-19 infection and access to prevention and care and intersectionality with general health inequalities.

7 Theory-based approaches to evaluation use an explicit theory of change to draw conclusions about whether and how an intervention contributed to the observed results. Chen, H.-T. (1990). Theory-driven evaluations. Newbury Park, CA: Sage Publications Inc.

8 A ToC explains how an intervention is expected to produce its results. The theory typically starts out with a sequence of events and results (outputs, immediate outcomes, intermediate outcomes, and ultimate outcomes) that are expected to occur owing to the intervention. Blamey, A., & Mackenzie, M. (2007). Theories of change and realistic evaluation: Peas in a pod or apples and oranges. Evaluation, 13(4), 439–455.

Figure 1 Overall evaluation approach



2.3 Data collection and analysis

The evaluation data were collected through mixed methods, including a desk study, survey, KIIs, and FGDs. The desk study of secondary sources included WHO global frameworks, strategies, work plans, budgets, agreements with the Government of Ukraine (GoU), WHO/EURO strategies and guidance, national policies and strategies, COVID-19 related dashboards, situation analyses, government statistics and data produced by UN agencies, and others (over 50 documents). A full list of the reviewed documents is available in Annex 3.

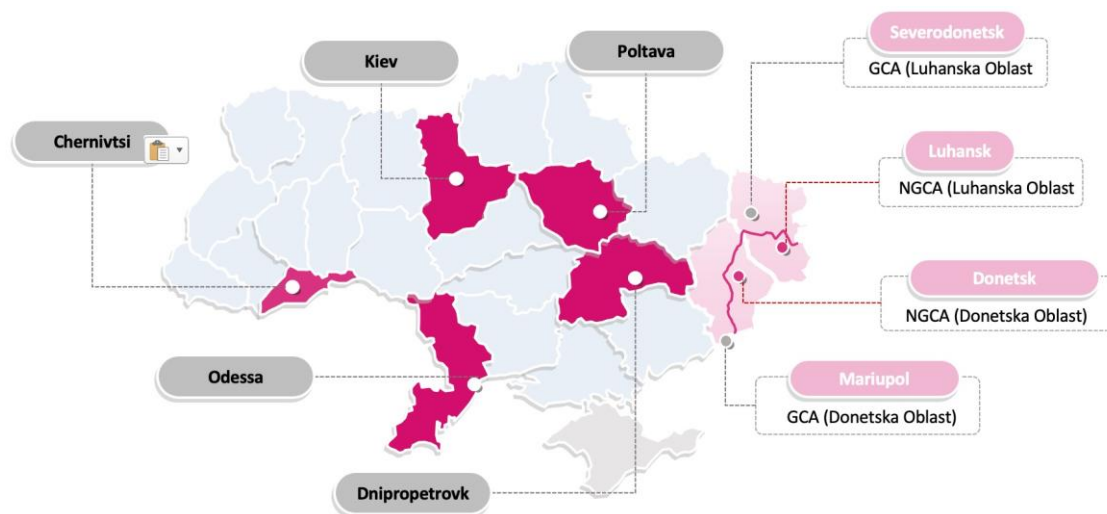
The evaluation collected varied perspectives on EQs through interviewing 86 informants representing 42 agencies and organisations, including the WHO staff working directly on the COVID-19 response in Ukraine, GoU representatives from health and other sectors, donors, UN agencies, CSOs/IPs, international non-governmental organisations (INGOs), members of the Health Cluster, private sector actors, and other partners. A list of key informants in each of the stakeholder groups can be found in Annexe 4.

Additionally, following purposeful sampling, the evaluation has conducted 17 FGDs gathering opinions of 87 health workers from COVID-19 designated hospitals, primary health care facilities/hospitals, labs, HIV service providers, and prisons, as well as providers of services for pilots on outreach and contact tracing. These FGDs were held in a face-to-face setting in Dnipropetrovsk, Kyiv, Odesa, and Poltava, as well as an online setting in Chernivtsi, Donetsk, Luhansk, Mariupol, and Severodonetsk (Figure 2).

The bilingual (English and Ukrainian) online survey (see Annex 7) was implemented through (1) colleagues of the interviewed stakeholders for their additional input ("warm list"), and (2) a broad range of relevant stakeholders with professional knowledge about the COVID-19 response in Ukraine ("cold list"). Perception survey data

received from 39 respondents representing WHO, donors, UN agencies, governmental institutions, CSOs, INGOs, other partners, and the private sector has been used to substantiate and triangulate the KII and FGD findings.⁹

Figure 2 Sites of online and offline FGDs



The collected data and information were reviewed, compared for triangulation, and sorted for outliers and differences/convergence of opinions among different groups of stakeholders. Summarised findings – organised around the EQs – were presented during the country-level learning (online) event, attended by the key stakeholders from WCO Ukraine and WHO EVL. The learning event served as a platform to validate and enrich summative findings as well as for WHO stakeholders to voice their expectations concerning the evaluation report.

2.4 Ethical considerations and quality assurance

During data collection, evaluation ethics¹⁰ were considered by ensuring that the respondents could openly express their opinions and protecting the confidentiality of their answers. Following the UNEG Code of Conduct for Evaluation in the UN System¹¹, respondents were informed about the evaluation purpose and the use of the information provided. Based on a strong commitment to the security of personal data in compliance with the General Data Protection Regulation (GDPR), the evaluation ensured that sensitive information could not be traced to its source. A summarised key informant list (Annex 4) is free from identifying information about the interviewed stakeholders.

The evaluation team applied quality control tools and an internal quality assurance mechanism across evaluation activities and deliverables. This included weekly evaluation team consultations with the member responsible for quality assurance and weekly engagements with WHO EVL on methodological aspects of the evaluation. Moreover, key representatives of WCO Ukraine were updated on progress and gaps in data collection with swift follow-up from the country office side. Deliverables of the evaluation went through the feedback loop of the ERG.

⁹ A caveat here of not having a representative sample is a result of an intentional survey design that has been employed primarily as a data triangulation method and an opportunity to give voice to stakeholders not included in the primary data collection efforts with KIIs and FGDs.

¹⁰ The revised ethical guidelines define ethics as 'the right or agreed principles and values that govern the behaviour of an individual within the specific, culturally defined context within which an evaluation is commissioned or undertaken.' Ethical guidelines for evaluation (2020). UNEG. Available at: [http://file:///Users/test/Downloads/2020 per cent20Ethical per cent20Guidelines per cent20for per cent20Evaluation-1.pdf](http://file:///Users/test/Downloads/2020%20per%20Ethical%20Guidelines%20for%20per%20Evaluation-1.pdf) [Accessed 19 February 2022].

¹¹ The Code of Conduct prescribes the independence of judgment, impartiality, honesty and integrity, accountability, respect and protection of the rights and welfare of human subjects and communities, confidentiality, avoidance of risks, harm to and burdens on those participating in the evaluation, accuracy, completeness and reliability of the report, transparency.

2.5 Methodological limitations

Methodological risks and mitigation mechanisms defined during the inception phase helped to overcome the main constraints to gathering a credible evidence base for the evaluation. Nonetheless, due to the characteristics of evaluation design and implementation, the following limitations should be taken into account when considering the information collected and analysed in this report:

Limited participation of external stakeholders: The majority of the respondents identified during the inception period were willing to take part in the evaluation. However, due to their continued involvement in the ongoing COVID-19 response, many respondents had to re-schedule interviews. Furthermore, due to the time needed to obtain the necessary official introductions to consult with state agency staff at the sub-national level, organising FGDs (both offline and online) took more time and effort than anticipated. Notably, the most challenging group of stakeholders to include in the evaluation were from state institutions at the national level. Despite such difficulties, after several rounds of invitations and active support from WCO Ukraine, the evaluation team was able to reach most stakeholders, albeit fewer than planned from key government institutions and none from the private sector. This restricted the base of evidence available for analysis, for all EQs.

Limited data on the experience of the affected population: During the inception phase, WHO and the evaluation team agreed to exclude direct interviews with the affected population, not only due to COVID-19 safety-related and other constraints – particularly in ECA – but also because it would be difficult to establish clear causal links between WCO Ukraine's contribution and the effectiveness of the response to the affected population. Specifically, WCO does not provide direct services to the population but rather supports state institutions to serve the population (see also Theory of Change in section 3.2).

Limited data for comprehensive results analysis: This includes data on outcomes and consistent and comprehensive tracking of deliverables of 28 grants/awards since 2020. WCO Ukraine has gathered a large part of this information in one logframe but has only done so from August 2021. Notably, WHO HQ/EURO guidance in aligning all activities with Strategic Preparedness and Response Plan (SPRP) with country preparedness and response plan (CPRP) pillars changed during 2020, which impeded having a consistent comprehensive overview. These gaps in the depth of the evaluation analysis led to a limited ability to disaggregate data by the project (grant/award) and report on progress on reaching project outcomes.

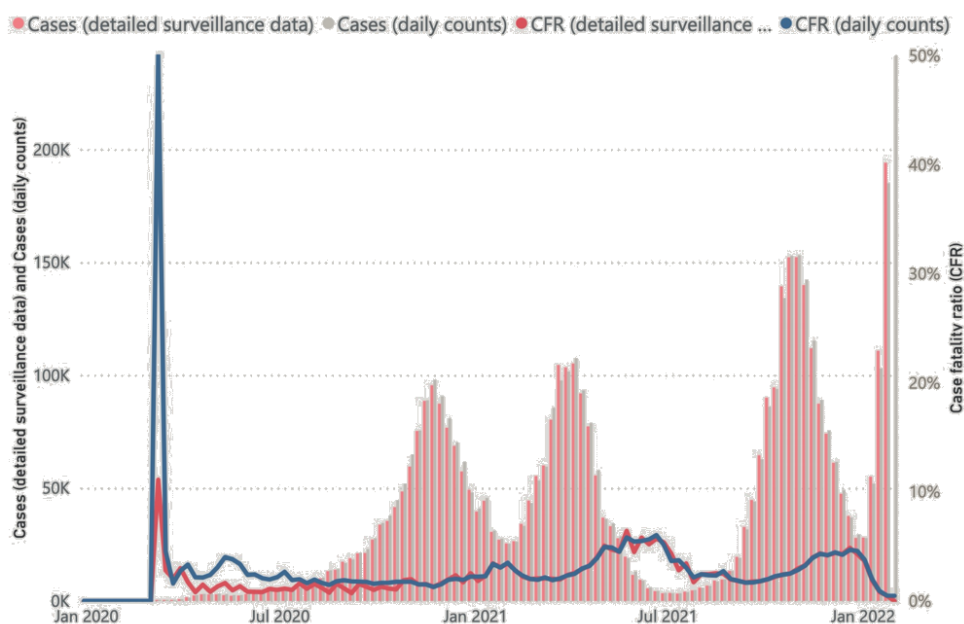
The limited granularity of findings collected remotely: Due to COVID-19-related travel restrictions, most of the data collection (apart from FGDs in four locations) was conducted remotely. Most interviews were held virtually, leading to challenges in scheduling as well as gaining nuanced insights into the discussed topics. Moreover, even when conducting FGDs in face-to-face settings, safety precautions prevented evaluators from independently observing the work of facilities and pilots supported by WCO Ukraine. This restricts the depth of analysis for the evaluation findings, conclusions, and recommendations.

3 Country and operational context

3.1 Country context

Ukraine has been one of the most severely affected countries in the European region in terms of the number of confirmed COVID-19 cases and deaths due to COVID-19 (Figure 3). The country has been affected by several COVID-19 waves and was ranked ninth in the region concerning the number of confirmed cases at the beginning of the evaluation (2,370,425 on 23rd September 2021).¹²

Figure 3 COVID-19 cases and case fatality ratio in Ukraine, Jan 2020-Jan 2022¹³



With the first case detected on 29th February 2020, the pandemic hitting Ukraine has significantly changed the scope and scale of WCO Ukraine's work. Whereas in 2019 (pre-COVID-19) two-thirds of the WCO's focus was on development and one-third on humanitarian aid, the balance has radically shifted to 90 per cent attention to the COVID-19 response and the rest divided between ongoing support to the healthcare reform and humanitarian aid. Moreover, in one year WCO funding has increased from US\$ 5-10 million/year to a total of close to US\$ 50 million, and the WCO Ukraine grew from 25 to over 90 staff and consultants.

Noteworthy key characteristics of the context in which WHO's COVID-19 response in Ukraine has been taking place include the following:

- Since 2014, in addition to its normative role, WHO has led and coordinated the health strand of the international humanitarian response to 3.4 million people – one-third of whom are elderly – in Donetsk and Luhanska oblasts in the conflict-affected Donbas region of Ukraine. To date, WHO is working with local and international partners to help provide primary care services and essential medication on both sides of the 427-kilometre-long "contact line". The organisation facilitates access to emergency and specialist care when needed as well as provides ambulances and medicines, including vaccines and drugs to combat tuberculosis (TB), diabetes, HIV, and cancer. This protracted humanitarian situation has been exacerbated by the COVID-19 pandemic, posing many additional challenges to the already-struggling population. Since 23 March 2020, in an attempt to contain the spread of the virus, severe restrictions

¹²<https://who.maps.arcgis.com/apps/dashboards/ead3c6475654481ca51c248d52ab9c61>, [accessed 23rd September 2021]

¹³<https://app.powerbi.com/view?r=eyJrIjojYWVhZGVkNWU0NmM0Ni00MDAwLTJlYVVMtN2EwNTM3YiQzYm-RmlwiwCl6ImY2MTBjMGI3LWJkMiQ0NGIzOS04MTBiLTNkYzI4MGFmYiU5MCIslmMiQjh9>, [accessed 19th February 2022]

imposed on people's movement resulted in nearly no passenger traffic taking place across the contact line between the government-controlled areas (GCAs) and non-government-controlled areas (NGCAs), as well as a significant gap in the delivery of humanitarian assistance.¹⁴

- Prior to the COVID-19 outbreak, the WCO in Ukraine had assisted the GoU in responding to several other communicable disease outbreaks including the world's second-largest measles outbreak, as well as diphtheria¹⁵, and – most recently – polio outbreaks¹⁶.
- WHO has been supporting the MoH in developing its governance capacity to lead the process of health system transformation and building modern institutions since 2015. Health reforms have continued to take place concurrently with the initiation and implementation of the COVID-19 response.¹⁷
- In addition, prior to the COVID-19 pandemic, a third of Ukraine WCO's work was focused on health emergencies (e.g., ECA) and two-thirds on development related to health systems and disease programmes.
- Since late 2019, shortly before the COVID-19 outbreak in March 2020, the MoH has been headed by four different Ministers, while two Prime Ministers, two Deputy Prime Ministers, and three Ministers of Foreign Affairs have moved in and out of offices. This has posed clear challenges to the WHO support in Ukraine.

3.2 WHO programming of COVID-19 response

In 2020-2021, WHO spent more than US\$30 million as part of its significant financial and human resource mobilisation efforts for COVID-19 response operations in Ukraine. The county office organised most of its work on the COVID-19 response, supported by more than 28 awards/grants, along with Ukraine's CPRP¹⁸ pillars. The ToC developed for the purpose of this evaluation (Figure 4) illustrates how the resources and activities of the WCO Ukraine's COVID-19 response are organised in alignment with the CPRP. The ToC also depicts how WCO Ukraine's COVID-19 response fits under Core Priority 2 of the emergency preparedness and response (EPR), and emergency strategic priority/outcomes of the GPW13 and WHO European Programme of Work 2020–2025 – “United Action for Better Health in Europe”¹⁹, linked not only to CPRP but also to the humanitarian community's humanitarian response plan (HRP) in Ukraine

¹⁴ https://reliefweb.int/sites/reliefweb.int/files/resources/eecp_crossings_march_2020_-_march_2021_-_20210401_-_eng.pdf

¹⁵ In 2018, Ukraine reported more measles cases than all EU countries in the same year, and in 2019 the most measles cases in WHO's European region.

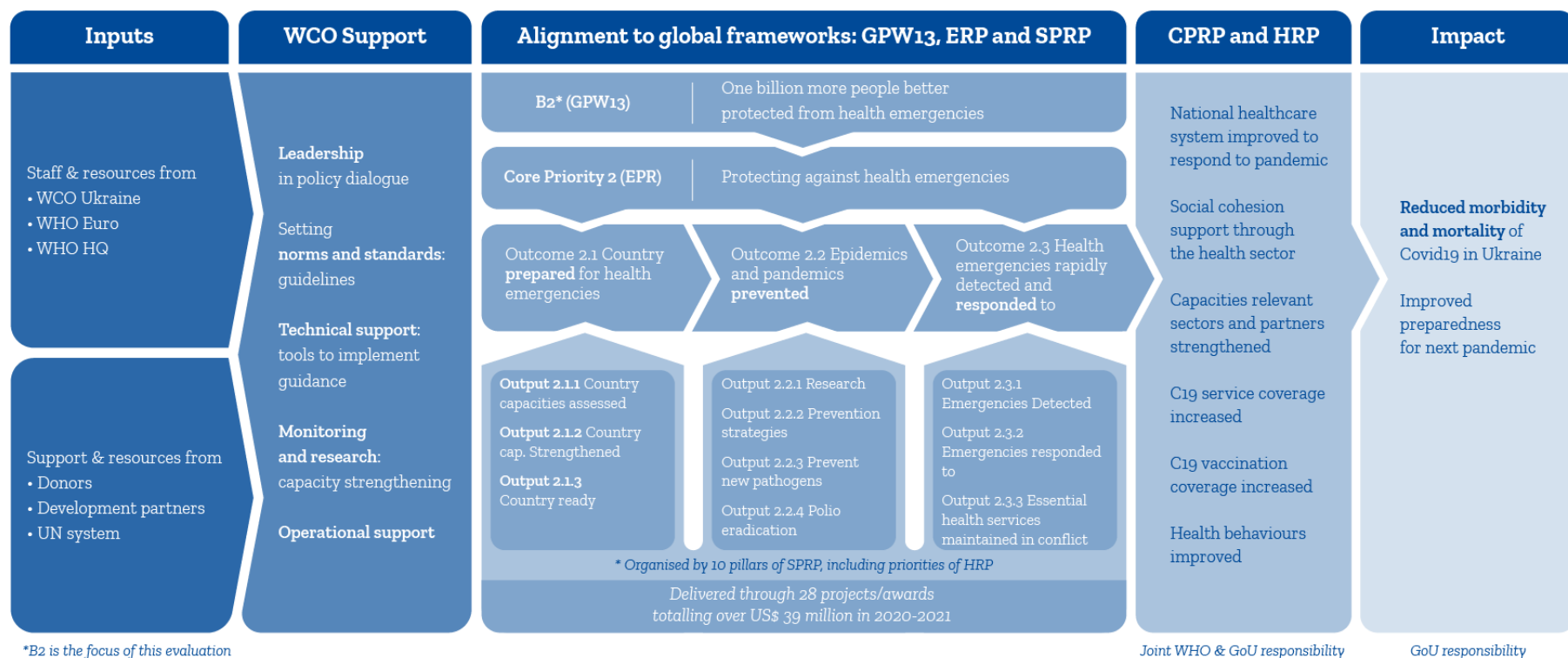
¹⁶ In October 2021, the Covid-19 outbreak was declared a public health emergency in Rivne and Zakarpattya, graded by WHO as level 2. <https://reliefweb.int/report/ukraine/ukraine-vaccine-derived-poliovirus-type-2-outbreak-situation-report-7-19-november>

¹⁷ Since 2017, when the Ukrainian parliament passed a law to reform the healthcare system law, the reform was implemented in phases with the aim to – at the primary level – ‘objectify’ the procedure of medical care provision, link the medical care provision to the financing of the medical services, and better control the expenditure of healthcare funds (European Asylum Support Office (EASO). (2021, February). EASO Ukraine FFM report – healthcare reform and economic accessibility. Reliefweb. <https://doi.org/10.2847/190187>

¹⁸ The priorities have been drawn in the CPRP approved by the Cabinet of Ministers of Ukraine (CoM) on 3rd February 2020. There is also a Ukraine 2020 Emergency Response Plan for the COVID-19 pandemic (March 2020. https://reliefweb.int/sites/reliefweb.int/files/resources/Ukraine_per_cent202020_per_cent20Humanitarian_per_cent20Response_per_cent20Plan_per_cent20to_per_cent20COVID-19.pdf

¹⁹ “European Programme of Work 2020-2025: United Action for Better Health”, WHO Regional Office for Europe. Retrieved October 19, 2021, from <https://apps.who.int/iris/handle/10665/339209>

Figure 4 Theory of Change of WCO Ukraine's COVID-19 response, designed for the purpose of this evaluation



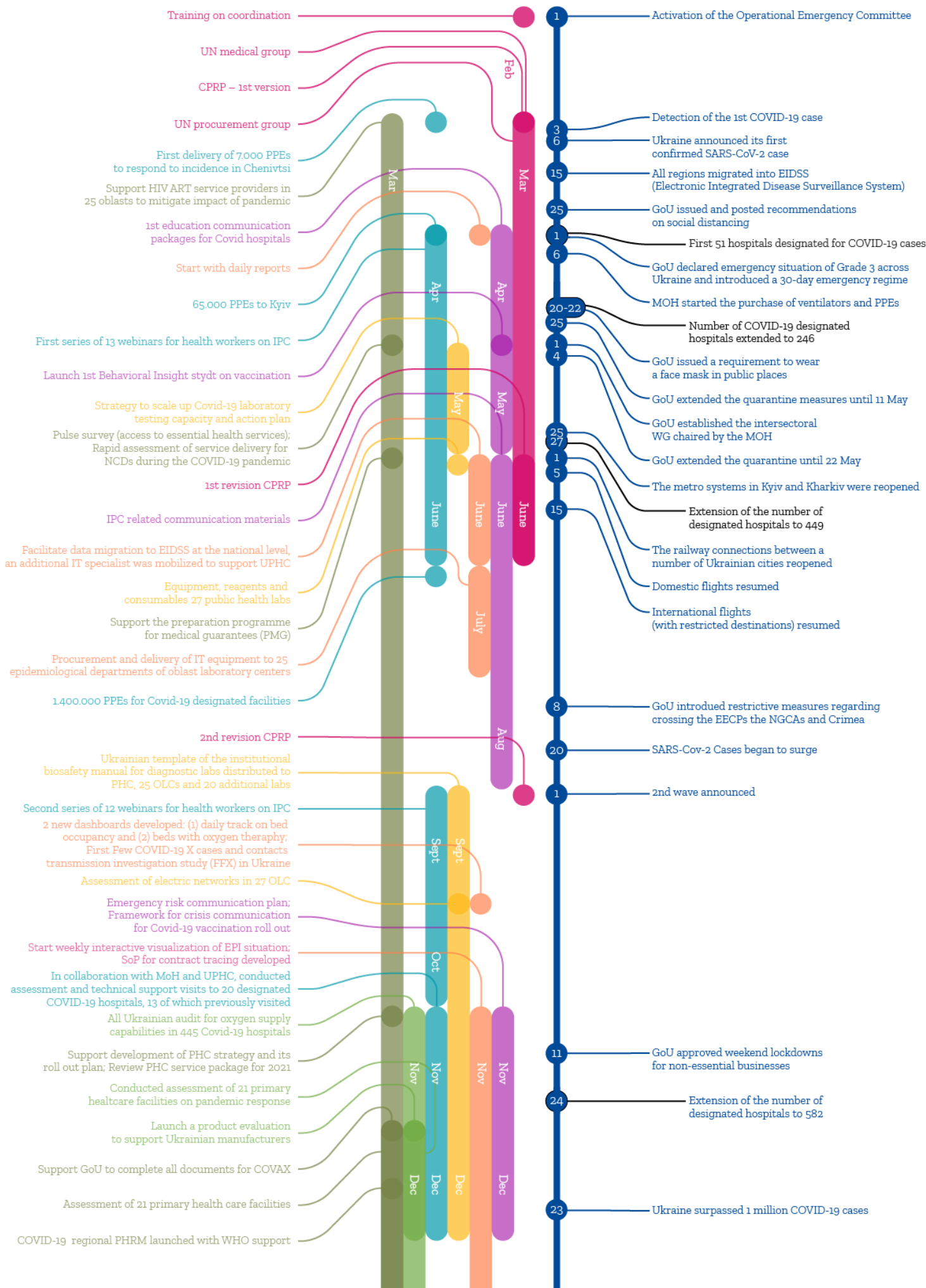
Based on the understanding that CPRP pillars reflect the organising principle for activities under the WHO COVID-19 response, the evaluation findings were collected and analysed – wherever possible – devoting attention to them. A brief overview of WCO Ukraine's operations per pillar is presented in Table 3, while an elaborated version can be found in section 4.2 of this report and in greater detail in Annex 5.

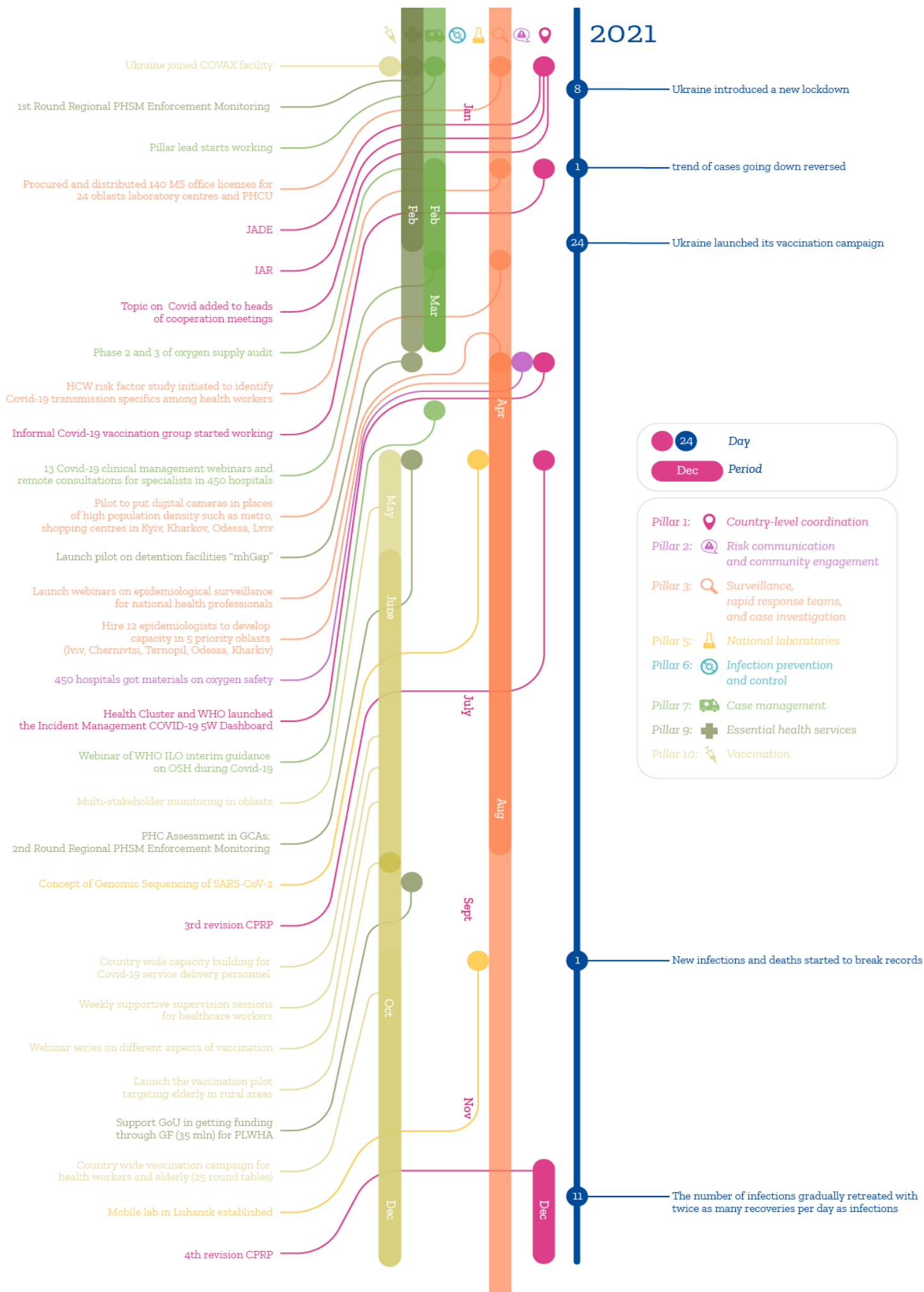
Table 3 WCO Ukraine's key areas of work aligned with CPRP pillars

Pillars	Budget in US\$	Highlights
Pillar 1: Country-level coordination, planning and monitoring	672,969	<ul style="list-style-type: none"> Developing Ukraine's CPRP to COVID-19 and supporting multisectoral coordination mechanism. Ensuring effective implementation of the International Health Regulations (2005) (IHR 2005). Strengthening the health system in the conflict settings.
Pillar 2: Risk communication and community engagement	844,110	<ul style="list-style-type: none"> Ensuring effective risk communication on COVID-19. Engaging and timely informing communities on the health measures.
Pillar 3: Surveillance, rapid-response teams, and case investigation social measures	921,658	<ul style="list-style-type: none"> Working on strengthening capacities to ensure high-quality surveillance, case investigation, and rapid response. Supporting regional and sub-regional epidemiologic and surveillance capacity in oblasts through training programmes and ensuring a strong system to deal with a potentially communicable disease outbreak beyond COVID-19. Behavioural insights study to monitor behaviours and attitudes of the population of Ukraine towards COVID-19.
Pillar 4: Points of entry, international travel, and transport	200,000	<ul style="list-style-type: none"> Developing guidance, joint statements of support, and monitoring the measures taken by the government and private entities that influence international travel and trade.
Pillar 5: National laboratories	13,779,005	<ul style="list-style-type: none"> Improving nat. and regional capacities to diagnose COVID-19. Scaling up operational and technical capacity for COVID-19 detection in line with optimal strategies.
Pillar 6: Infection prevention and control	2,795,986	<ul style="list-style-type: none"> Ensuring a safe environment for patients and healthcare workers through improving adherence to infection prevention and control practices.
Pillar 7: Case management	4,579,385	<ul style="list-style-type: none"> Supporting quality care for the patients with respiratory symptoms through improving clinical standards and approaches in Ukraine.
Pillar 8: Operational support and logistics	2,642,190	<ul style="list-style-type: none"> Strengthening capacity to meet specialised supply chain needs, including for PPE and oxygen, laboratory and vaccination activities.
Pillar 9: Maintaining essential health services and systems, including mental health	786,367	<ul style="list-style-type: none"> Strengthening the capacities to maintain equitable access to essential service delivery throughout an emergency. Actively monitoring the implementation of public health and social measures in all Ukraine oblasts.
Pillar 10: Vaccination	3,484,563	<ul style="list-style-type: none"> Supporting the availability and accessibility of vaccines and ensuring the safe and effective vaccination process in Ukraine.

3.3 Response timeline

The evaluation covers the period from January 2020 to December 2021, with a focus on identifying how the response evolved in relation to the protracted COVID-19 pandemic. The timeline (pages 20-21) has been constructed based on findings from KIIs/SGDs, FGDs and document review, and it presents major milestones of COVID-19 in Ukraine (e.g., GoU declaring a state of emergency, lockdowns, COVID-19 cases increasing/decreasing, etc.) and key actions of WCO Ukraine per pillar. This illustration is referred to throughout the report to illustrate the preparedness, responsiveness, timeliness, and efficiency of WHO's work in Ukraine in addressing the coronavirus pandemic in 2020-2021.





4 Findings

The findings of the evaluation are presented for each of the four main evaluation questions and associated sub-questions on the relevance, effectiveness, efficiency, and explanatory factors of WHO's COVID-19 response in Ukraine (Table 1).

4.1 Relevance, Appropriateness

EQ 1: How well **aligned** has WHO's support to the COVID-19 response in Ukraine been with the stated needs of the government, the specific needs of the affected population, and WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies?

Key finding 1: The WHO COVID-19 response was in line with the needs of the GoU and aligned with its strategies/policies that refer to the needs of affected populations. Among the key documents illustrating this alignment is the CPRP. In addition to basing its response on WHO global guidance for COVID-19 (as set out in the SPRP) as the pandemic evolved, WCO Ukraine continued to rely on WHO global guidance, e.g., on developing a national deployment and vaccination plan for COVID-19 vaccines and ACT.

Key finding 2: Throughout the COVID-19 response, WHO and other UN agencies have promoted an improved focus on vulnerable groups' needs and supported its analysis.

Key finding 3: As the pandemic progressed, WCO Ukraine continued using WHO and UN instruments to align, review, and improve national frameworks: CPRP, humanitarian response plan HRP, and the national deployment and vaccination plan (NDVP). Throughout the pandemic, WCO Ukraine supported – independently and in collaboration with other UN agencies – data collection, analysis, and reporting on needs, doing so proactively in several areas.

Key finding 4: WCO Ukraine kept upscaling and adapting their services based on their own and UN organisations' analysis of emerging needs, anticipating GoU requests, which is seen as a key strength of the response throughout the pandemic.

*Rel.1 How well **aligned** has WHO's COVID-19 response been with the needs of the Government, affected population, and WHO's broad approach to humanitarian action and health emergencies?*

KIs indicate that, **at the beginning of the pandemic, WCO Ukraine was able to capitalise on its pre-COVID-19 capacity enhancement**, namely practising multisectoral coordination and risk communication for potential Public Health Emergencies of International Concern (PHEIC) under the IHR. Specifically, in November 2019 WCO Ukraine participated in a JADE (Joint Assessment and Detection of Events) functional simulation exercise for national focal points organised by WHO EURO.

“When CPRP was developed, it was done correctly: initially, WHO and UPHC developed this plan together and then distributed it to other UN agencies and international organisations for feedback”

Key informant, Ministry of Health

Early on in the pandemic, to support GoU in their COVID-19 response, WCO Ukraine initiated and led several coordination platforms and was instrumental in preparing the CPRP (March 2020) in collaboration with national and coordination with international stakeholders. Ukraine was the first country in the WHO EURO region to start developing a CPRP almost immediately after WHO issued its guidance in February 2020. This allowed WCO Ukraine to move rapidly to attract funding and mobilise further technical expertise. For further alignment, the Country Office also organised its work on the COVID-19 response according to CPRP pillars.

Desk study of WHO documents and KIIs show that, In addition to basing CPRP on WHO global guidance for COVID-19 Strategic Preparedness and Response Plan (SPRP)²⁰, as the COVID-19 pandemic evolved WCO Ukraine continued to rely on WHO global guidance such as the national deployment and vaccination plan (NDVP) for COVID-19 vaccines²¹ and Access to COVID-19 Tools (ACT) Accelerator²².

A majority of stakeholders surveyed endorsed the view that assisting the development of the CPRP and other key national COVID-19 response documents in collaboration with key national and international stakeholders helped to ensure a good alignment with the national needs. Indeed, most of them (83 per cent) expressed their satisfaction with how the response has helped to meet the stated needs of the Government and affected population and been aligned with the national frameworks: CPRP, HRP, and NDVP.

Furthermore, KIIs with governmental stakeholders confirm that **WHO sustained its normative guidance on health emergencies to GoU** by technically supporting UPHC – the national focal point on IHR – in self-reporting on the country's capacity to prevent, detect and rapidly respond to public health threats on the e-SPAR platform²³. Most recently within the period covered by this report, in January 2021 – with WCO Ukraine's assistance – UPHC has filled in an extensive self-evaluation workbook with various indicators for the IHR (2005) Joint External Evaluation Tool, which has been reviewed by the external evaluation team and a report has been drafted for mandatory annual self-assessment.

*Rel.2 To what extent has WHO's COVID-19 response been explicitly **informed by an analysis** of the most salient dimensions of heightened (or differential) vulnerability across specific sub-populations (e.g., along gender, geographical, social, or other meaningful lines)?*

KIIs and documents reviewed indicate that throughout the COVID-19 response, WHO and other UN agencies have promoted an improved focus on, and analysis of, vulnerable groups' needs. Vulnerability assessment specifically informed the rollout of vaccination and case management recommendations (Pillars 7 and 10). WCO Ukraine has supported national processes to take into account the advice of the WHO Strategic Advisory Group of Experts on Immunization (SAGE), the European Technical Advisory Group of Experts on Immunization (ETAGE) and others for the recommendations that the National Immunization Technical Advisory Group (NITAG) put forward to MoH. As a result of these informed recommendations, the Ministry has approved a list of priority groups with priority access to vaccination. See the elaboration on this topic in section 4.2 (effectiveness, coverage).

*Rel.3 How **consistently and systematically** has WHO undertaken reliable ongoing monitoring and situation analysis as a means of assessing needs and adapting its response accordingly? How well has WHO adapted its response to changing needs and conditions?*

KIIs and survey responses show that, as the pandemic progressed, WCO Ukraine proceeded with using WHO and UN instruments – SPRP, NDVP, ACT – to align, review, and improve national frameworks. WCO Ukraine coordinated three out of four revisions of the CPRP (June 2020, September 2020, and May 2021). For these revisions, Interviewees commented positively on WHO's ability to draw on timely technical expertise for its revisions of CPRP and, as a result, to finalise materials quickly.

“WHO was instrumental in setting up NDVP with relevant indicators”

Key informants, national authorities

²⁰ “COVID-19 Strategic preparedness and response plan”, Geneva: World Health Organization; 2021. Retrieved October 19, 2021, from <https://www.who.int/publications/i/item/WHO-WHE-2021.02>

²¹ WHO 2021. *Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines*. [online] Available at: <https://www.who.int/publications/i/item/WHO-2019-nCoV-Vaccine-deployment-2021.1-eng>

²² WHO. 2021. *The Access to COVID-19 Tools (ACT) Accelerator*. [online] Available at: <https://www.who.int/initiatives/act-accelerator>

²³ Extranet.who.int. n.d. *e-SPAR Public*. [online] Available at: <https://extranet.who.int/e-spar/#submission-details>

Further, to assess and improve the current response to the COVID-19 outbreak in the country, WHO supported MoH in conducting an External Review of Implementing Measures (EIA) in Ukraine in January 2021. This exercise allowed relevant national stakeholders to review the response capacity of the health system in addressing the COVID-19 outbreak and identify five main priority areas to improve the ongoing response.

WCO Ukraine continued – independently and in collaboration with other UN agencies – to undertake monitoring and situation analysis to assess needs and adapt its response accordingly. As shown in the timeline (pages 22–23), the early priority in April–June 2020 was supporting GoU in procuring PPE, lab, and other necessary medical equipment, and coordinating national and international state and non-state actors in defining and prioritising procurement needs. WHO also devoted significant effort to bringing transparency considerations into the procurement processes, the majority of which were dedicated to equipping national laboratories (Pillar 5). WCO Ukraine led an analysis of needs and launch of the new procurement system, the success of which was aided by coordination with the Vice-Prime Minister and Cabinet of Ministers of Ukraine.

Later in 2020, as COVID-19 service quality became a point of attention, WCO Ukraine, in collaboration with MoH and UPHC, assessed the needs of designated COVID-19 facilities in the area of Infection Prevention and Control (IPC, Pillar 6). Specifically, the Country Office carried out assessments and technical support visits to 27 designated COVID-19 hospitals in March–July 2020, technical support visits to 20 designated COVID-19 facilities in November–December 2020 and 30 on-site IPC assessments in 2021. WCO Ukraine coordinated with donors, resulting in financial support from the Republic of Germany to define the oxygen therapy capacity needs of 433 out of 445 COVID-19 dedicated hospitals in Ukraine (Case Management, Pillar 7).

WCO Ukraine's work towards needs assessment included collaboration with the UN Human Rights Monitoring Mission in Ukraine (HRMMU) on the study of the pandemic's impact on Human Rights.²⁴ The Country Office also collaborated with the ILO to raise awareness on the impact of COVID-19 on health workers by jointly organising a webinar entitled "COVID-19: occupational health and safety for health workers" (April 2021). Attended online by 500 participants, the webinar discussed the key challenges and responses of Ukrainian health workers²⁵ and promoted the practical use of the WHO-ILO Interim guidance with the same title.²⁶

"WCO was instrumental in providing access to information in hospitals and providing comments on the impact on healthcare workers as well as the finalisation of the briefing note."

Key informant, UN agency

Overall, a large majority of survey respondents (84 per cent) expressed their satisfaction with the COVID-19 response in Ukraine being explicitly informed by evidence/science, while only a few respondents (principally from UN organisations and INGOs) were dissatisfied, specifically about publicly-available information on the pandemic being too generic to properly inform planning the local-level response.

"Although preparedness to address COVID-19 pandemic was not visible in the very beginning, in several months WHO could build a strong and excellent team to offer its scaled-up support."

Key informant, UN agency

Not only has WCO Ukraine continued to assess different areas of need but also – and most importantly – the Country Office has been upscaling and adapting its support to address emerging needs. Various respondents highlighted that from the beginning of the COVID-19 pandemic, WCO Ukraine was prompt in

²⁴ <https://ukraine.un.org/en/124052-briefing-note-impact-covid-19pandemic-healthcare-workers-ukraine>

²⁵ As reported by ILO in its briefing of 5th May 2021, as of mid-April 2021 78,919 cases of COVID-19 infection had been reported among workers of health institutions, including 708 deaths. In total in Ukraine, the health sector employs 735,000 workers, of whom 83 per cent are women.

²⁶ WHO-ILO Interim guidance "COVID-19: Occupational health and safety for health workers" https://www.ilo.org/global/industries-and-sectors/health-services/WCMS_769309/lang--en/index.htm

gathering relevant expertise and further developing its capacities of measurement, data collection, and needs assessment.

This point is illustrated by the fact that during March–April 2020 WCO Ukraine mobilised teams for eight pillars of the COVID-19 response and – as WHO expanded to include other pillars to the pandemic response – added Pillar 9 (Essential health services) in autumn 2020 and Pillar 10 (COVID-19 vaccination) at the beginning of 2021.

Furthermore, from day one WCO has recognised the need for data to support surveillance and has assisted in developing and using multiple dashboards to monitor and fine-tune the COVID-19 response (Textbox 1).

Textbox 1 Dashboards developed and supported by WHO in Ukraine

(a) On COVID-19 cases (8 pages)²⁷

- Suspected/confirmed/recovered/deaths by oblast (daily and accumulative from Jan 2020 until August 2021, sex and age disaggregated, per oblast)
- Daily active cases per 100,000, average daily incidents/PCR tests/positive test results, average weekly incidents per 100,000, and average crude mortality per 100,000, per oblast
- Bed occupancy/beds/active cases (from Sept 2020 to August 2021), per oblast

(b) On WHO training, webinars, visits (2 pages)²⁸

- Disaggregated by the pillar, oblast, and type of activity, covering Jan–Dec 2020

(c) On vaccines (10 pages)²⁹

- Start of vaccination by date, per vaccine
- Procured doses, per vaccine, per procurement mechanism
- Cumulative uptake by month
- Cumulative doses received and remaining per month
- Vaccination by age group, target group and vaccine
- Vaccination by dose (no data)
- Vaccination of health workers by dose
- Vaccination of elderly by dose

(d) On bed occupancy and oxygen availability³⁰

- Per oblast (from September 2020 until present)

Another example of responding to the emerging needs is following up on key findings of the UN Briefing Note on the Pandemic Impact on Human Rights³¹ that revealed extremely low salaries of healthcare workers, unpaid bonuses, a gender pay gap and gender-based violence in the workplace. WCO Ukraine has picked this issue up and developed guidance for authorities to address this widespread issue and discussed the topic of non-payment of bonuses with MoH.

Additionally, following the previously mentioned joint webinar entitled “COVID-19: occupational health and safety for health workers” (April 2021), ILO and WHO have published a brief³² (in May 2021) with practical guidance for national and local authorities and employers and workers’ representatives for the implementation of WHO and ILO recommendations to prevent SARS-CoV-2 transmission at work in non-healthcare settings.

²⁷ <https://app.powerbi.com/view?r=eyJrIjoiMz1lMTRkMzQtMDRhNi00YmZlLWI4MzUzY2Y4OWQwNTlk-Njc3IiwidCI6ImY2MTBjMG13LWJkMjQtNGZlOS04MTBiLTNkYz1lMGFmYjU5MCIsmMiOjdh9&pageName=ReportSection0260a1c87b91fd84544>

²⁸ <https://app.powerbi.com/view?r=eyJrljoiNjkzZGY5MjMtOTk5MC00YTM4LTlhOT-QtMmZlZmRhZjdjOGYyLiwidCI6ImY2MTBjMGJlZWJkMjQNGzOS04MTBlTnkyZi4MGFMmYU5McGlsmMiOjh9>

²⁹ <https://app.powerbi.com/view?r=eyJrljoiMWNjNzZkNjctZTNiNy00YmMzLTkxZjQlNmJiZDM2MTYxNzE>

³⁰ <https://app.powerbi.com/view?r=eyJrJoiOTUuNDhmNzUtNDJRjNS00MzNiNWFKYjUtMjYmNmJkZDhjZDJlIiwidC16ImY2MTBjMG13LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIslmMiOiJh9>

³¹ <https://ukraine.un.org/en/124052-briefing-note-impact-covid-19pandemic-healthcare-workers-ukraine>

³² Policy brief on preventing and mitigating COVID-19 at work https://www.ilo.org/safework/WCMS_793047/lang--en/index.htm

According to WCO Ukraine, these agile adaptations based on continuous needs assessments – among others – were aided by applying WHO regulations for emergencies. These regulations proved advantageous not only for the nimble emergency response but also for advancing a development issue such as health reform. See the elaboration on this topic in section 4.4 (explanatory factors).

4.2 Effectiveness, Impact, Coverage

EQ2: What **results** has WHO's support to the COVID-19 response in Ukraine produced?

EQ3: To what extent have WHO's interventions **reached** all segments of the affected population, including the most vulnerable?

Key finding 1: The effectiveness of WCO Ukraine's initial response to COVID-19 was limited due to Ukraine's imbalanced capacities for implementing the International Health Regulations (2005) (IHR) and several ongoing structural changes internal to WHO in 2019. However, as one of the WHO's priority countries in the European region, having staff with an emergency mindset and dedicated procedures in place before the COVID-19 pandemic, WCO Ukraine could swiftly mobilise and engage effectively in the response.

Key finding 2: WCO Ukraine achieved its targets for deliverables in respect of all 28 separate financial contributions worth over US\$ 38 million that were obtained during the period from March 2020 to November 2021. Progress has been excellent/good in all ten CPRP pillars, with main achievements in five out of ten pillars (1, 3, 5, 6, and 7). The reasons for this progress include a combination of relevant strategies and agile action.

Key finding 3: WHO – in collaboration with other UN agencies – has worked to promote an improved focus on the needs of vulnerable groups, using vulnerability assessments to specifically inform the roll-out of vaccinations (pillar 10) and recommendations to improve case management (pillar 7). As a result, vaccination efforts in Ukraine have been largely informed by vulnerability assessments resulting in increased vaccination coverage of vulnerable groups, although some have been left behind. WHO has also supported safeguarding equitable access to COVID-19 prevention and care, where coverage remains a challenge.

Key finding 4: The health and peace aspects in conflict areas were important and WHO was effective in providing technical and neutral mediation services. WCO Ukraine was able to increase its funding for the humanitarian response as part of the COVID-19 response, sustain its already expanded operation in the NGCAs and expand operations in GCAs.

Key finding 5: WCO Ukraine developed a systematic monitoring tool for the complete COVID-19 response, which was deployed in early 2021 and monitored budget utilisation throughout the response. WCO Ukraine as a whole, and the Incident Management Support Team (IMST) in particular, have been undertaking regular monitoring visits and/or technical assessments applying the WHO global or regional guidance from the outset of the response and acting on the monitoring data obtained.

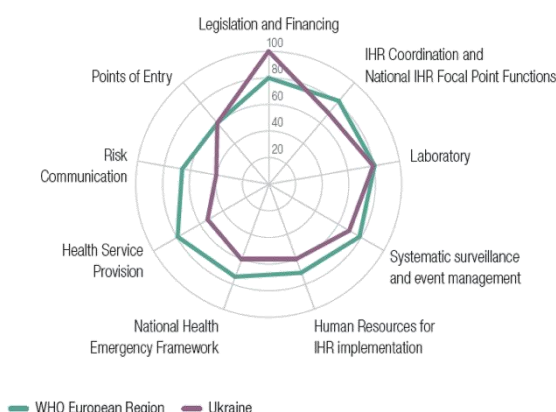
Eff.1 What **preparedness measures** were in place at the onset of COVID-19, what was WHO's role in establishing these preparedness measures, and how adequate were these measures as a means of bracing the country for COVID-19?

Prior to the COVID-19 pandemic, Ukraine had imbalanced capacities for emergency preparedness and its response mechanism as evidenced by the self-assessment of implementing the IHR conducted in 2019 as well as the document review and interviews with key stakeholders during this evaluation (Figure 5). The 2019 self-assessment on IHR implementation capacities had shown that despite scoring 100 per cent on legislation and financing capacity³³ (of radiation response) and being in line with the regional average of WHO Europe for core

³³ i.e., have in place legislation addressing the needs of radiation emergency preparedness and response, specifying the roles and responsibilities of relevant stakeholders as well as a monitoring and feedback system for an emergency public financing mechanism and access to an emergency contingency fund for public health emergency. Moreover, budgets for the implementation of IHR capacities for all IHR hazards are executed in a coordinated manner.

capacities of points of entry and laboratories, Ukraine only scored 20 per cent on planning for emergency preparedness and its response mechanism (capacity of national health emergency framework) as well as capacity for infection prevention and control (capacity of health service provision). Ukraine also scored below the regional average on risk communication (40 per cent), indicating that formalised all-hazard emergency risk communication mechanisms to proactively engage with the public and affected communities in local languages are only in place at the national but not yet the intermediate and local levels.

Figure 5 Country self-assessment on selected core capacities for the implementation of the IHR in 2019, source: The Global Health Observatory, WHO³⁴



According to KIIs, WHO not only technically supported UPHC – the national focal point on IHR – in preparing and submitting mandatory annual self-assessment reports on the e-SPAR platform but also assisted efforts to address identified weaknesses of the system.

In January 2020, Ukraine set up an Emergency Operation Committee through the MoH. Governmental stakeholders confirmed that WHO's contribution to this preparedness measure was providing technical assistance of the WHO Emergency Response Department and IHR to the UPHC in 2019. This technical assistance covered the framework of cooperation for developing the Early Detection and Response System and supported the specialists of the Emergency Response Department and the IHR with operating systems and relevant hardware.

On 3rd February 2020, Ukraine approved a COVID-19 National Action Plan (NAP). The NAP tasked the Chief State Sanitary Doctor (concurrently the Deputy Health Minister) with ensuring intersectoral coordination within the government. As the document review shows, around the same time, WCO Ukraine conducted a table-top exercise (TTX) on the COVID-19 response for various national stakeholders, including beyond the health sector. The main aim of the exercise was to identify main areas of improvement in the overall response capacity at the national and regional levels and to facilitate a multisectoral response. WHO also arranged for over 100 different guidance documents for the health system to be available in local languages. One of the aspects appreciated by the national health authorities – according to the evaluation findings – was the global evidence and analysis provided by WHO to the GoU that helped them assess and mobilise financing for the COVID-19 response.

Key informants corroborate that the preparation of the NAP and follow-up legislation has engaged strategic stakeholders at different levels – national ministries/state authorities as well as regional governments – to design and implement national and regional response plans, standard COVID-19 medical pathways and procurement plans for the health system.

Despite these efforts, national authorities considered Ukraine's preparedness for COVID-19 below par when the pandemic hit the country in March 2020, with a lack of PPE and other medical devices being identified as an immediate challenge.

³⁴ WHO. n.d. *The Global Health Observatory*. [online] Available at: <https://www.who.int/data/gho> [Accessed 3 April 2022].

Several stakeholders also highlighted that the ongoing process of health sector reform meant there was, on occasions, a lack of clarity on roles that different agencies had to play, which also impeded preparedness. By March 2020, the reform had established new health agencies, but key legislative changes had not been completed. Furthermore, the reform had largely been focused on health financing and primary health care with only limited attention to aspects of national surveillance, laboratory capacity, and other building blocks for emergency response. Several stakeholders even suggested that the country would have been better prepared five years ago when legacies of the former Soviet system, including higher levels of central command and control over services and facilities, were still in place. Nevertheless, in the face of COVID-19, **Ukraine's health system appears to have been in better shape than some of its European neighbours'**. COVID-19-related mortality in Ukraine is high, but with 121 deaths per 100,000 population, it is still below the average of the European region (131 deaths per 100,000 population) as of August 2021.³⁵

Aside from that, since 2014 Ukraine has been one of the WHE Programme's priority countries in the European region and, as a result, the country had an emergency mindset. Ukraine had a grade 2 emergency rating due to the measles/polio outbreaks and the conflict in ECA. Hence, WCO Ukraine had a WHE Emergency Response and Preparedness Team of five staff members plus a Health Cluster Coordinator in Kyiv and WHO Field Offices in Donetsk, Luhansk, and Severodonetsk, all of which proved to be invaluable as components of the pandemic response. The country office also had its own emergency procedures and standard operating procedures (SOPs) in place prior to the pandemic which facilitated the establishment of the IMST and rapid procurement of PPE. Coupled with the fact that, **as of early January 2020, WCO Ukraine was one of the largest offices in the WHO EURO region with a total of 25 staff members**, allowed the WCO rapidly and easily repurpose staff to focus on the COVID-19 response.

Nevertheless, external stakeholders suggested that WHO's general focus on non-communicable diseases and health sector reform could have been among the key factors inhibiting preparedness for a health emergency. Significant staff turnover (including the departure of the WHE Lead in February 2020, with the replacement not being in post until May 2020) along with the relocation of WCO Ukraine's Kyiv office to new premises also hampered preparedness to a degree. In the words of one staff member, *"COVID came one year too early for us"*.

*Eff.2 To what extent **have planned objectives and outcomes been achieved** by WHO's COVID-19 response in relation to the WCO's response plan? (previously EQ2.1)*

WCO Ukraine worked towards CPRP pillar-specific objectives and award-specific targets for deliverables through 28 separate awards during the period from March 2020 to November 2021. Besides, WHO support for the COVID-19 response in Ukraine was guided by the objectives of CPRP and HRP, articulated in the Theory of Change designed for this evaluation and described in Figure 4.

Analysis of the WHO records show that **WCO Ukraine has been consistently achieving its targets for deliverables as per the 28 awards** and has had an average absorption rate of the awards very high at 98 per cent.

When looking at the achievement of the higher level - the objectives, as stipulated in the Ukraine CPRP (May 2021), that the GoU has set in collaboration with WHO and other partners for its COVID-19 response – varied progress per pillar is observed. Overall, the assessment of progress towards CPRP pillar objectives shows that the progress has been good or excellent across pillars, with main achievements in five out of ten (pillars 1, 3, 5, 6, and 7). While a greater detail on each CPRP pillar is presented in Annex 5, below we present a summative overall assessment as well as selected key achievements and shortcomings. The legend of the ratings is as follows: excellent progress - when document reviews, interviews and WCO reporting provided converging information towards reaching objectives; good progress – when the same sources converged on delivering even

³⁵ Covid19.who.int. n.d. *WHO Coronavirus (COVID-19) Dashboard*. [online] Available at: <https://covid19.who.int> [Accessed 3 April 2022].

though there were also indications that further work was needed; reasonable progress - when information included elements of progress combined with clear issues related to implementation; and limited progress - when information recognised implementation but also sunsetting of the priority or the activity.

Progress towards specific objectives of Pillar 1: Country-level coordination, planning, and monitoring

1	Support establishing a public health EOC to strengthen communications and coordination for effective public health response	Good progress
2	Develop emergency response plan related to the pandemic spread of infectious diseases and enhance a procedure of interaction of health care facilities during PHEIC	Good progress
3	Support monitoring of COVID-19 response activities at national/regional level	Excellent progress
4	Support coord. response to MHPSS population needs through cross-sectoral MHPSS WG as a part of humanitarian emergency response with expanded function of COVID-19 response	Good progress

- WHO supported the establishment of the Emergency Operation Centre (EOC) under the UPHC – a first in the health system of Ukraine – which enabled tracing the polio outbreak, among others. Subsequently, by a decision of the MoH, EOC has merged with the Disaster Medicine Centre, which - according to key informants - raises concerns about the sustainability of these efforts.
- Ukraine was one of the first countries in the WHO EURO region to develop a comprehensive emergency response plan (CPRP) and to integrate the COVID-19 response into the HRP. WCO Ukraine worked to establish and lead various coordination platforms at the national level (including humanitarian work in ECA) with the participation of national and international partners.
- Ukraine is among a few WHO Member states that have regularly updated its CPRP although stakeholders felt the need for even more frequent updates.
- WHO supported the monitoring capacity of the COVID-19 response at national and regional levels by launching a Joint External Evaluation (JEE) for implementation of the IHR (September 2021- January 2022, the first in Ukraine) and intra-action review (IAR)³⁶ for the COVID-19 response (March 2021).
- WCO's role in the initiation and facilitation of various multi-stakeholder coordination platforms is highly appreciated. One particular achievement was coordination around the procurement of COVID-19 response commodities. As a member of the national procurement group led by the Vice Prime Minister, the UN procurement working group as well as the lead of the informal UN working group on procurement, WHO facilitated agreement on the commodity list for the COVID-19 response, thus avoiding duplication of efforts.

Progress towards specific objectives of Pillar 2: Risk communication and community engagement

1	Dev. and impl. of public awareness campaigns during transition; distribution of timely info on available mental health services, stress mgmt strategies and new/updated WHO/IACS tools for MHPSS in accessible formats.	Reasonable progress
2	Support the MoH/UPHC in developing risk communication plan including for the roll-out of the COVID-19 vaccination campaign	Reasonable progress
3	Capacity building on strategic COVID-19 communication.	Good progress

³⁶ The IAR is a country-led facilitated process conducted during the COVID-19 outbreak in-country, bringing together a small group of COVID-19 responders with knowledge of the public health response pillars under review <https://www.who.int/publications/i/item/WHO-2019-nCoV-Country-IAR-2020.1>

- In support of the mental health and psychosocial support strategy (MHPSS), WHO coordinated the development and regular update of a service mapping in Donetsk and Lugansk oblasts. Among others, national trainers were trained to help health workers to provide psychosocial support and use stress management techniques in the workplace
- To identify and address behavioural changes related to the COVID-19 pandemic, WCO carried out numerous behavioural insight studies and awareness campaigns for a wider public as well as targeting groups with low adherence and low-risk perception related to COVID-19. Those campaigns are estimated to have delivered relevant COVID-19 and vaccination evidence-based messages to more than 22 million people.
- Several external challenges such as national authorities not affording adequate priority to communication on COVID-19, significant turnover of communication staff in the MoH and UPHC, and a lack of communication budgets in many public health institutions combined to slow progress.
- WHO built capacity on strategic COVID-19 communication by providing frontline workers with webinars on PCR testing, oxygen therapy and oxygen supply, and IPC to enhance their safety and health.
- Despite WCO Ukraine having had three times the number of communication staff compared to some other, broadly similar WHO country offices, key informants do not see WHO as a major, visible player in risk communication in Ukraine. This is mainly due to the fact that as part of the coordination among partners, WHO and UNICEF specified their shares of responsibility for the NDVP. While WHO focused on healthcare workers, the whole domain of responsibility for Risk Communication and Community Engagement (RCCE) to the wider population was with UNICEF.

Progress towards specific objectives of Pillar 3: Surveillance, rapid response teams, and case investigation

1	Enhance existing surveillance systems to enable monitoring of COVID-19 transmission at regional level, including active case finding in various contexts, and adapt tools and protocols for contact tracing and monitoring.	Good progress
2	Produce epi situation analysis, health system capacity, monitoring of public health measures, study behavioural insight, etc. on regular basis, produce projection of transmission and hospitalisation for planning purposes.	Good progress
3	Support regional epidemiologic and surveillance capacity through integrated short and long-term training programs and ensure strong system to deal with potential communicable disease outbreak beyond COVID-19.	Good progress

- WCO's support for the COVID-19 response contributed significantly to improving national public health surveillance. The roll-out of the Electronic Integrated Disease Surveillance System (EIDSS) in Oblast Laboratory Centres (OLCs) across the country is noteworthy. Following five years prior support from the US Defence Threat Reduction Agency (DTRA) a single data exchange system for the whole of the country's public health system was established within three months of the start of the pandemic with support from WHO. A plan to connect the public health system to the clinical system for COVID-19 (another area for improvement that had been stagnant for years) was also finally delivered under WHO leadership. Ukraine now has a comprehensive and operational contact tracing strategy and is the second country in the world (after Argentina) to adopt the WHO contact tracing software Go.Data. The latter was achieved through WHO pilots in Chernivtsi, Odesa, and Lviv oblasts, including donating equipment and training 146 epidemiologists and 264 PH specialists. However, the costs of scaling up the contract tracing system in other oblasts remain a challenge.
- Another achievement is the development of the Public Health and Social Measures (PHSM) tracking system,³⁷ in which WCO Ukraine was a forerunner. In June 2020, the WCO turned WHO global guidance 'Considerations in adjusting public health and social measures in the context of COVID-19'³⁸ into a traffic light system for recommendations on social measures. Five months later, the same system was scaled up through WHO HQ and EURO.
- WHO has launched the WHO-UPHC E-Learning platform³⁹ containing comprehensive courses for COVID-19 response professionals on surveillance, epidemiology, IPC, and the application of EIDSS and Go.Data. However, according to

³⁷ Background information: WHO global guidance that recommends stricter or softer measures to be taken depending on the virus circulation from level 0 (no restrictions on a daily basis) to level 4 (full lockdown) depending on a certain level of public health performance.

³⁸ Who.int. 2021. *Considerations for implementing and adjusting public health and social measures in the context of COVID-19*. [online] Available at: <https://www.who.int/publications/i/item/considerations-in-adjusting-public-health-and-social-measures-in-the-context-of-covid-19-interim-guidance>

³⁹ Portal.phc.org.ua. n.d. *Платформа Центру громадського здоров'я*. [online] Available at: <https://portal.phc.org.ua/uk>

national authorities, they lack the resources needed to purchase analytical services from private companies, an important barrier for them to producing forecasts for COVID-19.

Progress towards specific objectives of Pillar 4: Points of entry, international travel, and transport

1	Designation of the points of entry and assessment of core capacities	Good progress
2	Enhance inter-sectoral coordination mechanism to support routine and emergency response	Good progress
3	Enhance the mechanisms for the timely exchange of public health information with neighbouring countries	Limited progress

- WHO supported UPHC in conducting a rapid assessment of eighteen points of entry (PoEs) in Odesa, Lviv, Zakarpattia, Chernigiv, Sumy and Kharkiv oblasts, visiting two international airports, one seaport and fifteen ground crossing points. Respondents valued the assessment as highly important for the implementation of IHR.
- In June 2021, to strengthen intersectoral coordination to tackle health threats such as COVID-19, at the request of GoU, WHO supported a TTX attended by 45 participants from relevant governmental and development partners. As a result, around 80 recommendations were made based on the "One Health" approach.
- WCO only started work on this pillar in April 2021, without a dedicated budget, because per CPRP, work under this pillar had previously been led by IOM. Insufficient time to implement the planned activities under objective 3 and the absence of the vision of GoU – e.g., on whether sanitary quarantine units should be established on PoEs or be part of the Regional Centres for Disease Prevention – led to insufficient progress towards achieving this objective.

Progress towards specific objectives of Pillar 5: National laboratories

1	Conduct assessments of laboratories involved in COVID-19 diagnostics using WHO Lab Assessment Tool and map PCR capacities existing in public health	Excellent progress
2	Improve COVID-19 safety and testing service delivery	Excellent progress
3	Enhance human resource capacities on real-time PCR and biosafety in laboratories	Excellent progress
4	Support building Whole Genome Sequencing capacity	Good progress

- WHO conducted an assessment of the 30 largest state laboratories at the frontline of COVID-19 diagnostics using the WHO Laboratory Assessment Tool for laboratories implementing COVID-19 testing (LAT).
- A major achievement in this area is the equipment of all public labs in the country with PCR capabilities as well as improvements in their biosafety and biosecurity. Drawing on funding from the EU, USAID, and the World Bank, and with support from WHO the capacity of Ukraine's public laboratory system for COVID-19 testing has expanded from being very limited to handling up to 50,000 samples daily (including additional capacity as a result of the establishment of some new facilities).
- WHO supported the MoH/UPHC in drafting the national sequencing strategy for COVID-19 and other infectious diseases and building the sequencing capacity. Next-generation sequencing was launched at UPHC, sequencing reagents and supplies were procured for the Institute of Molecular Biology and Genetics (Kyiv) and the needs of the SARS-COV-2 National Reference Laboratory (Virology Laboratory of UPHC) to perform NGS sequencing at the level of 600 samples per month were assessed.

Progress towards specific objectives of Pillar 6: Infection prevention and control

1	Support endorsement of IPC regulation at national level	Good progress
2	Enhance internal and external monitoring/audit of IPC practices	Excellent progress
3	Provide essential PPE and other IPC items to the healthcare facilities involved in COVID-19 response in Ukraine	Good progress

- Early in the pandemic, with significant support from WHO, the numbers of infections and deaths among healthcare workers were limited by the delivery of PPE throughout Ukraine including ECA. WCO Ukraine provided 90 per cent of the COVID-19 designated hospitals in the country with PPE – partly procured from local producers – and has achieved a significant scaling up of the IPC capacity throughout Ukraine.
- Interviewed stakeholders assess the two years since the onset of COVID-19 as revolutionary in terms of infection control. As the pandemic developed, a new focus was placed on creating IPC policies for Ukraine, including how to repurpose hospital wards as well as improve waste management practices and reprocess medical devices. A new order on IPC which became mandatory for all medical institutions with effect from 1 January 2022 is reported to include 95 per cent of the WHO recommendations and regulates not only the implementation of infection control measures but also the system of surveillance for infections.

Progress towards specific objectives of Pillar 7: Case management

1	Support strengthening of hospitals capacities by procurement of essential bio-medical and other equipment.	Good progress
2	Ensure capacity building and improve access to WHO guidelines and evidence on COVID-19 for healthcare workers.	Good progress
3	Support enhancing of clinical management of COVID-19 cases, incl. integration of mental health and psychosocial considerations into clinical case management.	Good progress
4	Clinical protocol is updated regularly with linkage to WHO guidelines	Reasonable progress

- WHO supported the MoH to scale-up oxygen capacity in 255 hospitals with donation and modernisation of equipment in 122 facilities and evaluated PPE produced by Ukrainian manufacturers to confirm that WHO-recognised standards were met. Additionally, critical gaps for the treatment of severe COVID-19 patients with low blood oxygen levels were covered by providing 424 oxygen concentrators and the latest technologies and equipment for COVID-19 treatment at all levels of care, as well as five intensive care units with mechanical ventilators for hospitals in Kharkiv and Mariupol.
- At the request of the Minister of Health, WHO carried out three phases of an all-Ukrainian audit for oxygen supply capabilities across 520 COVID-19 hospitals and shared the results with the MoH, NHSU, and UPHC. For this purpose, in the absence of WHO's specific guidance, the country office converted the existing WHO guidance for oxygen therapy devices into an assessment tool. This assessment not only provided the Minister of Health with a strong baseline to plan procurement but also inspired WHO HQ to design a global assessment tool for oxygen supply.
- 450 hospitals' healthcare workers were trained in a WHO- and MoH-designed curriculum of case management of COVID-19 patients in severe and critical conditions, while 60 hospitals benefited from monitoring and mentoring visits, assistance in developing SOPs, and improving patient journeys. 8,000 clinicians received COVID-19 clinical management seminars from WHO focusing on screening, triage, and oxygen treatment, and 30 trainers drawn from across Ukraine were trained on the clinical management of patients with COVID-19.

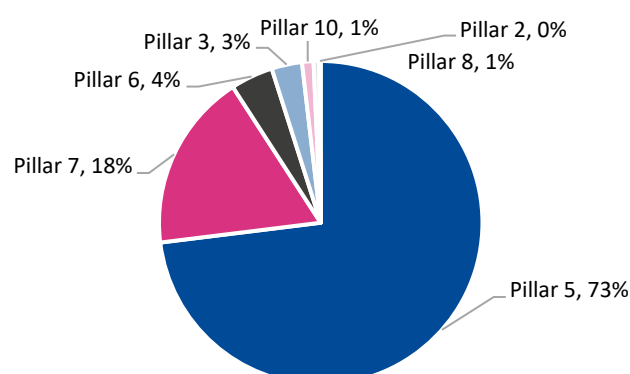
- Respondents also highlighted the challenges faced in progressing towards the objectives of this pillar. One is the multiple amendments in COVID-19 treatment protocols,⁴⁰ which, it is suggested, made it difficult for medical personnel to adapt, while another is the lack of clarity on responsible positions within the MoH. Some other areas of improvement mentioned are the frequency of communication with members of the COVID Protocol Approval Working Group, bringing the Ukrainian COVID-19 protocol up to the WHO recommended standards, and work to prevent the use of antibiotics for COVID-19, and monitoring and evaluation of investigational new therapeutic agents.

Progress towards specific objectives of Pillar 8: Operational support and logistics

1	Support development/upgrade of a mechanism of rapid procurement and supply system at national level	Good progress
2	Support operational assessment of the current storage capacities, system of transportation and distribution.	Good progress
3	Support capacity building on best practices of procurement agencies and supply systems, access to global supply systems, etc.	Reasonable progress

N.B. this pillar is cross-cutting, its results are supportive of progress made in other pillars (Figure 6)

Figure 6 Supply values under the WHO COVID-19 response in Ukraine, by pillar, as of September 2022, Source: OSL Data



- Having said that, it should be noted that one of the WHO's key achievements under this pillar includes delivering over 1.5 million units of PPE, covering the needs of 50 COVID-19 frontline hospitals in all regions of Ukraine for a minimum of one month at full capacity at the beginning of the pandemic, and later supporting the logistics and distribution of an additional 7 million PPE units. WHO also equipped the whole country immunisation programme with PPE and distributed essential supplies (ventilators, oxygen concentrators, pulse oximeters, patient monitors) to the Ukrainian frontline hospitals. This was enabled by developing a comprehensive and integrated supply management system (eSMS) for the country office that helps to better organise the complex procurement processes in emergencies.
- Pillar 8 has implemented tools to assure a high-level quality of service and supply and put in place specific quality control measures starting with the reception of cargo at a warehouse.
- WHO also performed direct deliveries of supplies to health facilities with key areas of support and distribution during 2020-2021 being (a) IPC (total value of inbound goods of US\$3.74 million), (b) clinical management (US\$3.51 million), and (c) laboratory (US\$2.24 million)⁴¹.
- Throughout the COVID-19 response and through targeted investments, WHO has supported the Central Procurement Agency of Ukraine by tackling the weakest part of this institution – quality assessment. With WHO support, a functioning dedicated unit has been established within the Central Procurement Agency of Ukraine, resulting in

⁴⁰ Specifically, fourteen amendments in the order on the organisation of medical care for patients with COVID-19 and eight amendments in the protocol for provision of medical care for the treatment of COVID-19 within seventeen months.

⁴¹ Based on the OSL Dashboard as of 3 November 2021.

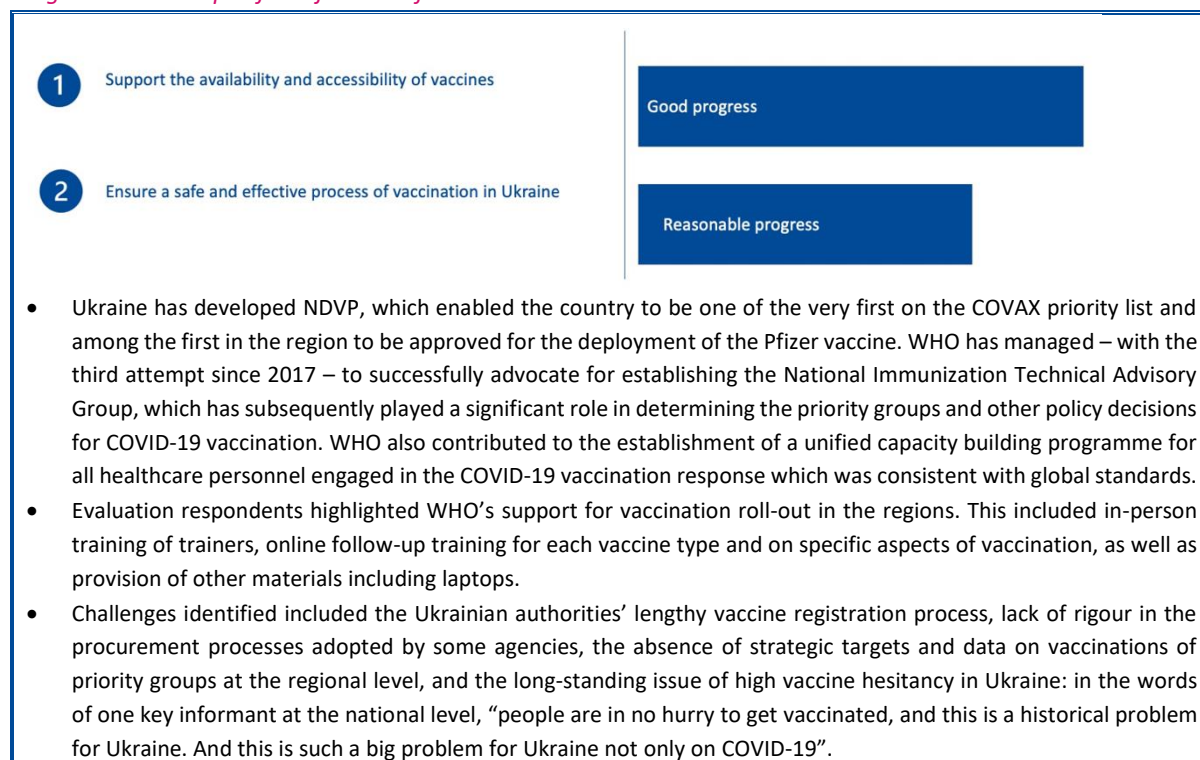
improved COVID-19-related procurement. However, broader improvements in the central procurement system are still to be seen.

Progress towards specific objectives of Pillar 9: Maintaining essential health services and systems, including mental health



⁴² mhGAP-IG 2.0 helps doctors to identify and provide support to people experiencing stress, anxiety, depression, self-harm/suicide, and substance use disorders on a timely basis.

Progress towards specific objectives of Pillar 10: Vaccination



Eff.3 What overall level of **coverage** has been achieved through WHO support to the response? Have there been any differential results in response effectiveness across **various sub-populations**? To what extent has WHO's interventions reached the **most vulnerable groups**? What overall level of coverage has been achieved through WHO support geographically? What – if any – outstanding **coverage gaps** remain?

This section builds on the recognition that WHO – per its mandate and its support agreement with GoU - does not directly work with any particular population group except for healthcare workers, but rather collaborates with the government and other partners in ensuring that the needs of vulnerable groups are addressed.

KIIs and desk study verify that **WHO – in collaboration with other UN agencies – has promoted an improved focus on the needs of vulnerable groups**. In comparison to before the COVID-19 pandemic period, when hardly any vulnerability data were routinely collected, WCO Ukraine has supported the collection and analysis of data concerning the vulnerability and needs of such groups at the national level and in ECA. According to a thematic report by the HRMMU,⁴³ in 2020 the COVID-19 pandemic placed several vulnerable groups at a higher risk,⁴⁴ creating new vulnerabilities (e.g., among frontline health workers) and affecting women disproportionately, including through a rise in domestic violence and a significant increase in unpaid care work. The report also identifies - as a direct or indirect consequence of the COVID-19 pandemic - concerns about acts of violence, incidents of hate speech, and discriminatory acts towards specific groups who might be perceived to be (potentially) infected by the virus (e.g., LGBTI, Roma, homeless persons, and healthcare workers). Together with other UN agencies, the WCO emphasised to GoU the importance of addressing these vulnerabilities, highlighting the needs of particularly vulnerable groups (e.g., residents of long-term facilities, detention centres and prisons) and

⁴³ "The Roadmap (NDVP) to the introduction of a vaccine against the acute respiratory disease COVID-19 caused by the novel coronavirus SARS-CoV-2, and implementation of mass vaccination in response to the COVID-19 pandemic in Ukraine for 2021-2022 (being updated)", APPROVED by order of the Ministry of Health of Ukraine, December 24, 2020, № 3018 (as amended by the order of the Ministry of Health of Ukraine, Version of 08.07.2021. Retrieved from <https://govtribe.com/file/government-file/ndvp-with-ammendments-july-2021-eng-dot-pdf-1>

⁴⁴ There groups are (a) persons in places of detention with a lack of specialised medical care, including sexual and reproductive health and mental health, and delayed transfers of prisoners and detainees to hospitals; (b) women and girls; (c) persons with disabilities, (d) older persons, those living in long-term care facilities; and (e) persons living in homelessness.

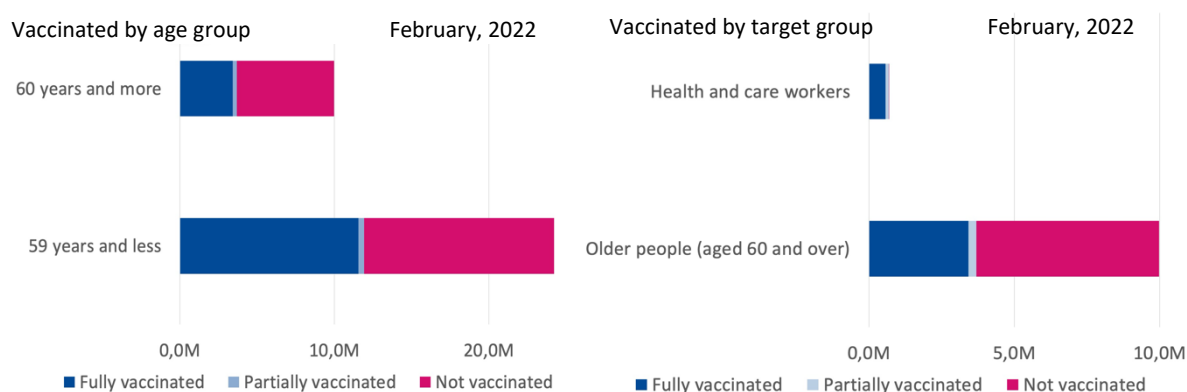
using existing vulnerability assessments to specifically inform the roll-out of vaccinations (Pillar 10) and recommendations to improve case management (Pillar 7) among those groups.

Analysis of key documents indicates that **vaccination efforts in Ukraine have been informed by vulnerability assessment**. As a result of recommendations by WHO SAGE, ETAGE, and NITAG, in February 2021 the MoH approved a list of priority groups with access to vaccinations, including four out of six populations highlighted by the HRMMU report.⁴⁵

Per triangulated findings of KIIs with governmental and WHO stakeholders, to support the implementation of the NDVP, WCO Ukraine staff supported all oblasts in tailoring vaccination services to differing needs, including on both sides of the conflict in ECA. In addition, WHO has implemented innovations to boost vaccine uptake among the elderly (60 years and older). Two initiatives were judged to have been particularly effective: a short advocacy and outreach campaign in two villages of Poltava which reportedly resulted in a 10 per cent increase in vaccine uptake and was subsequently rolled out across the oblast; and a joint effort with the MoH to use KRPOSHTA (national postal service) to boost vaccine uptake among the elderly living in remote settlements with limited access to medical facilities. In addition, WHO procured and donated two buses to Dnipropetrovsk oblast for outreach vaccination services targeting the elderly and people with disabilities in remote settlements.

According to GoU data, these efforts resulted in **reasonable vaccination coverage of vulnerable groups**, including large numbers of people displaced from Crimea and ECA⁴⁶. According to the WHO dashboard summarising officially reported COVID-19 vaccination data (Figure 7), 99 per cent of targeted health workers were vaccinated by February 2022, specifically 0.56 million health workers fully and 0.11 million partially (compared with a target of 0.68 million). In comparison, by February 2022, vaccine uptake among those aged over 60 years old remains low at 37 per cent, with only 3.41 million being fully and 0.27 million - partially vaccinated in comparison to the target of 9.9 million fully/partially vaccinated.

Figure 7 Vaccination data, WHO dashboard⁴⁷



In terms of vaccination coverage of the general population, by January 20, 2022, the uptake with the complete vaccine series is 33.2 per cent, which places Ukraine at the bottom third place among fourteen Central and Eastern European countries⁴⁸.

According to the evaluation findings, other than health workers and elderly people (as above), the existing national vaccination database does not provide disaggregated data on vaccination rates among other, specific

⁴⁵ <https://govtribe.com/file/government-file/ndvp-with-ammendments-july-2021-eng-dot-pdf-1>

⁴⁶ <https://health-security.rnbo.gov.ua/vaccination>

⁴⁷ <https://app.powerbi.com/view?r=eyJrJoiMWNiNzZkNjctZTNiNy00YmMzLTkxZjQzNmJiZDM2MTYxNzE-wliwidCl6ImY2MTBjMGI3LWJkMjQ0NGIzOS04MTBiLTNkYzI4MGFmYjU5MCIslmMiOjh9>

⁴⁸ Ranking based on people fully vaccinated against COVID-19 per 100 of the population in Central and Eastern European countries as of January 20, 2022, <https://www.statista.com/statistics/1242734/cee-covid-19-vaccination-rate/>

vulnerable groups. Limited data from survey respondents suggest that rates might remain low among forcibly displaced people, people living in rural and remote areas and people living in closed facilities. However, this is disputed by evaluation findings from penitentiary facility stakeholders who highlight low vaccination rates in the latter group due to a lack of medical personnel and a lack of trust in medical care providers.

According to the evaluation respondents, **despite progress being achieved to reach vulnerable populations with vaccination efforts, some groups have been left behind** such as people with disabilities, people living in poverty, and homeless people who are – reportedly – not reached by vaccination campaigns. National health authorities add that there are coverage gaps in the vaccination of populations residing in closed facilities and nursing homes. Moreover, respondents emphasise a need for promoting COVID-19 vaccinations among the general public, with an emphasis on addressing the COVID-19-related infodemic.

“We need to work with anti-vaccinators. It’s still unclear how to work with them.”

Key informant, National health authority

According to WHO, another area in which vulnerability assessment related to COVID-19 was essential is safeguarding equity in access to medical care. According to national healthcare agencies, WHO advice on access to healthcare for vulnerable groups and assistance in tracking access barriers among people with chronic diseases, the elderly, medical staff as well as other vulnerable groups was highly appreciated and effective. WHO efforts to improve mental health support during COVID-19 (specifically mental health and psychosocial support for healthcare workers) and maintaining access to HIV/TB services were noted as specific areas of achievement.

Eff.4 How has the WCO's humanitarian response (or support for health sector reform) been affected by the virus?

The health and peace aspects in conflict areas have been important and WHO has been effective in providing technical and neutral mediation services. WHO has launched a peacebuilding project across the whole country, also covering GCA, aimed at generating community-based dialogues, localised conflict analysis, and mediation focusing on health system trust, access and delivery, COVID-19 demystification, and health reforms. With the support of humanitarian actors in the field, WCO helped to conduct several needs assessments in ECA, including Public Health Situation Analysis (January 2021), Aligning Health and Decentralization Reform in Ukraine (2021), and COVID-19 in Donetsk Oblast (GCA): Hospital Readiness and Capacity Assessment (January-March 2021).

According to an analysis of HRPs 2019-2021, **WCO has been able to increase its funding for the humanitarian response as part of the COVID-19 response**. WHO's share of total funding under the humanitarian response plan increased from 3 per cent to 4.6 per cent (or by 42 per cent - from US\$5.5 million to US\$7.8 million - in cash terms) between 2019 and 2021 while 44 per cent of the procurement budget (or US\$8,386,519) for the WHO COVID-19 response was allocated to ECA during March 2020-October 2021.

Key informants confirm that **WCO Ukraine has been able to sustain its operation in the NGCAs**, where only a few agencies are working, i.e., WHO, ICRC, UNHCR, and OCHA. Evaluation interviews confirmed that procurement was based on needs whereby Luhansk was prioritised by the WCO due to the absence of basic infrastructure. In addition, WHO launched a mobile lab in Luhansk NGCA, which was considered by WHO HQ as a potential game-changer in terms of being able to quickly respond to health emergencies.

According to WCO records and KIs, **WCO has enlarged the team and expanded operation in GCAs by opening a field office in Mariupol (Donetsk GCA)**. WHO provided technical assistance and other support to healthcare facilities, other institutions, health professionals and patients in GCA. Inputs included training, webinars, and workshops, and delivered commodities for infection prevention and control, and consumables for laboratories. This expansion has been appreciated by governmental stakeholders and UN partners.

“Thanks to WHO and other partners, there is at least some access to health services for the population in NGCAs.”

Key informant, National health authority

Triangulated findings from governmental and development partners verify **that WCO has been able to continue work on health sector reform**. Specifically, WHO provided technical advice for the revisions to the health budget to finance COVID-19 services, including the development of comprehensive service packages and provider payment methods, while ensuring continued financing of other essential health services. COVID-19 has called into question some aspects of the GoU health reform programme. While current plans envisage the significant delegation of decision-making and increased reliance on the private sector for service delivery, the pandemic has highlighted a possible need for a network of healthcare providers that can be centrally managed in times of crisis. Key governmental informants stated that Ukraine's health reform programme will likely change as a consequence of the COVID-19 response, e.g., recent experience suggests hospital funding should not be based solely on activity since there is a need to fund unused or 'stand-by' capacity to respond to unforeseen events, and there will be a need to include infection control standards in hospital contracts and monitor compliance.

*Eff.5 To what extent has WHO's COVID-19 response in Ukraine produced **unintended outcomes** (positive or negative) and how has it managed these while adapting to the “new reality” of a prolonged response?*

Analysis of WCO Ukraine's internal records shows that, **as a consequence of COVID-19 work, WCO has been able to expand and strengthen internally**. The office grew quickly with staff numbers increasing from 25 to over 100 within just 1.5 years. To onboard new staff, the country office has established its own system of capacity building including (i) a country induction course, (ii) weekly workshops on corporate systems and (iii) regular retreats.

Both WCO Ukraine and its partners confirm that **WCO also increased engagement with external partners**. The Ukraine CO provided support to other WHO country offices; for example, pillar leads trained WHO Central Asia and Caucasus offices in specifications of biosecurity and laboratory equipment as well as mental health practices used in Asian and Latin American countries. Domestically, WCO played a central role as the lead of the health sector working group and in day-to-day coordination with key government stakeholders and implementing partners relevant to the COVID-19 preparedness, response, and recovery. WCO Ukraine also worked to improve accountability and communication with donors and partners. For example, monthly reports on WCO Ukraine's COVID-19 response activities were shared with the diplomatic corps (many of whom are funders), senior GoU leadership and oblast governors.

*Eff.6 To what extent has WHO **monitored its performance in delivering results** and the factors affecting it, learned from this information and knowledge and fed these sources of learning into its ongoing response?*

To monitor its own performance in delivering results, according to document review and interviews, **WCO Ukraine developed and subsequently introduced a systematic monitoring tool for the complete COVID-19 response in early 2021**. This tool - a logframe - provides a consolidated overview of all targets and risks and tracks them against achievements and mitigation. By end of November 2021, the tool had gathered details for fourteen (out of 28) awards and four frameworks (GPW13, SPRP, HRP, and PIP – Pandemic Influenza Preparedness Plan). Since then, the logframe has been used for managing the progress of the response through close monitoring of

gaps and (over-) achievements of targets for deliverables as well as for donor reporting. Notably, the logframe shows a hierarchy between outputs and outcomes. The logframe also does not define targets for outcomes. The evaluation did not identify evidence of internal performance indicators or tools that measure achievement/progress at the outcome and impact levels.

Further, KIIs with WCO Ukraine staff reveal that weekly financial monitoring of the COVID-19 response by IMST, using an in-house developed tool, has been helpful in **monitoring budget utilisation**. The tool is structured per pillar and includes information about committed and actual spending per award and in total. Data are updated by the Programme Support Manager and shared with the Incident Manager and Pillar Leads regularly and have proven useful for tracking implementation rates and deadlines for budget utilisation in line with donor agreements.

WCO internal records and interviews with Pillar Leads show that, at the early stages of the pandemic, the WCO Ukraine team conducted needs and gap assessments using the WHO global or regional guidance. Later on, WCO undertook monitoring visits – including with WHO global or regional guidance – to track the implementation progress of the recommendations provided, the level and appropriateness of procured equipment use as well as the application of acquired knowledge on the COVID-19 response by health workers in their daily work. Frequent visits to the field were made, not only by Kyiv-based pillar leads and their teams but also by the WHE Incident Manager and the WHO Representative who took time to observe and assess ground-level COVID-19 response efforts all over Ukraine, including in ECA. Those visits were viewed very positively.

KIIs with external stakeholders and document review back up the finding that **WHO has been acting on the collected monitoring data**. Building on data about the COVID-19 response in each oblast, WHO provided specific recommendations to COVID-19 designated hospitals, public health centres (PHCs), OLCs as well as relevant government authorities at the regional and national level. Health workers from the COVID-19 designated hospitals, PHCs, and labs underlined the usefulness of the technical advice gained during the monitoring visits of the WHO staff (Pillars 5, 6, and 7).

“WHO has visited some health facilities even 2-3 times. They studied the needs and provided recommendations on case management, oxygen stations, and epidemiological control”

FGDs, COVID-19 Designated Hospital

“WHO has a strong technical team... They helped us understand the gaps of our labs and how to overcome them”

FGD, Laboratories

Once NDVP had been developed, WHO added immunisation efforts to its COVID-19 response performance monitoring areas. Regional authority representatives expressed satisfaction with the quality of the multi-stakeholders monitoring visits on COVID-19 immunisation (Pillar 10). Trained trainers shared their appreciation with the weekly WHO-UPHC joint online coaching on and supervision of COVID-19 vaccinations. Here, again WHO used

“During the monitoring visits, WHO paid specific attention towards the cold chain, monitored the vaccine storage, transportation, and vaccination of in-patients. The monitoring allowed to reveal the problems at the regional level”

Key informant, Regional authority

observations made during monitoring to scale up its support. Based on data collected jointly with the MoH from the regions, WHO defined the key challenge of medical workers in entering individual patient data on COVID-19 vaccinations into different medical information systems (MISs). Consequently, WCO made recommendations for MISs revision and detailed instructions and video tutorials for healthcare personnel involved in data entry.

KIIs with external stakeholders show that, since May 2020, WCO Ukraine has been conducting regular situational analysis for BIs⁴⁹ to inform the COVID-19 response and updates on the epidemiological situation⁵⁰ (Pillar 3), circulated daily, weekly, and bi-weekly among the government, partners, and heads of cooperation. Other key monitoring efforts of WCO Ukraine include (a) the PHSM enforcement monitoring at the regional level during the lockdowns in January and May 2021 with a focus on compliance with safety measures and physical distancing in public places in 40 cities across Ukraine, conducted in collaboration with the Kyiv International Institute of Sociology; (b) bi-weekly review of contact tracing teams' performance in Chernivtsi, Odesa, and Lviv oblasts (Pillar 3); (c) a monitoring and evaluation mission to study a fire incident in February 2021 that claimed the lives of three patients and one doctor (Pillar 7); and (d) continued support of HIV/AIDS service providers (regional AIDS centres/centres for disease control) in monitoring and improving the HIV care among people living with HIV, testing, treatment, and viral load suppression (Pillar 9).

"WHO provided analytical dashboards to enable monitoring of hospital bed occupancy for COVID patients, which was extremely helpful for us"

Key informant, National health authority

Overall, the majority of survey respondents (72 per cent) – including civil society, implementing partners, health authorities, UN organisations, and other partners – appreciated how WHO has monitored its performance in the COVID-19 response. 20 per cent of respondents – among them all surveyed INGOs and UN agencies as well as 10 per cent of WCO Ukraine respondents – believed that the monitoring could have been conducted more often and in more areas. According to WHO, a higher frequency of performance monitoring would have been desired but is tied to the quicker recruitment of staff for the COVID-19 response. It was also mentioned that WCO Ukraine had uninterrupted monitoring resorting to its remote forms in 2020 due to the nationwide lockdowns and restrictions on movement and overcoming challenges such as healthcare workers' access to the internet, usage of the new software (Zoom, Teams), and openness to sharing difficulties online.

4.3 Efficiency, Coordination, Coherence

EQ 4: *How successfully has WHO harnessed the resources at its disposal (including financial, human, physical, intellectual, organisational, and political capital, as well as partnership) to achieve maximum results in the COVID-19 response in Ukraine in the timeliest and most efficient manner possible?*

Key finding 1: To respond to the COVID-19 pandemic in Ukraine and provide support in a timely, well-prioritised manner, WCO Ukraine was quick and effective in mobilising both human resources (increasing from 13 to 74 staff by August 2021) and financial resources (over US\$ 38 million as noted earlier) through efforts of the WHO team at all levels (global, regional, and country).

Key finding 2: WHO achieved cost-effectiveness in procurement by forging long-term agreements with local private companies, employing a two-tier approach (i.e., selective purchase through the global procurement system and locally), and developing and launching an electronic supply management system to optimise the cost-quality ratio of goods purchased for the response.

Key finding 3: Throughout the pandemic, the WHO response in Ukraine has benefited from good working relationships across all levels of WHO.

Key finding 4: WCO Ukraine used its political capital by coordinating with government and development partners including the UN. Some partners would like to see more collaboration to advance work on vaccine uptake.

Key finding 5: WHO's comparative advantages are high-level health sector technical expertise and its role as a trusted broker, while its limited visibility at the sub-national level in Ukraine is considered a weakness.

⁴⁹ BIs were conducted by Pillar 2 in 2020 and Pillar 3 in 2021.

⁵⁰ Overall, WCO Ukraine has been circulating six different types of situation analysis updates: (i) daily epi situation; (ii) daily hospital dashboard; (iii) weekly epi dashboard; (iv) weekly situation updates; (v) Bi-weekly situation update; and (vi) other ad-hoc epi analysis.

Coh.1 How rapidly was WHO able to mobilise, scale up, and provide support in a timely, well-prioritised manner?

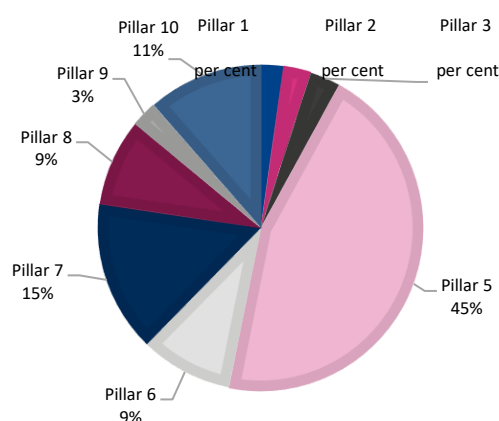
Most stakeholders appreciate how well WHO mobilised, scaled up, and provided support in a timely, well-prioritised manner. Several UN partners and INGOs praised WHO for mobilising resources, placing COVID-19 high on the agenda in a humanitarian context and bringing technical expertise to support work in NGCAs. COVID-19 designated hospital managers and healthcare workers mentioned that WHO provided timely support particularly at the beginning of the pandemic when there were no centralised orders and other support from the MoH.

In terms of improvement areas, several respondents highlighted less agility in responding to questions from media (e.g., on emerging virus variants) while WHO staff themselves suggested there would have been scope for improvements in procurement and supply of consumables and medical equipment to cover the demands of oblasts.

As previously mentioned, the quick mobilisation of financial and human resources was aided by WCO Ukraine setting up the COVID-19 IMST with the support of WHO EURO's COVID-19 IMST.⁵¹ According to WCO Ukraine's leadership, working in such a multidisciplinary team – put in place to draw on complementary expertise to respond to the threat posed by the new COVID-19 disease – proved more efficient than regular emergency teams of the UN system. WCO organised IMST around CPRP pillars and added one more, on mental health to reflect the impacts of the conflict in eastern Ukraine. Further, WCO repurposed human resources of the existing emergency programme to staff the COVID-19 response. According to WCO respondents, having an emergency programme prior to COVID-19 enabled them – through reprofiling programme staff and building on their emergency mindset – to be quick/timely in their COVID-19 response.

In parallel and due to efforts in mobilising human resources, WCO rapidly generated financial support for the COVID-19 response, starting by accessing flexible resources from the Global COVID-19 Solidarity Response Fund as early as the first quarter of 2020. WHO records show that, by November 2021, WCO had secured funding from 28 grants and awards, with the largest share (46 per cent) of projects lasting up to a year (8-12 months long), followed by 29 per cent short-term projects (1-6 months), 22 per cent medium-term projects (14-24 months) and 4 per cent long-term projects (36 months). According to WCO financial records, by November 2021 three out of ten pillars drew the largest allocations from grants and awards (72 per cent of total funding), namely Pillar 5 (45 per cent of total funding), Pillar 7 (15 per cent), and Pillar 10 (11 per cent). The smallest budget was allocated for Pillar 1 (2 per cent of the total funding), while no budget was allocated for Pillar 4 (Figure 8).

Figure 8 Budget distribution for COVID-19 response in Ukraine per pillar, source: WCO financial records



⁵¹ The IMST at the WHO EURO level was put in place as early as 23rd January 2020. <https://reliefweb.int/report/world/two-years-covid-19-what-it-takes-run-emergency-response-across-53-countries>

WCO human resources were scaled up to keep pace with the emerging needs of the COVID-19 response, supported by the increasing availability of funds. In the first quarter of 2020, when the Country Office received a sizeable grant from the mission of the Directorate-General for Neighbourhood and Enlargement Negotiations (DG NEAR), staff allocations were 1 per cent across pillars, resulting in a need to rely on WHO EURO staff/consultants. However, funding from diverse sources and with varying durations allowed the WCO to cover the main staffing needs to support Ukraine's COVID-19 response as early as the third and fourth quarters of 2020. From January 2020 to August 2021, IMST staffing increased by a factor of six, from 13 to 74, while the number of those staff and consultants based in the field increased from 6 to 20 people (Figure 9).

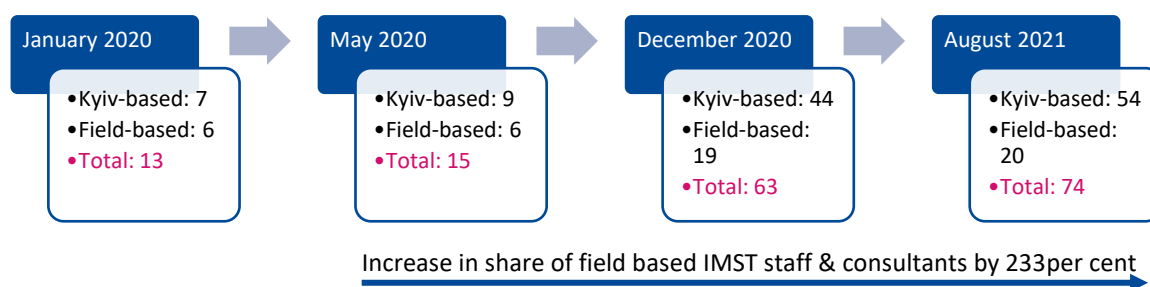
"Although preparedness to address COVID-19 pandemic was not visible in the very beginning, in several months WHO could build a strong excellent team to offer it scaled-up support"

"It is impressive to see how WCO Ukraine grew from a small office with vertical programmes in the beginning of 2020 to – after 1.5 years – an enormous machine functioning well."

Key informants, UN agencies

Scaling up human resources included an expansion of WHO's geographical presence. Prior to the pandemic, there was only WHO field presence in ECA. Since the start of the pandemic, five mediators and five field consultants under Pillars 1 and 3 have been hired, based in seven oblasts of western, eastern, and southern Ukraine (Figure 9).

Figure 9 Evolution of the WCHO Ukraine WHE/IMST from January 2020–August 2021⁵², source: WHE/IMST Organigrams



According to WHO stakeholders, mobilising staff was not without certain issues, mainly related to lengthy recruitment procedures. WCO mobilised its workforce for the response by following two procedures: (i) emergency deployment and (ii) general recruitment. While the former was generally problem-free, the latter encountered considerable delays, reportedly due to the requirement to rely on WHO HQ and regional offices (including the EURO dedicated Emergency Human Resource Officer). Although the general recruitment process was effective in addressing challenges in recruitment it also proved time-consuming with competitive recruitment taking between 4-15 months.

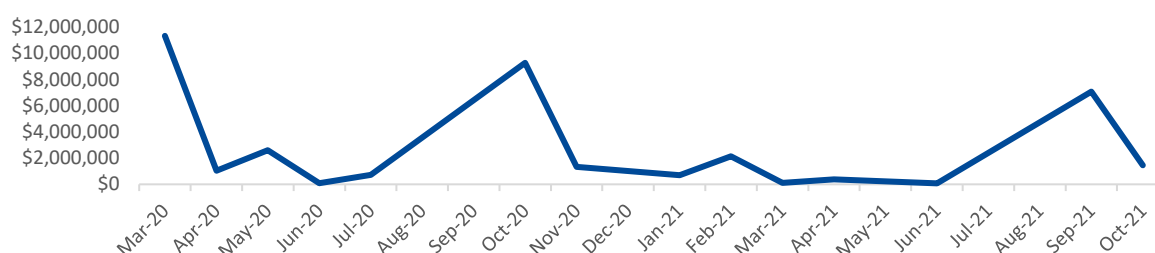
Coh.2 To what extent have **key financing vehicles incentivised** a One WHO and One UN approach as intended?

Evaluation findings confirm that strong WCO leadership and proactive resource mobilisation from combined efforts of WHO HQ, WHO EURO, and WCO Ukraine (One WHO) resulted in substantial financial support to the response. External stakeholders testify that WHO has been proactive with donors, approaching them and preparing proposals to access necessary funds to support its COVID-19 response. WCO mobilised resources both independently and using the "One WHO" and "One UN" approaches. The latter was used to raise funds through the United Nations Central Emergency Response Fund (CERF). According to WHO respondents, "One WHO" resource mobilisation resulted in 60 per cent of funding for the COVID-19 response being fundraised by the WCO locally and the other 40 per cent with the support from WHO EURO and WHO HQ. As a result of resource mobilisation efforts by the Country Office team, the WCO in Ukraine has the largest resource package for the COVID-19 response in the WHO EURO region.

⁵² The numbers do not include the Operational Support Unit staff

Per WHO financial records, **within the first three months after the start of the pandemic, WHO was able to mobilise about US\$15 million** – 39 per cent of the total funding – from donors such as the EU, CERF, USAID, Finland, Germany, and the UK. In October–November 2020 a further US\$10.5m was mobilised mainly from the World Bank and COVID Pool Fund of WHO HQ. Further, in September–October 2021, the third batch of awards – 8.5m, or 22 per cent of the total funding – was secured from USAID, the UN, the UK, and Germany. As of November 2021, WHO had mobilised US\$38,327,100 through 28 awards for the COVID-19 response in Ukraine (Figure 10).

Figure 10 Funding mobilised for the WHO COVID-19 response in Ukraine during March 2020–November 2021, Source: WCO Financial Records



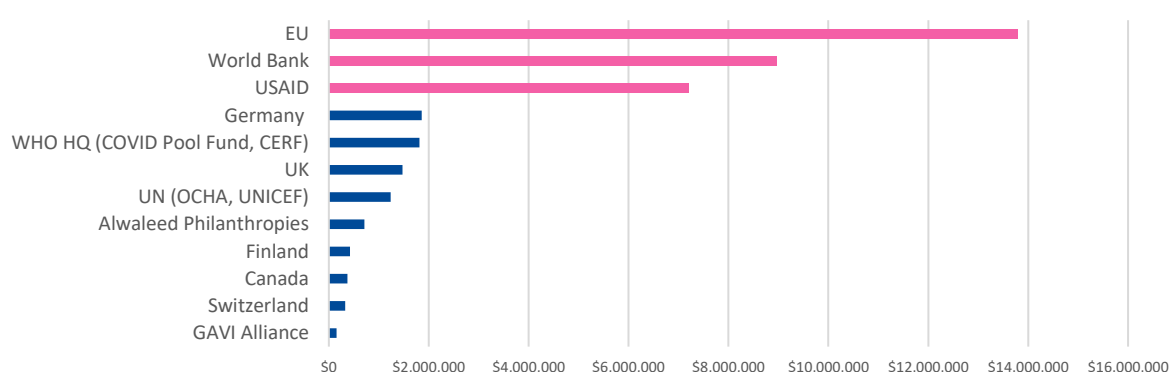
As per the financial reports, 63 per cent of the overall funding (US\$24,249,963) came from three large awards with US\$5m to US\$10m budgets: (1) DG NEAR, EU COVID-19 Solidarity Programme for the Eastern Partnership – Health (US\$9,990,609); (2) World Bank - Procurement of medical supplies to combat the spread of COVID19 (US\$8,961,156); and (3) USAID - Saving Lives and Interrupting Chains of Transmission: WHO's Response to COVID19 in Eastern Ukraine (US\$5,298,198). The balance came from 25 smaller awards (Figure 11).

Figure 11 Number of COVID-19 response awards raised by WHO during March 2020–November 2021, grouped by size, Source: Financial Records



Overall, twelve donors supported the WHO COVID-19 response in Ukraine (Figure 12). The three largest donors were the EU, the World Bank and USAID, providing 78 per cent of the total funding between March 2020–November 2021. 69 per cent (or US\$26,409,960) of the funding was mobilised through thirteen awards during the first year of the pandemic, while the other 31 per cent (or US\$11,917,140) was secured through fifteen awards during the second year of the pandemic.

Figure 12 Donors of the WHO COVID-19 response in Ukraine during March 2020–November 2021, Source: WCO Financial Records



Coh.3 Given the inputs invested in preparedness and response efforts and the results achieved to date, how cost-effective has WHO's COVID-19 work in Ukraine been over time?

WCO Ukraine has been successful in achieving target spending rates with an overall absorption rate of 98 per cent (to 19th December 2021). Budget utilisation under Pillars 1, 5, 7, and 8 was 100 per cent while Pillars 10 (94 per cent) and Pillar 9 (96 per cent) were slightly underspent due to slower than expected vaccination and routine immunisation rollout. WCO respondents added that it was easier to manage the disbursement of funds that are derived locally or directly- than those provided through WHO EURO. The latter are neither fully allocated nor is their management delegated to the Country Office. Different authorisation steps needed for spending or budget revision also lengthen the process of disbursing funds acquired through the Regional Office.

To gain time, WHO has been pre-financing project/award activities in order to progress support for life-saving activities while administrative matters, including on the donor's side, were settled. Donors were generally appreciative of that practice.

"Bureaucracy in WHO normally is unbelievable heavy, but this time – perhaps due to COVID-19 – the Organisation was efficient in terms of quickly disbursing funds."

Key informant, UN agency

Further analysis of financial records shows that procurement of consumables and other goods accounted for almost half (US\$ 18.9 m) of the COVID-19 response budget and a number of measures were adopted to ensure it was cost-effective.

Initially, the global WHO procurement mechanism was adopted in order to ensure quality assurance of consumables and other goods for the response. However, delays arose, reportedly due to the WHO Global Service Centre using protocols that were unknown to the WCO and did not enable local monitoring of procurement status. As a result, the lab equipment and trauma kit for the NGCAs arrived late. Also, the minibus ordered in September 2021 to manage potential evacuations in case of need which was in stock at the vendor's site, has not been shipped as of April 2022. To address this, WCO Ukraine applied a two-tier approach for procurement (i.e., PPE and oxygen were purchased through the global procurement system, while the consumables and goods for laboratories were purchased locally), prioritising local procurement. Hence, as of September 2021, three-quarters of procurement (76 per cent) by value has been local. By the end of 2021, the quality assurance of oxygen biomedical items was completed, and local procurement could be done on these as well.

Other measures adopted to enhance the cost-effectiveness of procurement included: (i) Support from Operation Support and Logistics (OSL) staff members at WHO HQ to set up a strong local OSL team with national rather than international experts leading processes; (ii) adoption of long-term agreements (LTA) for services such as warehousing and distribution; (iii) integration of related roles such as procurement, finance management and distribution; and (iv) an integrated supply management system for complex procurement in emergencies. The latter led to cost-quality ratio of goods purchased for the response as well as improved lead time for delivery, preventing challenges of centrally led procurement mechanisms.

The Country Office also demonstrated a strong focus on cost-effectiveness when establishing the mobile lab in Luhansk NGCA by using WHO staff to design the lab, purchasing the equipment locally, and reducing maintenance costs by hiring a local engineer.

Coh.4 How well has the Organisation worked as *One WHO* to harness its collective financial, human, physical, intellectual, organisational, and political capital to achieve results in an efficient, linked-up manner across all three levels of the Organisation?

WHO internal stakeholders testify that **cooperation within the WCO is well established and based on linking work in CPRP pillars**. The evaluation found a well-established collaboration between IMST and the Health System Teams as well as among various pillar teams. Pillars 2 (communication) and Pillar 8 (OSL) are cross-cutting and provide support to other pillars. Pillar 5 (labs) cooperates with Pillar 3 (surveillance) as they rely on projections of the anticipated number of COVID-19 cases. Pillar 5 also collaborates with the Health System Team on pandemic influenza preparedness. Pillars 6 (IPC) and Pillar 7 (case management) exchange information from technical visits and training. Pillars 6 (IPC) and Pillar 3 (surveillance) collaborate in research on infection control in health facilities, including COVID-19 incidence among health workers. Nonetheless, some WCO staff highlight that even more interlinkages between pillars are required, as well as more systematic rather than sporadic collaboration.

Further, KIIs with WHO stakeholders reveal that, **throughout the pandemic, the WHO response in Ukraine has benefited from good working relationships across all levels of WHO**. The Ukraine Country Office is very well integrated with HQ and the European Regional Office. WHO EURO and WHO HQ colleagues are satisfied with the responsiveness to requests for information from WCO Ukraine, as well as updates and support from the Country Office's field teams. In turn, from the start of the pandemic, WHO senior management from WHO EURO and HQ provided ongoing support to the Country Office senior management team and played an important role in facilitating the dialogue with Ukrainian national authorities and strengthening the health system. The Regional Director visited Ukraine twice from March 2020 to December 2021 and had several calls with the Minister of Health. The WHO Director-General and the COVID-19 Technical Lead participated virtually in the All-Ukrainian Forum on COVID-19 in February 2021.⁵³ As a result of these interactions, Ukraine was prioritised for vaccines among other countries in the European region, Pillar 10 (vaccination) was reinforced with additional staff and Pillar 9 launched a special mental health programme in penitentiaries.

WCO has closely engaged with the EURO Resource Mobilisation Unit, which resulted in donor funding in the first quarter of 2020. When the DG NEAR mission started exploring options on how to support the COVID-19 response at the beginning of the pandemic, they chose to partner with WHO EURO on a proposed project for six countries, from which approximately 40 per cent was allocated to Ukraine.

At the operational level, WCO Pillar Leads and Technical Specialists at WHO EURO and HQ remained in constant contact. One HQ staff member from the OSL Operations Group was based in Ukraine for a considerable time to establish the OSL Team for the COVID-19 response. The Country Office receives a weekly epidemiological update on the global IHR situation, which was highlighted as especially helpful for media briefings, similar to the 'Science in 5'⁵⁴ videos from HQ, which WCO continuously translated and disseminated to national partners. Areas mentioned for improvement were the consultation of national staff in preparation of COVID-19 guidelines, and procurement through the WHO Global Service Centre, as mentioned above.

Coh.5 How effectively has WHO partnered with other entities at the global, regional, and country level to achieve results in the most relevant, effective, and efficient manner possible?

According to KIIs, WCO has used its political capital by coordinating topic-specific task forces and regular platforms with the government and partners. From the beginning of the pandemic, WCO played an active role in coordination with the health sector and beyond. Coordination platforms include a working group on COVID-19 procurement and a task force on vaccine-preventable diseases and immunisation. External stakeholders indicate

⁵³ This forum took place with the participation of top officials of Ukraine, the European Union, and international organisations. Dr Tedros Adhanom Ghebreyesus, Director-General of the WHO together with the President of Ukraine Volodymyr Zelenskyy, and Ursula von der Leyen, President of the European Commission conducted the opening session of the high-level event. Maria Van Kerkhove, COVID-19 Technical Lead at the WHO, and Jarno Habicht, Representative of the WHO and Head of the WHO Office in Ukraine have participated in the discussions.

⁵⁴ Who.int. n.d. COVID-19: Science in 5. [online] Available at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/media-resources/science-in-5> [Accessed 3 April 2022].

that the WCO has a very skilled and enthusiastic team that cooperates masterfully with other partners. The WHO representative in Ukraine has established close coordination with all relevant actors on the national side, in particular the MoH, the Ukrainian Public Health Centre, the Vice Prime Minister's Office, the Prime Minister's Office, the Ministry of Foreign Affairs, the President's Office, and the Security Council. This coordination evolved along with the pandemic. The initial focus was on getting PPE to the country and buying oxygen concentrators. By mid-2020 the focus had shifted to systems and supplies for hospitals, and later it centred on access to vaccines and vaccination services. WCO Ukraine has also been able to share information and experience from other countries with GoU counterparts and has contributed with the knowledge to other WHO Country Offices.

The evaluation found positive perceptions of **WHO's working relationship with the health entities in NGCA (Donetska and Luhanska oblasts)**. During interviews, it was highlighted that since the pandemic started the WCO has strengthened health cluster work in ECAs. A few respondents from other regions mentioned that coordination with the regional health authorities could be improved in terms of – for example – vaccination campaigns with local NGOs.

The majority of development partners consider the collaboration with WCO to be effective.

Civil society, implementing partners, UN organisations, and INGOs appreciate the cooperation mechanisms at the inter-agency level; for example, the health cluster, and heads of cooperation meetings. WHO heads the health cluster and has performed well, especially in terms of delivering data from NGCAs for the needs assessment part of HRP, even though WHO does not share the work undertaken in NGCAs with other members of the health cluster for confidentiality reasons. A minority of INGO and UN organisations believe that coordination within the health cluster could be improved as WHO reports post-factum and does not share plans in advance, and there is criticism about information sharing on a joint UNICEF-WHO assessment on perceptions around vaccinations. The multisectoral biosafety working group and the emergency operation centre are considered by WCO partners to be less effective as national cooperation mechanisms. External stakeholders mention that participation in the working group was difficult due to ad-hoc scheduling and there has been a perceived lack of outputs, e.g., guidance is yet to be produced.

“WHO has done a good job at the beginning of the pandemic, especially with briefings and updating the international community on COVID-related matters.”

Key informant, Donor

Most respondents – including UN partners and WHO staff – consider the **UN system collaboration to be effective**. Noteworthy aspects of this collaboration include: (a) at the strategic level, WHO representatives (WRs) holding regular bilateral meetings with heads of other UN agencies to coordinate the overall COVID-19 response and humanitarian response; (b) the WHO lead organising solution-oriented discussions on operational issues, e.g., clearance of humanitarian cargo; and (c) the Health Cluster Coordinator coordinating UN agencies to exchange information on their efforts in ECA. There are mixed views among WCO Ukraine and UN partners about the usefulness and effectiveness of the UN Procurement Working Group, a temporary group active during the first months of the pandemic. Some UN agencies also would like to see more collaboration between WHO and UN/development organisations as well as CSOs specialising in social change to address low vaccine uptake in the country.

The evaluation found that **WHO cooperation with the private sector is limited due to internal rules**. In line with the WHO FENSA guidelines,⁵⁵ WHO does not routinely work directly with the private sector, unlike other UN agencies such as UNICEF and UNDP. During the COVID-19 response, the main area of cooperation with the private sector was the procurement of goods and services on global or local markets. However, in the evaluation interviews, it was underlined that FENSA does not pay sufficient attention to the issue of triangular partnerships, which in some cases need to be established among the national health authorities, WHO and the private sector to resolve some issues, e.g., getting the products (vaccines or medicine) registered in the national system.

⁵⁵ 2018. *Guide for Staff on Engagement with Non-State Actors: Framework of Engagement with Non-State Actors*. FENSA, WHO.

Coh.6 What have been the *comparative advantages and weaknesses of WHO* and other key response partners in preparedness, response, and coordination?

Survey respondents consider **the health sector technical expertise and knowledge to be the comparative advantage of WHO at all levels**. Indeed, as previously stated, WCO mobilised relevant and highly professional international and national resources, an achievement recognised by external stakeholders. According to them, WCO also built upon the reputation of the organisation in the international arena and raised the profile of WHO in Ukraine. This included providing well-presented data on infection rates and hospitalisations in regions, sharing protocols, materials, and providing appropriate online information and training opportunities related to COVID-19 risk management.

“WHO's strengths are, of course, its knowledge and experience. No one has the same knowledge and experience as the WHO, especially the experience of different countries.”

Key informant, Regional health authority

WCO's comparative advantage, per KIIs and survey respondents, include access to international technical expertise and normative guidance, UN and global support networks and the non-governmental sector.

Another comparative advantage highlighted by evaluation informants is that **WHO is a trusted broker between the government and other stakeholders in health**. They recognised that, during the COVID-19 pandemic response, WHO acted as a broker between government and development partners globally and nationally. Further, external stakeholders perceived that WCO capitalised on that fact to engage and lead multiple coordination platforms that helped to mobilise efforts and resources quickly. More specifically, the WCO leadership was proactive in establishing coordination platforms, i.e., opportunities for the government and donors to communicate with each other in a structured way on health issues as well as to coordinate cross-sectoral decision-making, convene networks nationally/internationally, monitor activities of national and international partners on the COVID-19 response and channel efforts and funds to needs that have not been covered by other partners. Both internal and external stakeholders pointed out that the close relationship between WCO and the MoH helped with advocacy, strategic planning as well as the implementation of the national response.

Consolidated evaluation findings based on KIIs with national and regional state authorities, an INGO and a UN agency also revealed weaknesses of WHO which evolve around the limited visibility at the sub-national level in Ukraine. This deficient visibility of WHO support at the sub-national – specifically regional – level emerged from the evaluation as a significant issue and potential improvement opportunity. The establishment of WHO field offices throughout the country to assist and help with the control of polio, measles, etc was suggested as a possible response.

4.4 Explanatory factors

EQ 5: What have been the main *internal and external factors* influencing WHO's ability to respond in the most relevant, effective, efficient, and equitable manner possible?

Key finding 1: The major internal factors that supported the response include the reputation of WHO, strong leadership within WCO Ukraine, the increased availability of experienced national staff, the effective mobilisation of human and financial resources by different levels of WHO, staff management practices and the clear delineation of roles and responsibilities within WCO Ukraine. Inhibiting internal factors included delays caused by centralised WHO processes of the Global Service Center in Kuala Lumpur for the recruitment of human resources and lengthy processes for the procurement and shipment of goods.

Key finding 2: External factors that supported the WHO response included having a strong national counterpart moving to a high leadership position in-country. External inhibiting factors include recurrent changes in

national counterpart agencies, disruptions caused by ongoing reforms, vaccine hesitancy and global shortages and challenges to supply chains.

Key finding 3: WCO Ukraine as a whole and the IMST team (pillars 3, 5, 6, 7, 8 and 10) have been monitoring and adjusting their performance in an agile manner to adapt to emerging needs.

*Expl.1 What have been the main **internal factors** enabling and inhibiting WHO's ability to respond in the most relevant manner possible?*

According to triangulated evaluation findings from KIIs and survey responses, the major internal factors that supported the response include the reputation of WHO, strong leadership within WCO Ukraine, the increased availability of experienced national staff, the effective mobilisation of human and financial resources by different levels of WHO, staff management practices and the clear delineation of roles and responsibilities within the WCO. A highlighted inhibiting internal factor is the lengthy process when implementing all WHO Emergency SOP (ERP) provisions, particularly related to staff recruitment and the procurement of goods. These internal factors are further explained below.

WHO's reputation is widely perceived to be a key internal factor aiding the ability to respond in the most relevant manner possible. Respondents testify that the reputation of WHO in Ukraine concerns not only technical knowledge and expertise in health emergencies but also WHO's fiscal transparency, as demonstrated by the absence of breaches and rigorous internal audit and oversight mechanisms.⁵⁶ This reputation has been especially important in circumstances where standards were relaxed and the mobilisation of large funds was rapid given the need for a quick and nimble response to the COVID-19 pandemic, during which the risk of corruption became more apparent.

"People in Ukraine trust WHO more than they trust the government because it is seen as less vulnerable to corruption and able to offer reassurance that advice is consistent with international best practice"

Key informant, leadership of a public office

"WHO has a focal point in each oblast in Ukraine. Keeping a footprint everywhere is critical to, among others, gathering evidence. When we submit solid evidence to the government, this triggers change"

Key informant, UN agency

"The WHO coordinator helped us a lot in the relationship with medical institutions. This is what the WHO coordination should be like. Even when the WHO could not help us, they always found a solution and redirect us to other UN organizations. And wherever we went, communication remained excellent."

Key informant, NGO working in ECA

Per survey responses, building on the reputation of the Organisation and fostering good collaboration with its key national counterpart – the Ministry of Health – is the second internal factor enabling WHO to respond in the most relevant manner. Here, the **strong leadership of the WHO Representative** to proactively initiate and lead multiple coordination platforms together with the WHO Emergency Programme Lead and Health Cluster Coordinator is highlighted. More about coordination can be found in section 4.2 and Annex 5 on Pillar 1. In addition, external stakeholders have highlighted the qualifications and important roles played by many key staff members at WCO.

⁵⁶ WHO is overseen by the Office of Internal Oversight Services (IOS), which inspects, monitors, and evaluates WHO's internal control, financial management, and is also responsible for addressing any alleged breaches. The IAO produces an annual report that is submitted to the World Health Assembly (WHA). The report includes summaries of investigations into allegations of misconduct at WHO. In addition, the Panel of External Auditor also monitors WHO's operations in terms of its financial risk management and the efficacy of the Organisation's internal control system. Kohler, J.C., Bowra, A. *Exploring anti-corruption, transparency, and accountability in the World Health Organization, the United Nations Development Programme, the World Bank Group, and the Global Fund to Fight AIDS, Tuberculosis and Malaria*. Global Health 16, 101 (2020). <https://doi.org/10.1186/s12992-020-00629-5>

A third internal enabling factor to note, according to survey responses, is the collaboration between WHO HQ, WHO EURO and WCO Ukraine to mobilise substantial financial and human resources. The former is elaborated on in section 4.3 (efficiency, coordination, coherence). As for the mobilisation of human resources, WHO sources show that it has begun early in the second quarter of 2020 when WHO deployed clinical support (3rd-5th March 2020) and laboratory support missions (9th-13th March 2020)⁵⁷ to Ukraine and the WCO office started repurposing its staff and contracting national experts. This soon led to increased availability of experienced national staff who could move quickly to initiate the response. The WHO implementation team has subsequently grown gradually in terms of numbers and skills, with many WHO staff members being partly or fully repurposed to the COVID-19 response. Evaluation respondents have strongly appreciated the **timely mobilisation of the relevant, highly-professional international and national human resources** and staff present in key places, especially ECA.

A final noteworthy factor that enabled WHO to respond in the most relevant manner possible in Ukraine, per KIIs with WCO stakeholders and development partners, was **organising the work in pillars with a clear delineation of roles and responsibilities**. One aspect of this that was strongly appreciated by external stakeholders is the distinction between the WCO's overall responsibility for the COVID-19 response and the humanitarian response. Another aspect – according to Country Office leadership – is the work in pillar teams and the significant effort devoted to stimulating teamwork while working remotely. This included organising monthly events, bringing staff together for organisation-wide retreats and robust internal monitoring, which have paid off in terms of maintaining the energy to proceed. The latter point on internal monitoring is elaborated on in the final part of this section (answer to EQ Exp.3)

Together with the factors enabling their effective response, WCO Ukraine also highlighted an internal factor that inhibited the efficiency of their work, concerning the **procedure for recruiting staff through centralised WHO processes** of the Global Service Center in Kuala Lumpur. Among the two forms of the general recruitment procedure – direct appointment (i.e., a temporary – up to 6 months – contract without an option of reappointment) or competitive recruitment (i.e., longer-term contact) – WCO Ukraine has been favouring the latter. Within the competitive recruitment procedure, the Country Office could opt for (i) a temporary assignment – a consulting contract or (ii) a fixed-term – staff contract. In practice, following the latter offered more in terms of commitments as it included entitlement to holidays, vacations, and sick leave, but could only be advertised if three conditions were met: (i) secured funding for two years in place, (ii) programme support costs of 13 per cent being budgeted, and (iii) suitable internal candidates being available. In the absence of these conditions – which was typically the case – the Country Office resorted to competitive recruitment with temporary assignment contracts. It took fifteen months to recruit the Administrative Officer for IMST and his duties had to be performed by the WHO Representative for overall office and by WHE Lead for Emergency Operations during the most acute phase of the crisis (March-December 2020). Given the scale of the COVID-19 response authorization for recruitment of an Emergency Operations Officer was provided and this additional capacity was welcomed by WCO. The recruitment of the Pillar 7 (case management) Lead took seven months. During May-December 2020, this pillar was led by the Incident Manager jointly with the WHO Representative with the advice from the Clinical Management Lead of the WHO Regional Office, which was quite challenging. Recruitment of the two staff members for the Pillar 10 (vaccination) took nine and ten months, which delayed the comprehensive monitoring of the coverage of COVID-19 vaccination until September 2021.

“Approval is just a click of the button in the system, but it takes two weeks”

Key informant, WHO

Additionally, according to WCO Ukraine stakeholders, certain key performance indicators of the WHO Global Service Centre proved impractical in emergency settings, such as taking nine working days to approve contracts of the returning staff members.

⁵⁷ <https://apps.who.int/iris/bitstream/handle/10665/334205/70id07e-COVID19-Timeline-200749.pdf?sequence=1&isAllowed=y>

*Expl.2 What have been the main **external factors** enabling and inhibiting influencing WHO's ability to respond in the most effective manner possible?*

A country-specific external factor enabling WHO to effectively respond to the COVID-19 pandemic was having a strong national counterpart moving to a high leadership position in-country while inhibiting factors include recurrent changes in national counterpart agencies, disruptions caused by ongoing reforms, and vaccine hesitancy. Global shortages and challenges to supply chains are the key external factor that has inhibited WHO from responding most effectively. These factors are further explained below.

According to survey respondents and KIIs, a key positive, country-specific external factor enabling WHO to respond was WCO Ukraine's significant effort in cultivating **good working relationships with the MoH and other public health national counterparts**. Several key informants stressed that given the political landscape and the frequent changes in high leadership positions within the healthcare system, having such collegial collaboration at the start of COVID-19 with an experienced and reputable State Sanitary Doctor of Ukraine

paid off when Victor Liashko – who served in this position from March 2020 – was further appointed as the Minister of Health by the Verkhovna Rada (the Ukrainian parliament) in May 2021. It might have aided WCO Ukraine to save time in getting on the same page as the highest healthcare public authority in the country in responding to the COVID-19 pandemic.

"A fortuitous development was to have a strategic connection with the chief medical doctor who became minister of health. It could be a lesson to cultivate such strategic relationships."

Key respondent, UN agency

Both internal and external stakeholders defined other external country-specific factors to be more inhibiting to the effective response. One such frequently mentioned factor was the **recurrent changes in the senior leadership of key national counterpart agencies**. Several UN organisations highlighted challenges that had arisen as a result of multiple changes to political leadership in the health system throughout the pandemic. Nevertheless, interviewed stakeholders noted how WCO Ukraine has been adept at updating newcomers to the high political positions in public offices and working with them as well as maintaining (and sharing) up-to-date knowledge of any changes in the roles and functioning of different healthcare authorities in Ukraine.

Changes in public health authorities were not only at the level of political leadership. Specifically, the smooth working processes of WHO with their Ukrainian counterparts were disrupted when the GoU moved to a massive merit-based assessment process, after employing civil servants on a contract basis since the summer of 2020. By December 2021, all civil servants including the staff of MoH faced a choice to pass a full competition-based recruitment process with five stages of testing or otherwise be fired. It should be repeated here that the COVID-19 response has been taking place in the context of Ukraine being halfway through its reform efforts as well as a six-year ongoing conflict in the East. While there are more extensive studies into the state of the reform and humanitarian situation in Ukraine, key aspects that the evaluation respondents found most inhibiting to WHO's work are indeed disruptions to administrative reform processes and the unclarity of central and local government responsibility over the financing and delivery of public health services (encompassing disease prevention, health promotion and health protection). Again, as development partners and governmental stakeholders testify, WCO Ukraine has found a way to turn the challenge of working within a landscape of "moving pieces" into an opportunity to guide and strengthen the capacities of different departments of MoH.

A further critical external factor – similar to many other countries – that influenced the effectiveness of the COVID-19 response has been the extensive **vaccine hesitancy**. Ukraine currently has the seventh-lowest rate of vaccine uptake in Europe, with 36 per cent uptake of at least one dose and 34 per cent uptake of a complete

vaccine series.⁵⁸ Based on the WCO/WHO EURO's survey of behavioural insights into COVID-19 in Ukraine there was no increase in vaccine acceptance among females, and reduced acceptance among people aged 18–50 together with those from the South, Kyiv, Centre, and Northern regions between May 2020 and March 2021. At the same time, the mortality from infection is unacceptably high in Ukraine. Different studies reveal that this situation is unlikely to improve – in August 2021, pollsters from the Democratic Initiatives Foundation⁵⁹ recorded that over 56 per cent of the adult population of the country are not planning to be vaccinated in the near future. Another poll⁶⁰ shows that 43 per cent are opposed to COVID-19 vaccinations. Among the respondents, many report distrust in the public health care system.

A key international external factor highlighted by WHO itself – especially when assisting the GoU in COVID-19-related procurement – has been the global shortage of PPE, PCR tests and other lab and ICU medical equipment. Despite this, with strong global supply chain mechanisms, WHO has delivered most of the large-scale procurements of these goods ahead of schedule. Other major delays registered with the essential supplies procurement global platform were related to an increase in prices of the order and unspecified delivery costs. WHO mitigated this by involving the WHO HQ supply officer, hiring a local supply chain officer, and searching for an alternative procurement solution for 2021 and beyond.

*Expl.3 To what extent has WHO **monitored its performance in terms of internal functioning**, learned from this information and knowledge and fed these sources of learning into improving its own performance?*

As previously mentioned, WHO has responded to the evolving COVID-19 pandemic by putting in place a stable yet agile COVID-19 IMST. First mirroring the IMST structure of WHO EURO and in collaboration with the regional office, WCO Ukraine's IMST has also been organised around key response pillars, ensuring that individuals with different areas of expertise from across the Organisation were brought together to share information and advice in order to develop a comprehensive response.

As of August 2021, the IMST had 82 people, of whom 23 per cent were supervisors, 32 per cent staff members and 45 per cent consultants (Figure 13). Only nine out of 44 staff members have had fixed-term contracts, while the rest have had temporary assignment contracts.

Figure 13 COVID-19 Incident Management System Team, Source: IMST Organigram



⁵⁸ reliefweb. 2022. *Ukraine 3 March 2022 Public Health Situation Analysis (PHSA) – Short-form*. [online] Available at: <https://reliefweb.int/sites/reliefweb.int/files/resources/ukraine-phsa-shortform-030322.pdf>

⁵⁹ Wilson Center. 2021. *Vaccine Hesitancy in Ukraine: The Sign of a Crisis in Governance?*. [online] Available at: <https://www.wilsoncenter.org/blog-post/vaccine-hesitancy-ukraine-sign-crisis-governance>

⁶⁰ Ratinggroup.ua. 2021. *Суспільно-політичні настрої населення (21-23 жовтня 2021)*. [online] Available at: https://ratinggroup.ua/research/ukraine/obschestvenno-politicheskie_nastroeniya_naseleniya_21-23_oktyabrya_2021.html

To aid the exchange of information and complementarity of work among different pillars while maintaining team spirit while working remotely, WCO Ukraine senior management has made use of the weekly IMST meetings and regular morning coffee meetings (2-3 times per week) with pillar leads and the IMST team (Table 4). While this approach has indeed worked in terms of bringing staff members of both IMS and the Health System on the same page regarding WHO's COVID-19 response, the evaluation findings reveal that working across pillars and in coordination with external stakeholders came at the price of declining staff energy.

Table 4 Types of IMST staff meetings conducted in WCO Ukraine

Frequency	Type of Meeting
Weekly	IMST Staff Meetings (every Monday, 2 hours, all staff)
	Morning Coffee Staff Meetings (in 2020 every Monday, Wednesday, Thursday; in 2021 every Tuesday and Wednesday, 30 minutes, all staff)
	IMST Pillar Leads Meetings (every Thursday, 1 hour, only pillar leads)
	EURO Staff Meetings (once per week, 1 hour, only pillar leads)
	Regular pillar team meetings (several per week)
Monthly	IMST Staff Meetings (once per month, 2 hours, all staff)

Interviewed WCO Ukraine informants explained that a considerable amount of their time is spent on internal (5-6 mandatory staff meetings for pillar leads weekly) and external meetings frequently organized by the National Health Authorities and UNCT. Furthermore, administrative procedures such as preparation of the documentation for recruiting staff or consultants and the procurement of goods needed in their respective pillars reportedly occupy about 35 per cent of supervisors' time. Staff also have supervisory duties, including the responsibility for final products prepared by the consultants. All of this limits the room for expert- or content-related work by WHO supervisors and staff, while the amount of work in the emergency mode is not reduced. This results in continuous work without weekends for a prolonged period, which shows signs of being detrimental to staff health.

"If you have five consultants in your team, it means you will supervise them for technical deliverables and will be still responsible for the final one. You cannot assign consultants to represent the WHO at a high level or in any decision-making meetings. Consultants can attend those meetings and only support you with providing the information they heard but they will not be able to make any decisions".

Key informant, WHO

According to WCO Ukraine internal stakeholders, WHO management has been monitoring staff performance and well-being, including monitoring visits from WHO EURO representatives who discussed administrative work, procurement, logistics, and other operational issues with staff, including those deployed in oblasts. The operational staff has testified to also benefitting from close monitoring and exchange with Pillar Leads, inventorying and addressing gaps and shortcomings. Management attention to the work done seems to be appreciated by WCO Ukraine staff, as well as an offer of psychological training and staff retreats to maintain motivation for working on the COVID-19 response. Finally, attention is paid to staff development, albeit working in emergency settings. This is done by each employee drawing up a Personal Management Development Plan at the beginning of the year with training, team development, a cut-off in the middle of the year, and an assessment at the end of the year, a common practice in all WHO offices. According to WCO Ukraine leadership, a challenge remains to keep up the energy within the IMST for longer than six months.

WCO Ukraine has been regularly reviewing their internal organisation to reshape the IMST structure in the best possible way to address national needs. One specificity from other Country Offices in the WHO Europe region is that the IMST in Ukraine includes mental health. WCO Ukraine leadership believes that this decision is important as they foresee that the protracted nature of the COVID-19 pandemic will make mental health a topical issue 1.5 years from now.

5 Conclusions and recommendations

This section sets out overall conclusions based on the various findings detailed earlier in the report.

5.1 Conclusions

PREPAREDNESS

WHO's Thirteenth General Programme of Work (GPW13) defines, as one of its three targets, that one billion more people should be better protected from health emergencies by 2023⁶¹. Work towards that target has been underway for some time but COVID-19 has highlighted weaknesses in global pandemic preparedness. That fact was recognised by the 74th World Health Assembly in May 2021 which noted that "the COVID-19 pandemic has revealed serious shortcomings in preparedness for, timely and effective prevention and detection of, as well as response to potential health emergencies."⁶²

Achievements by WHO in Ukraine thus need to be considered against the backdrop of acknowledged global weaknesses. In that context, the evaluation suggests that WCO Ukraine's preparedness was strong. The WCO had been actively engaged in the humanitarian response in the ECA for a number of years. Hence, the staff had a good understanding of many relevant issues and a number of key procedures were in place by the end of 2019. Those capabilities helped to ensure that additional financial and other resources to address the challenges of COVID-19 were quickly mobilised and that systems and processes could be rapidly modified (or established) to underpin the response itself.

The evaluation confirmed that human factors were also an essential component of preparedness. The fact that staff at the country level had well-established mechanisms to access expert professional knowledge and resources quickly and confidently, both nationally and internationally, from within and beyond WHO has also been a key strength from a preparedness perspective.

The WCO team had also built up good political capital which proved to be a major asset and reflected a history of close collaboration, built on strong interpersonal relationships, between senior leaders in WCO on the one hand and both elected representatives and senior public servants in the Government of Ukraine on the other. The part played by national staff in facilitating effective work across relevant national public agencies was particularly notable as an important factor underpinning preparedness while strong ties among WHO staff at the country, Regional, and Headquarters helped to ensure there was a sound basis for cooperation as the pandemic unfolded.

There were, nevertheless, some issues that were not entirely helpful to be prepared at the country level. Specifically, Ukraine had been struggling to implement all aspects of the International Health Regulations (2005), there had been several personnel changes at senior levels among counterparts in the Government of Ukraine, and the period immediately prior to COVID-19 arriving in Ukraine had seen a number of changes in Country Office staffing and office accommodation.

In summary, the evaluation has concluded that a combination of context (several years' experience of emergency response), capability (in the form of technical knowledge from within and beyond the whole of WHO) and collaboration (across the levels of WHO and with relevant government counterparts) meant that the Ukraine Country Office was relatively well-prepared for COVID-19.

⁶¹ The WHO Executive Board has subsequently approved that the term of GPW13 be extended to 2025.

⁶² WHA Resolution WHA74.7, at page 22 Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA74-REC1/A74_REC1-en.pdf#page=1 [Accessed 4 April 2022]

RESPONSE

The response was necessarily large in scale (covering a country that is both the seventh most populous and second largest in Europe), long in duration (almost two years covered by the evaluation and continuing thereafter) and diverse in its reach (encompassing urban, rural, and remote communities and areas which have faced several years of ongoing conflict).

In respect of COVID-19-related mortality and morbidity, the cumulative confirmed case rate in Ukraine was about three-quarters of the EURO average but the cumulative mortality rate was 15 per cent higher. Since those data may not be statistically robust and reflect many factors other than the part played by WHO in Ukraine, they should not be afforded undue weight in any assessment of the Country Office's response.

A more direct reflection of the response is provided by the evaluation's assessment of progress as "excellent" for five (16 per cent) and "good" for 21 (66 per cent) of 32 pillar-specific response objectives⁶³.

There was generally good alignment between the response and the needs of the government and affected populations. That alignment reflected the quality of pre-existing relationships at individual and institutional levels, investment in establishing robust plans at the outset (and subsequently adjusting them as required), a strong focus on the collection and use of data to monitor progress and guide decision-making, and high levels of trust and mutual respect.

Collaboration with other UN agencies was effective in ensuring there was an improved focus on understanding and addressing the needs of vulnerable groups at all stages of the response.

Agility alongside clear role delineation on the part of the WCO leadership team coupled with creativity in establishing and modifying "fit-for-purpose" systems and operating procedures, most notably in respect of procurement, ensured that the response evolved quickly as needs and circumstances changed. As a result, preconceptions among some partners that WHO was overly bureaucratic and slow to react were largely overcome.

The Country Office, often with strong support from Regional and HQ levels, was also able to quickly identify and capitalise on a wide variety of funding opportunities and subsequently put resources obtained to effective use. Targets for deliverables were achieved in respect of all 28 separate awards that were obtained during the period from March 2020 to November 2021 and a remarkably high overall absorption rate of 98 per cent was achieved.

Procurement was central to the response at all stages. There were some occasions when procurement of consumables or other goods was considered to have been slow but that was perhaps inevitable given the scale of the procurement undertaken and the situation that prevailed globally in the early months of the pandemic when supply chains were under stress. Overall, the evaluation has found that procurement - including the focus on the quality of goods and probity of processes - was an important strength in the response.

While some stakeholders perceived that WHO's response to COVID-19 has limited visibility in some regional levels within the country, many others commented very positively on the achievements in relation to vaccination and delivery of hospital-based care across the whole of Ukraine.

The only weakness that appears to have been of significant concern to a number of stakeholders was a perceived inability on the part of WHO to address the issue (and consequences) of vaccine hesitancy among the Ukrainian population. However, the evaluation team also notes that for the SPRP vaccination pillar, as part of the shared responsibility among partners, WHO's focus of work was with the healthcare workers while the risk communication and community engagement to the wider population was with UNICEF.

In respect of WHO's response in Ukraine, the evaluation has concluded that the Ukraine Country Office, with support from GoU, other partners and WHO, was able to perform very well.

⁶³ There was only one pillar-specific response objective where progress was judged to have been "limited": "Enhance the mechanisms for the timely exchange of public health information with neighbouring countries"

5.2 Recommendations

Recommendations reflect the prescribed timeframe for this evaluation (early 2020 to December 2021), and those directed to the Country Office reflect the country context, findings and conclusions at the time of the evaluation. However, the war and rapidly changing humanitarian situation in the country necessitate urgent attention to adapt the COVID-19 response given the changed environment and response capacities within the country, as well as within the region given many refugees. It is noted that the findings and recommendations provide useful lessons and insights for other WHO Country Offices, Regional Offices and HQ in their COVID-19 responses, noting the need to tailor to respective contexts.

COUNTRY-LEVEL RECOMMENDATIONS

Recommendation

Recommendation 1: Taking into account the rapidly changing humanitarian crisis situation in the country, the WHO Country Office in Ukraine should incorporate successful interventions and management practices of the COVID-19 response, and COVID-19 as a major communicable disease risk, into short, medium and long term strategic plans for humanitarian response.

Rationale: The country context, including the humanitarian situation and public health capacity, has been drastically changing since late January 2022. While the humanitarian response is the need of the hour, the WHO Country Office should incorporate COVID-19 response in its humanitarian response plans and update Emergency Response Plan (ERP) accordingly.

Recommendation 2: The WHO Country Office in Ukraine should continue and build on its current COVID-19 response strategy and approach to pandemic preparedness, and to further strengthen by:

- implementing a process to review/refine the Country Office strategy and programme taking account of, and accommodating, the evolution of the current pandemic and changes in internal/external institutional or operating environments; and,
- improving understanding of, attention to and incorporation of the needs of vulnerable groups and gender considerations in the context of the current humanitarian crisis in programme design, partner selection, targeting, protection and addressing access barriers.

Rationale: The findings and experiences documented in the current evaluation suggest a need to continue the strategic and operational pillars of the COVID-19 preparedness and response capacities, programmes and processes at the country level in Ukraine.

Recommendation 3: The WHO Ukraine Country Office should further scale-up efforts to address vaccine hesitancy for all vaccine-preventable diseases, including its negative impacts, by:

- working further to understand and tackle the underlying factors that result in poor vaccine uptake;
- continuing and, where possible, enhancing collaboration across the UN family and with civil society to build on outcomes of the behavioural studies/research on drivers of vaccine hesitancy;
- sustaining advocacy with the Government of Ukraine and relevant stakeholders on vaccine access in all areas of Ukraine, including ECA; and,
- adapting learnings and technical expertise from across WHO to develop locally appropriate measures to generate increased demand for vaccination including, where relevant, closer working with local media organisations and civil society.

Recommendation 4: The WHO Ukraine Country Office should plan now to ensure that progress in strengthening its national staff capacities is maintained to meet the changing demands of the pandemic response, including by:

- ensuring that career development and/or performance plans for relevant national staff set out clear growth opportunities which can support their taking on greater responsibilities (based on the staff appraisal results)⁶⁴;
- gradually introducing mid-level national staff to greater and more varied opportunities to take on higher-profile roles including representation of WHO in policy dialogue with senior-level counterparts in government and other agencies across a broad range of health-related issues; and,
- reviewing human resource policies and practices to ensure that changes introduced for strengthening national staff capacities are sustained.

Rationale: A majority of WHO Ukraine Country Office key staff members, including national staff, worked directly on COVID-19 response in the last two years (given the need and funding available) and continue playing an important role in supporting effective work across national and international agencies.

Recommendation 5: The WHO Ukraine Country Office should begin early planning for the 'new normal' post-pandemic, strategically adjusting its current level of support for Ukraine's health system in the medium to long-term. Early planning will be needed to ensure a well-managed transition that allows the Country Office to focus clearly on WHO's priorities as set out in GPW13 and other documents, prioritising:

- ongoing targeted support for humanitarian efforts and provision of technical support;
- putting institutional capacity building for Ukraine's programme of health reform at the centre of future plans; and,
- support for performing other core functions, such as: providing leadership on matters critical to health; engaging in partnerships where joint action is needed; shaping the research agenda; stimulating the generation, translation and dissemination of knowledge; setting norms and standards, and promoting and monitoring their implementation; articulating ethical and evidence-based policy options; providing technical support, catalysing change, and building sustainable institutional capacity; and, monitoring the health situation and assessing health trends.

Recommendation 6: The WHO Ukraine Country Office should systematise further organisation, prioritisation of, and reporting on WHO's operations at country level. Actions include to:

- align targets specified in various awards to CRPR pillars;
- explicitly prioritise work on certain Pillars (e.g., Pillars 3, 5, 6, 7, and 10, and making Pillar 1, beyond CRPR, a part of the mid-term strategic plan (2022-2023)) and on strengthening the health system in long-term strategic plans;
- emphasise and further develop tracking of outcome-level results (i.e., beyond deliverables, scope of support provided, activity-based quarterly reports), and scale up internal systems to spotlight these achievements;
- track and report on Country Office achievements for greater visibility and fundraising to sustain/increase the scale of WHO operations at the country level;

⁶⁴ Echoed in talent retaining efforts of WHO such as targeted efforts through career counselling, mentorship and leadership pathway programmes to build the capacities of female staff members at junior levels to prepare them for higher-level managerial position. Source: WHO. 2021. *Human resources: annual report, Report by the Director-General*. [online] Available at: <https://apps.who.int/gb/eb-wha/pdf_files/WHA74/A74_25-en.pdf> [Accessed 13 April 2022]

- continue to advocate with donors on the funding requirements for WHO's COVID-19 response throughout the country; and,
- adapt monitoring and evaluation systems and reporting into humanitarian response, including COVID-19, plans.

REGIONAL/GLOBAL-LEVEL RECOMMENDATIONS

The experience gained, and achievements made, by the WHO Ukraine Country Office over the past two years inform several good practices and several recommendations that are of potentially wider relevance for WHO in other Country Offices, Regional Offices and Headquarters.

Recommendation

Recommendation 7: All WHO Regional and Country Offices should be required to arrange for (and fund) relevant staff to participate in regular functional simulation exercises to understand and practice the role of the National IHR Focal Point, with learnings from such exercises disseminated widely and incorporated into preparedness planning at all levels of the Organisation.

Rationale: Simulation exercises have been carried out by WPRO (Exercise Crystal) since 2008 and, more recently, by EURO (Exercise JADE). A number of benefits were realised by the Ukraine Country Office because of its participation in Exercise Jade in 2019.⁶⁵

Recommendation 8: HQ and Regional Offices, in consultation with Country Offices, should establish clear “escalation” paths to permit greater flexibility in administrative processes during emergencies, including:

- use of “fast track” procurement and human resource recruitment processes which minimise process steps to achieve rapid responses when justified by specific operational criteria in health emergencies.

Rationale: During a fast-evolving situation such as the COVID-19 pandemic, the Ukraine Country Office frequently sought a high degree of responsiveness and rapid turnaround of requests in the areas of procurement and staff recruitment. Nevertheless, delays were experienced, despite the best efforts of HQ and other, centralised “back-office” functions.

Recommendation 9: Heads of Country Offices should be encouraged and supported to redouble efforts to break down siloed thinking and action, and foster synergies between programmes at the country level.

Heads of Country Offices should be encouraged to:

- maximize synergies across GPW13 and Country Office programme strategic priorities and programmes, and that these are not inhibited by structural or cultural barriers; and,
- promote a Country Office Business Model highlighting a multi-skilled team with Head of Country Office and Incident Manager leadership, along with identified staff/roles for information management, clinical expertise, operations/logistics, monitoring and evaluation, and as appropriate global health cluster co-ordination at technical level.

Rationale: The COVID-19 response created opportunities for synergies to be realised between Country Office work in humanitarian response, health reform, and pandemic response. Synergies among WHO's three strategic priorities are also highlighted in GPW13.

⁶⁵ Participation in such exercises is already “recommended” as an annual activity for all EURO Country Offices

Recommendation 10: Review the nature and extent of decision-making authority that is delegated to Heads of Country Offices with attention to allowing them greater agility and well-considered risk-taking.

***Rationale:** A notable feature of the response in Ukraine was the extent to which staff - led by the WHO Representative (WR) - were able to adapt approaches as demands changed and, in doing so, were not unduly restricted by established practice. Examples noted include new approaches to procurement and moves to capitalise rapidly on funding opportunities. The Country Office leadership team demonstrated a mature approach to taking and managing risks which ensured that responses were tailored closely to the needs of the Government, other partners, and the community. External stakeholders noted with approval the contrast with what can be perceived as a risk-averse and overly bureaucratic culture within WHO.*

Recommendation 11: WHO Country Offices, Regional Offices and Headquarters should increase investment in data and analytics, with a particular focus on forecasting, including to:

- further develop, use and refine country-centred planning systems, including multiple dashboards for monitoring and reporting progress as well as forecasting emerging pandemic hotspots and needs for goods and services; and,
- take advantage of established expertise in related fields and adopt leading-edge analytical techniques to support forecasting of needs and priorities and planning.

***Rationale:** The Ukraine Country Office's success in developing multiple dashboards to monitor and fine-tune the response to COVID-19 was viewed as a key strength. Crucially, data were not solely focused on reporting and evaluating progress retrospectively, but they were also used to forecast the trajectory of the pandemic and project future needs for goods and services.*

Recommendation 12: HQ, with support from Regional Offices, should take steps now to ensure that lessons learned from COVID-19 are captured and made available to support future preparedness and response. Suggested approaches could include:

- developing a specific community of practice across the Organization to systematically capture and translate lessons;
- using text analytics and artificial intelligence to mine diverse data sources.
- deploy the knowledge thus acquired in formal training situations (such as simulations – see recommendation 7), to guide planning or, on a more *ad hoc* basis, to respond to specific requests for advice or assistance from across WHO or from the Member States.

***Rationale:** There may be a natural tendency to delay the capture of institutional knowledge until the pandemic has passed (or diminished significantly in scale and scope). Doing so may, however, result in much valuable knowledge being lost as memories fade and priorities shift. Measures should be taken as soon as possible to capture, record and provide structured access to lessons learned from the pandemic.*

