



## UNOPS Midterm Review

UNOPS 'Light-touch Project Assessments' SDG 3

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# 1 Introduction

1. This short paper is part of a midterm review of UNOPS 2022-2025 strategic plan. It provides an overview of light-touch case assessments of two projects which may contribute to SDG 3: To ensure healthy lives and promote well-being for all at all ages.
2. The key questions the assessments aim to address are:
  - a) Is it possible to substantiate that this project has, or will likely in the future, contribute to SDG 3?
  - b) If yes, how has each project contributed / will each project contribute?
  - c) If not, how could the contribution of each project be ascertained?
  - d) What have been the main achievements and/or shortcomings of each project?
3. The projects being assessed are:
  - a) 'The Regional Artemisinin-resistance Initiative 3 (RAI3E) – Greater Mekong Subregion', in which UNOPS is the Principal Recipient of the Global Fund
  - b) 'The Kosovo Emergency COVID-19 Projects'.
4. Each case study includes a brief overview of the context, an outline of the project and an assessment of its contribution to change focused on SDG 3. The assessment also highlights where the project may be contributing to other SDGs. A theory of change is included which identifies UNOPS role and value addition to a 'contribution account'. The case study also captures key lessons including identifying achievements and shortcomings to address.

## 1.1 Overview of SDG 3

5. SDG 3 aims to ensure health and promote well-being for all at all ages by improving reproductive, maternal and child health; ending epidemics of major communicable diseases; and reducing non-communicable and mental diseases. It also calls for reducing behavioural and environmental health-risk factors. It has 13 targets and 28 indicators to measure progress towards these.

*Table 1: SDG 3 Targets and indicators*

SDG 3: Ensure healthy lives and promote well-being for all at all ages	
Target 3.1: Reduce maternal mortality	Indicator 3.1.1 is the maternal mortality rate
	Indicator 3.1.2 is the proportion of births attended by skilled health personnel
Target 3.2: End preventable deaths of new-borns and children under 5 years of age	Indicator 3.2.1 is under-five mortality rate
	Indicator 3.2.2 is neonatal mortality rate
Target 3.3: end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases	Indicator 3.3.1 is number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
	Indicator 3.3.2 is Tuberculosis incidence per 100,000 population
	Indicator 3.3.3 is malaria incidence per 1,000 population.
	Indicator 3.3.4 is Hepatitis B incidence per 100,000 population.

	Indicator 3.3.5 is the number of people requiring interventions against neglected tropical diseases.
Target 3.4: Reduce mortality from non-communicable diseases and promote mental health	Indicator 3.4.1 is the mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease. Indicator 3.4.2 is suicide mortality rate.
Target 3.5: Prevent and treat substance abuse	Indicator 3.5.1 is the coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders. Indicator 3.5.2 is the harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol.
Target 3.6: Reduce road injuries and deaths	Indicator 3.6.1 is the death rate due to road traffic injuries.
Target 3.7: Universal access to sexual and reproductive care, family planning and education	Indicator 3.7.1 is the percentage of married women ages 15-49 years whose need for family planning is satisfied with modern methods of contraception. Indicator 3.7.2 is the adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group.
Target 3.8: Achieve universal health coverage	Indicator 3.8.1 is coverage of essential health services Indicator 3.8.2 is the proportion of population with large household expenditures on health as a share of total household expenditure or income.
Target 3.9: Reduce illnesses and deaths from hazardous chemicals and pollution	Indicator 3.9.1 is the mortality rate attributed to household and ambient air pollution. Indicator 3.9.2 is the mortality rate attributed to unsafe water, sanitation, and lack of hygiene. Indicator 3.9.3 is the mortality rate attributed to unintentional poisoning
Target 3.a: Implement the WHO framework convention on tobacco control	Indicator 3.A.1 is the age-standardized prevalence of current tobacco use among persons aged 15 years and older.
Target 3.b: Support research, development and universal access to affordable vaccines and medicines	Indicator 3.B.1 is the proportion of the target population covered by all vaccines included in their national programme. Indicator 3.B.2 is the total net official development assistance (ODA) to medical research and basic health sectors. Indicator 3.B.3 is the proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis.
Target 3.C: Increase health financing and support health workforce in developing countries	Indicator 3.C.1 is Health worker density and distribution.
Target 3.D: Improve early warning systems for global health risks	Indicator 3.D.1 is the International Health Regulations (IHR) capacity and health emergency preparedness.

## 2 The Regional Artemisinin-resistance Initiative 3 (RAI3E) – Greater Mekong Subregion

### 2.1 Context

6. There has been significant progress towards the goal of eliminating malaria within the Greater Mekong Subregion<sup>1</sup> (GMS) by 2030. The Regional Artemisinin-resistance Initiative (RAI) was launched in 2012. Over the period 2012-19, the reported number of malaria cases dropped by 81% and deaths by 95%, with especially significant reductions in Plasmodium falciparum malaria. This progress has been especially important given the emerging threat posed by antimalarial drug resistant strains<sup>2</sup>. The global health community identified the importance of tackling this within the GMS and accelerating elimination efforts in the Subregion to avoid the risk of antimalarial drug resistance (strains) spreading to Sub-Saharan Africa, where malaria remains endemic and drives morbidity and mortality (particularly in under 5s). This in turn could have presented a substantial threat to meeting SDG targets 3.3 (communicable diseases) and 3.2 (child mortality).
7. Due to the progress in the GMS, both malaria transmission and burden are now largely focused in remote and hard-to-reach areas which are often heavily forested. The majority of cases are reported among forest goers and mobile and migrant populations, often in border areas. Eliminating malaria in one country requires elimination across the whole subregion and a strong regional approach.
8. Whilst many targets are on track, challenges the GMS faces in eliminating malaria include:
  - The populations with the highest malaria burden are often geographically and socially marginalized, with poor and unequal access to health services.
  - The cross-border nature of transmission – unofficial and unmonitored border crossings can ensure transmission from high burden to low burden areas. This risk has been evident by the recent uptick in malaria cases in border areas in Thailand due to the political situation in Myanmar and the resultant challenges for malaria control in Myanmar.
  - The shortage and skills of health workers to diagnose and refer malaria cases and limited follow-up to ensure that those referred can effectively access services/treatment.
  - Sustained national funding and strengthened institutional capability - currently an issue in Myanmar following covid 19 and political changes.
  - The need for strong and linked surveillance systems, and quick and responsive action to malaria events requiring sustained and flexible funding.

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<sup>1</sup> In the context of the RAI grants, the GMS refers to the Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Vietnam

<sup>2</sup> For example, where P. falciparum resistance to artemisinin and partner drugs has developed across the GMS in recent years.

## 2.2 Project Outline

9. The Global Fund-funded Regional Artemisinin Resistance Initiatives (RAI) started in 2013 in response to the emergence of drug-resistant malaria in the GMS. UNOPS became the Principal Recipient (PR) for the second grant, RAI2E (2018-20) following the identification of national capability gaps around grant management under RAI1E. UNOPS remains the Principal Recipient for the current grant, RAI3E (2021-23), which has disbursed USD 339 Million (231 Million for Malaria and 108 Million for the Covid-19 Response mechanism (C19RM)). and is working with partners on the funding proposal for RAI4E.
10. As agreed with UNOPS, this assessment focuses on the current grant (RAI3E) but considers the two previous grants and the important foundations they laid in ensuring RAI3E can achieve its intended impact. The main shift in focus from RAI 3 is the greater focus on malaria elimination (including accelerating progress towards this target) and the greater focus on the remaining populations which carry the majority of the disease burden (largely forest workers, migrant and mobile populations).
11. As PR, UNOPS' role focuses on grant management, providing technical support and health systems strengthening by building capability e.g. on procurement, supply chains, surveillance, financial management and monitoring and evaluation. UNOPS works with 39 Sub-Recipients (SRs) who it supports to implement the grant. SRs include national government agencies, civil society organisations, research institutions, international organisations and one private sector entity. The Regional Steering Committee (RSC) includes the Ministry of Health, donors, civil society, academia, people affected by the disease, the private sector and other relevant bodies, such as the Global Fund, WHO and the Bill and Melinda Gates Foundation. It provides the main mechanism for overall coordination and monitoring. The regional component is seen as key in terms of achieving the goal of malaria elimination and supporting development of innovative approaches to complement country components.

## 2.3 Assessing SDG Level Change

12. SDG 3 has 9 specific outcome targets with clear quantitative indicators and four 'implementation' targets which are expected to support how the outcome targets are achieved. The RAI 3 project is directly contributing to progress on SDG target 3.3 and indicator 3.3.3 by seeking to end the malaria epidemic by 2030 in 5 countries. It is also reasonable to expect that it is contributing to other SDG3 outcome targets, such as reducing preventable deaths for young children (3.2); improving access to essential medicines and services (3.8); as well as strengthening the capacity for early warning, risk reduction and management of national and global health risks (3.D) and strengthening the health workforce (3.C). Sustained impact on SDG 3.3. (malaria elimination) is also dependent on ongoing progress across the five countries in 3.D – in terms of strengthened surveillance systems (especially key in elimination phases of communicable diseases), and, to a lesser extent, 3.C and 3.8. Given the current political situation/instability, this may be especially challenging to achieve in Myanmar and progress that has been achieved may be reversed.
13. The degree of positive change/impact on SDG 3.3 achieved is shown in the results data for the GMS and in WHO monitoring of malaria across the SE Asia region. The period over which the project has been in operation has seen remarkable progress towards elimination of malaria in the Greater Mekong subregion, including an 87%

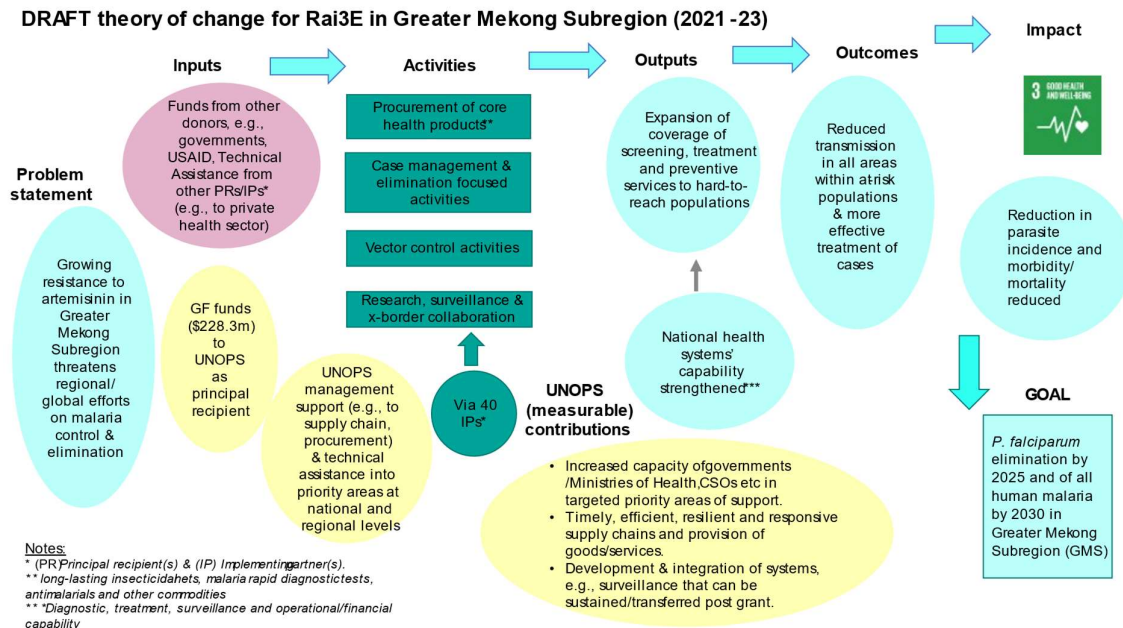
reduction in incidence and a 97% reduction in mortality between 2010 and 2020 (prior to the latest resurgence in Myanmar and Thailand). There was a particularly sharp reduction in incidence of plasmodium falciparum, for which resistance to artemisinin-based combination treatments is present across the region. It is reasonable to assume that malaria would not have decreased without a concerted intervention and a focus on multi-drug resistant species. The implication is that a large share of the reduction in the burden of the disease was due to the malaria intervention implemented by the national systems and the Global Fund, UNOPS and sub-recipients (CSOs and other partners).

14. It is also plausible that the RAI 3 project may indirectly contribute to SDG1 (Tackling poverty), SDG5 (Gender equality and women's empowerment) and SDG17 (Strengthening partnership). This may be possible through the following causal pathways - For example, by providing training and capacity building on gender-related issues in the target countries, UNOPS may indirectly improve key national and local stakeholders' understanding of these issues leading to improvements in treatment of and delivery of services in a way that supports greater gender equality (SDG5). By supporting a reduction in and eventual elimination of malaria transmission and in turn significant reductions in mortality and morbidity the intervention can help prevent families fall (further) into poverty (SDG1 - Tackling Poverty) by preventing loss of economic opportunities at household level due to malaria-related morbidity and mortality. The intervention's success has also been attributed to strong partnership working – with UNOPS playing a strong role – this includes at regional and country level, across funders, technical agencies, public and private sectors as well as civil society – arguably indirectly supporting SDG 17.7 (Encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships) and also depending on progress in this area.
15. Given the focus of RAI 3 on hard-to-reach and vulnerable communities (who often carry the burden of malarial cases in the region), the intervention is arguably dependent on and able to contribute to progress on SDG 10 (Reducing inequalities) – namely SDG 10.2 (empowering and promoting the social, economic and political inclusion of all) and 10.3 (Ensure equal opportunity and reduce inequalities of outcome). Stakeholders interviewed reported that the intervention has had to work around political barriers to ensure vulnerable groups were able to access services.

### 2.3.1 Theory of Change (ToC)

16. The project does not have an articulated theory of change. Therefore, the assessment team has constructed one based on RAI 3's performance framework and in consultation with the UNOPS programme team (Figure 1).
17. Underpinning the ToC is a targeted approach towards malaria elimination and a strengthening of national health system capacity to enable hard to reach communities (with the remaining malaria burden) to better access screening, treatment and preventative services for malaria. This expansion of services and treatment-seeking behaviour, alongside vector control activities, will directly reduce malaria transmission and cases within these populations. This will contribute significantly to the continued reduction in parasite incidence and morbidity and mortality that the GMS has seen in recent years, as well as reduce the threat of drug resistant malaria.

Figure 1: Constructed Theory of Change for RAI3E



18. There are some important assumptions underpinning the ToC:

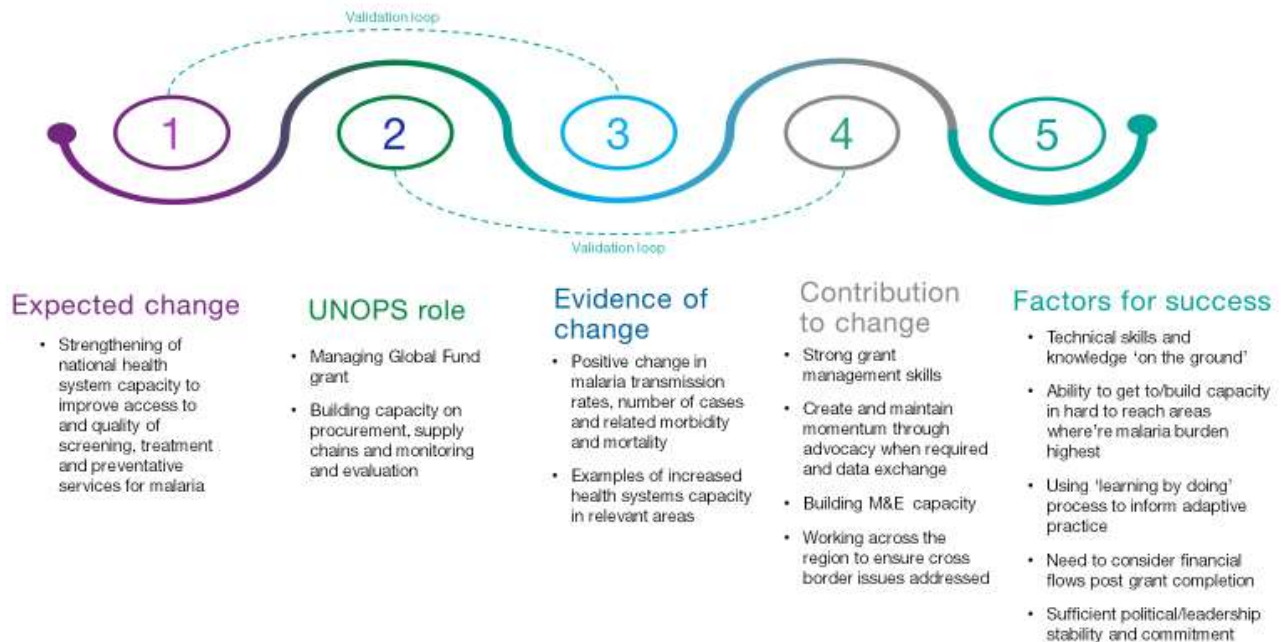
- Achieving the desired change depends on whether political contexts enable collaboration, capacity building of and direct funding to national governments. This is currently a challenge in Myanmar. The political situation has led to urban populations moving into rural areas and being exposed to malaria. There has been a significant turnover in the health workforce supported by RAI in Myanmar leading to losses in capacity that had previously been strengthened through RAI. It is also currently harder for the UNOPS team and partners to gain the required access to visit the locations in Myanmar and track/verify what is needed to eliminate malaria.
- It is assumed that health workers are able to access hard-to-reach target populations/areas. As target populations often live in remote, heavily forested areas, there is a need for face-to-face interaction to improve access to services and ensure referrals are followed up on.
- Sustained impact on health outcomes and at SDG/impact level also depends on national governments continue to invest/increase funds to support programme's goals. Donor support will gradually withdraw as progress towards elimination continues but sustained investment is required – especially in surveillance systems – to take the last steps towards elimination. Linked to this, there is the assumption that drug-resistant strains that evade treatment do not emerge to a significant degree in GMS.

### 2.3.2 The Contribution Account

19. RAI3E is in its third and final year of implementation. Figure 2 is the teams' snapshot assessment of UNOPS contribution at this stage, reflecting progress made in the previous RAI2E grant.



Figure 2: Summary of the UNOPS RAI3E Contribution Account



20. There is clear evidence of positive change in malaria transmission rates and incidence of cases and related morbidity and mortality. While there were many projects aimed at malaria, the regional initiative (RAI3E and its earlier phases) is particularly important in seeking to completely eradicate malaria and targeting multi-drug-resistant species. Local health systems had significant gaps in capacity that also needed Global Fund and UNOPS support and there is evidence that health system capacity has been strengthened in a number of relevant areas, partially thanks to UNOPS support, though there is no systematic model for tracking capacity

### 2.3.2.1 UNOPS Contribution

21. The progress achieved on malaria was a joint endeavour across 5 countries involving national systems, many partners and using funding provided by the Global Fund. In that sense, many organisations contributed and could claim ownerships of the impacts, not least the national health services. It is therefore not possible to isolate UNOPS's contribution to impact of the RAI3E and to the overall relevant health SDGs. However, there is clear evidence from stakeholders that UNOPS has played a significant role in achieving impact, have built important capacity, strengthened coordination and partnership aspects and have played to its strengths in ensuring the intervention is effective.

22. The basis of their contribution and of current effectiveness is seen as:

- Their strong grant management skills – disbursing significant funds (this is the GF's largest regional grant) quickly and effectively and strengthening health systems to ensure accountability and build ongoing capability. Previous to UNOPS becoming involved through the RAI contracts, there were capability gaps within the national

health systems which affected their ability to manage the grants effectively and sustain funding whilst they remained PRs.

- Helping to maintain a sense of urgency, to eliminate falciparum malaria before it becomes close to being untreatable and being quick and responsive to requests and flexible (where the grant and wider operating environments allow). Stakeholders noted their ability advocate with the Global Fund when changes are required.
- Stakeholders interviewed noted the ability of UNOPS to work at the regional level to manage and deliver this complex project across 5 countries and ensure that cross-border issues could be identified and tackled. Having a single coordination/management approach for RAI (led by UNOPS on behalf of the RSC) across all 5 countries has helped ensure collective action at regional level. This is key due to malaria's transmission routes and the interconnectedness of the GMS region. The regional response is underpinned by national and sub-national ownership and leadership and UNOPS is seen as being effectively embedded at country level whilst harnessing positive effects of the regional grant.
- Having improved exchange of data and information – especially important as the subregion reaches elimination phase – UNOPS has played a key role in building M&E capacity across the intervention.
- Their role in supporting the operational research components and ensuring learning is shared is seen as fundamental to building capability for innovative and rapid response which is increasingly important entering elimination phase.
- A degree of diversification within RAI is a deliberate strategy, with implementation through a range of different interventions and partners in an effort to reach the entire target population nationally but also targeting those in remote and otherwise hard to reach areas. For the most part, UNOPS are seen as effective in facilitating and coordinating such a diverse set of partners and able to build their capacity in different areas and at different levels, from national health ministries to volunteer community workers.

## 2.4 Learning

23. **An important aspect of how UNOPS was able to lead and contribute to impact in this case has been due to its regional presence.** Having the capacity and expertise to operate across the entire Greater Mekong subregion enabled a coordinated approach to targeting, controlling and eventually eliminating malaria. Malaria does not respect national boundaries and targeting populations in remote border areas (for example the border between Myanmar and Thailand) has been essential.
24. **UNOPS implementing approach to the Principal Recipient role in this project has been seen to add real value and provides a potential model for other interventions.** The intervention is set up in a way that enables UNOPS to conduct its core role in disbursing funds and supporting key processes, e.g., around procurement, and monitoring, whilst simultaneously building capability and emphasizing the role of SRs in implementation. UNOPS repeatedly stated its role as supporting implementation rather than leading it. This approach has helped develop strong working and trusting working relationships which have been key to driving success, helped build technical capacity across a number of areas and seen some gains as national government agencies increasingly feel able to lead key aspects of the intervention.

25. **The technical expertise within the UNOPS team and the fact they are often embedded at country level was seen as adding value.** They are therefore able to pre-empt and help resolve issues, provide additionality beyond their formal remit, understand local issues and be very responsive.
26. **The Operational research component (funded by RAI3E) with its focus on ‘learning by doing’ can if utilised, rapidly identify and deploy new approaches to malaria control.** The regional aspect of this improves shared learning and supports the scaling up of relevant solutions. This is especially important as it becomes more challenging to access hard-to-reach populations who carry the remaining disease burden.
27. **A more comprehensive interpretation of ‘gender equality’ could have been applied to the intervention.** While GESI considerations have been integrated into the intervention & UNOPS have supported IPs to strengthen their understanding of GESI and to better access vulnerable populations, a more comprehensive interpretation of gender equality could have been included, e.g. understanding the needs of men.
28. **Financial sustainability needs to be considered from the outset.** Whilst UNOPS has strengthened capacity within national health systems and the grant’s coordination mechanism (RSC) considers sustainable pathways for services, it is unclear the extent to which greater national resource would be provided once Global Fund money significant decreases. The overall capability of national governments to directly receive funding is uncertain.
29. **There have been additional benefits through developing the resilience of health systems.** It is notable that the localised capacity of health workers and volunteers at village level set up to combat malaria was also helpful when the region was hit by COVID and was one reason why the health interventions continued during the pandemic.

## 3 Kosovo Emergency COVID-19 Projects

### 3.1 Context

30. Kosovo reported its first case of COVID-19 in March 2020, and the Government declared a public health emergency for the whole country on 15<sup>th</sup> March. The Public Health response to the pandemic was led by the country’s health system, in which underinvestment and insufficient capacities/capabilities undermined their ability to respond. By 22<sup>nd</sup> April 2020 there were reported 630 confirmed cases and 18 deaths. Cases and deaths both continued to increase and WHO data shows there were many cases and deaths between June 2020 and April 2021, and additional ‘peaks’ during August/September 2022, January/February 2022 and July/August 2022. By February 2023, Kosovo has had 272,745 confirmed cases of COVID-19 and 3,196 deaths<sup>3</sup>.

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<sup>3</sup> <https://covid19.who.int/region/euro/country/xk>

## 3.2 Project Outline

31. The Government of Kosovo funded the 'Kosovo Emergency COVID-19 response Project' as part of their overall emergency response to the COVID-19 pandemic. The overarching aim of the project was to enhance the operational capacity of the Ministry of Health through the provision of specific equipment and supplies and upgrade of medical facilities. The project was delivered by the Kosovo Ministry of Health (MoH) and its development partners, including UNOPS, and supported by a World Bank loan under the COVID-19 Strategic Preparedness and Response Program (SPRP).
32. The project consisted of three main components: 1) Emergency COVID-19 response; 2) Supporting Households to comply with public health containment measures; and 3) Project Management, communications and community engagement.
33. UNOPS role was to help facilitate the emergency procurement of medical equipment, laboratory equipment, medication and other medical supplies. UNOPS work (across two related contracts) consisted of:
  - Procurement of medical equipment and civil works in upgrade of medical facilities (EUR 12.14m) finalised by the end of November 2022. This involved two phases:
    - Phase 1: Supply and delivery of medical equipment and other medical supplies (including imagery equipment, Life support Auto Ambulances, diagnostic equipment, ICU equipment and testing kits);
    - Phase 2: Implementation of Civil works for University Clinical Centre in Prishtina (UCCK) and all regional hospitals (Renovation of Radiology Department in Ferizaj Hospital, Renovation, and expansion of capacity of the Morgue in Prishtina, and installation expansion of the internal networks of medical gases (oxygen, compressed air and vacuum) in six Regional Hospitals.
  - Procurement of insulin and medicines from the essential list (additional financing of EUR 5M), finalised by end February 2022
34. Further funding (EUR 3.7M) was also secured from the Council of Europe Development Bank (CEB) for UNOPS involvement in the provision of critical medical equipment and facilities for the vaccination program in Kosovo which included both dry and cold vaccine storage and vehicles for the transportation of medicines and personnel. The EU also provided UNOPS with funding (EUR 5M) for medical equipment and PPE for COVID-19.

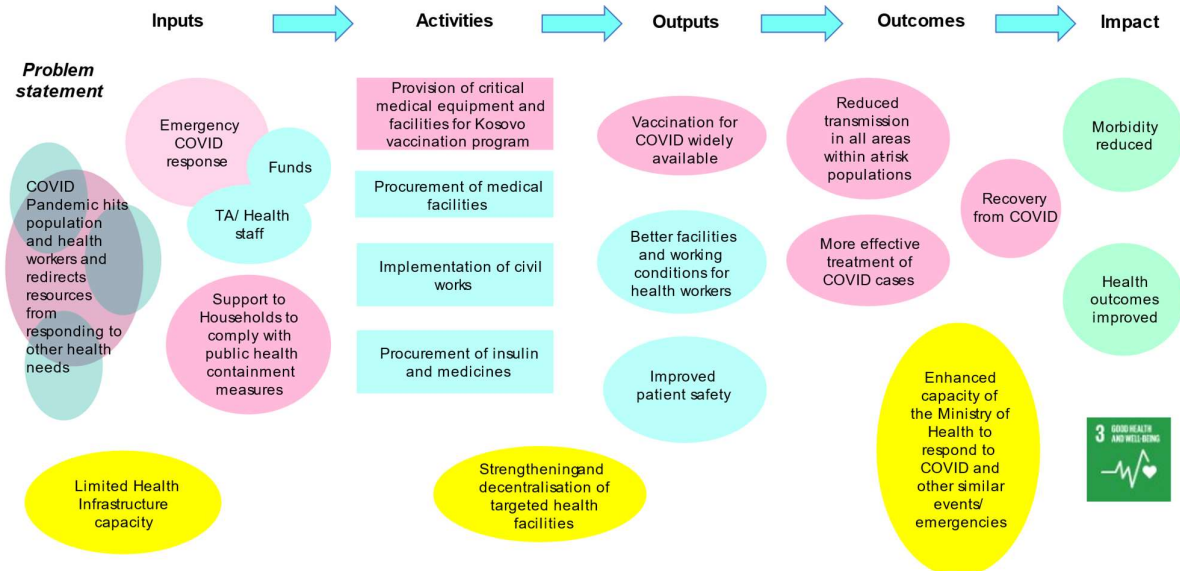
## 3.3 Assessing SDG Level Change

35. The assessment found that the project has contributed to SDG 3. The project was directly aligned to the 'Emergency preparedness' means of implementation for this goal (3.d.) and had direct contribution to target 3.8 around achieving universal health coverage. It also had indirect contribution to targets 3.2 and 3.3 on neonatal/child mortality and infectious diseases respectively.
36. Contribution of the project is not limited to SDG 3. It is likely that the project will have positive impacts on SDG 1 around poverty reduction (specifically target 1.5), SDG 9 around resilient infrastructure (target 9.1), SDG 11 around sustainable cities and communities (target 11.5) and SDG 17 around sustainable partnerships for development (targets 17.9 and 17.6), although the level of evidencing for these at this stage is limited.

### 3.3.1 Theory of Change

37. The Kosovo Emergency COVID-19 Project did not have an articulated Theory of Change (TOC), so, as shown in figure 3, the assessment team constructed one based on project documentation and discussion and refinement with the UNOPS country team.
38. The COVID-19 pandemic revealed an urgent need to improve the capacity of the health system in Kosovo. Modernisation and improvements in infrastructure, equipment and availability of essential supplies would allow COVID-19 patients to be treated more effectively and safely. This would lead to improved levels of patient recovery and reduced morbidity
39. Health outcomes are not confined to treating COVID-19. Improved health system capacity for emergency response now means there is an increased level of preparedness for any future health emergencies and how well a range of diseases can be treated, both communicable and non-communicable.

Figure 3: Draft Theory of Change for Kosovo COVID-19 Project



40. Underpinning the ToC are a number of assumptions and critical success factors:

- Underlying the design of the UNOPS component was an expectation that the pandemic would be tackled at both ends (demand and supply). So social distancing, and behaviour change to reduce risk of infection, vaccinations against COVID-19, social protection support, and appropriate use of the health system
- It assumes that health service workers are available to continue to make effective use of the increased health system capacity. This requires that their risks are minimised, and health is protected both for their own safety and in order to continue to work to treat others.
- Non-COVID-19 health risks will continue to need to be addressed despite the demands of the pandemic. For example, if the focus on COVID-19 vaccinations

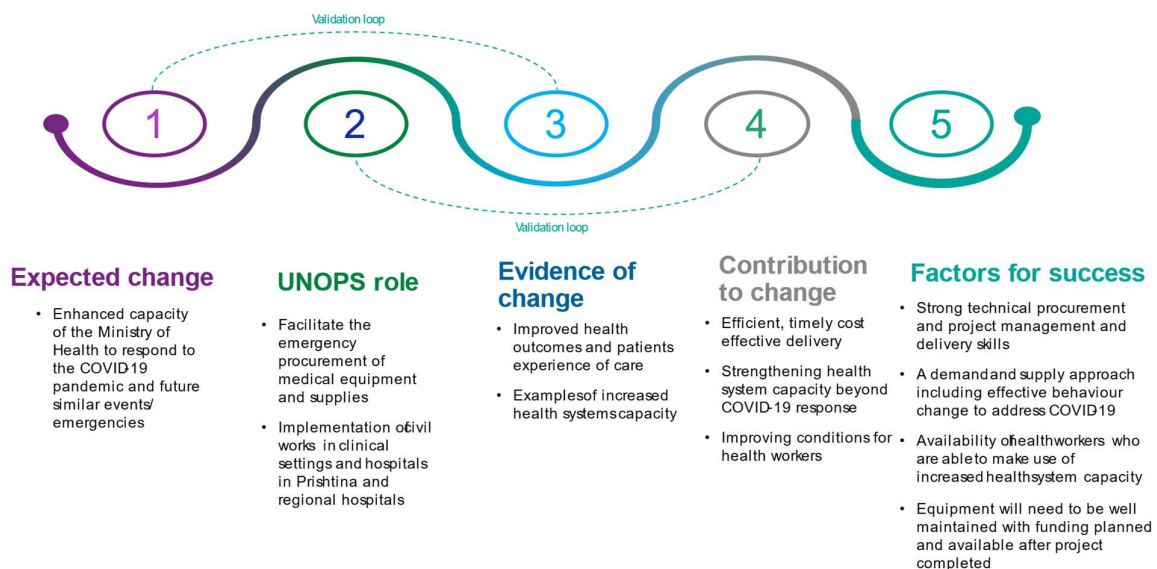
diverts attention away from regular routine immunisations for children and young adults, this would have a negative impact on the SDGs

- Equipment and infrastructure need to be well maintained after installation. This is by no means certain as it requires significant budgets to be provided from the government of Kosovo, not funded by the project beyond the initial stages when the equipment is being commissioned and tested.
- Treatment helps to reduce new infections and demands on the system. That is, it is reasonable to assume that by rapidly identifying, isolating and successfully treating COVID-19 cases, the level of new infections and the state of the pandemic are directly improved. Having said that, the major driver here is not treatment itself but behaviour change including social isolation and uptake of vaccination across the population

### 3.3.2 Contribution Account

41. UNOPS role in this project was a “Provider of Integrated Solutions”. UNOPS was implementing a complex set of projects with several interrelated parts, using systematic and comprehensive approaches and combining support services with technical advice. In particular, it was providing expertise in procuring supplies, equipment and enhancements to infrastructure and delivering within a tight timescale as required by the emergency response.

Figure 2: Summary of the UNOPS RAI3E Contribution Account



42. UNOPS work to date in Kosovo has been predominantly focused on the project management and infrastructure services, and (prior to the COVID response) in sectoral areas other than health. Recent examples include the population census in 2011, agricultural census in 2014, the construction of a high security prison in 2016 and construction of two Integrated border crossing points (Integrated Board Management with Serbia). It is with these services, and also procurement, whereby they demonstrate a strong track record of delivering high quality work in an efficient manner making them ‘a partner of choice’ for the government, and an ‘enabler’ for UN

agencies with a normative mandate. UNOPS are clearly considered to be a key partner for implementation, monitoring and supervising project work.

43. The ability of UNOPS to deliver in a timely manner is due in part to the efficiency of their internal procurement procedures, making use of LTAs and also the Emergency Procurement Procedures (EPP) which proved helpful in the context of this project. With teams comprising both international staff but also many local and national staff, there is a sound understanding of country context, procedures and necessary language skills.

44. UNOPS specific contribution to the change process has involved:

- **Facilitating emergency treatment for COVID-19 response during the pandemic:** The project allowed rapid response for COVID-19 patients and filled gaps in emergency preparedness, in ways that would have been further delayed or not feasible without UNOPS' expertise on procurement and project management
- **Strengthening health system capacity for treating a wider range of conditions and future preparedness for health emergencies:** The improvements in infrastructure and equipment have built capacity more broadly to serve populations on a range of health needs, improving health outcomes and patient's experience of utilising healthcare.
- **Timely procurement and implementation:** Feedback from key informants indicated that UNOPS were able to fill a gap which could not have been addressed by the government within the timescales required, so timeliness was a major contribution.
- **Value for money:** The project delivered 18% more outputs than requested by the agreement with the MoH. The agreed outputs were delivered on time while also achieving savings (relative to the original agreement) of 3.7 mill EUR. Most of the savings were then used to procure additional medical supplies by agreement with MoH, and the remainder of the savings were returned to the funding source.

45. Important secondary contributions have included:

- **Improved safety:** This relates to how medical gases are distributed across the hospitals to patients and how they are stored, with appropriate fire and safety measures in place.
- **Improved conditions for health workers:** In terms of the quality of the built environment and the functioning of the equipment. This is likely to be a significant factor in helping to retain staff in Kosovo.

## 3.4 Learning

46. **It is important to ensure there is sufficient capacity to maintain service delivery beyond the life of a project.** One key learning area identified by UNOPS was around the need for not just providing procurement services, but also to support the government in their own capacities and capabilities. While it was clear that the UNOPS support had built capacity in the health system through the new facilities and equipment in place, the reason for needing their support (weak government procurement systems) was not directly addressed. It is important to note this for the future, to avoid a situation of being dependent on external support from UNOPS (or another provider) for public procurement and service delivery.

47. **The pandemic catalysed upgrades to health systems.** Another learning was that the COVID-19 pandemic, whilst having devastating effects on health and economies

both in Kosovo and worldwide, was actually also an opportunity for catalysing financing and promoting actions to strengthen the health system i.e. using COVID-19 funds for broader investment in the health system. By the time the upgraded equipment (medical gases etc) was in place, the pandemic was largely under control, but the real benefit is that system was modernised and seen to be much more resilient to cope with future emergencies.