

**A Political Economy Analysis of Reform of Tuberculosis Treatment in  
Ukraine**

**DRAFT**

**June 7, 2015**

**Prepared for USAID/Kiev**

**By Cross Sectoral Programs Division  
Center of Excellence on Democracy, Human Rights and Governance  
Bureau for Democracy, Conflict and Humanitarian Assistance  
US Agency for International Development**

# **A Political Economy Analysis of Reform of Tuberculosis Treatment in Ukraine**

## **Table of Contents**

- Summary
- Question and Methodology
- Background on Ukraine and Health Services
  - a. Country Foundational Factors
  - b. Country Institutional Factors
  - c. The “here and now”
  - d. Ukrainian Health System and TB Services
- Questions for Field Visits
- Findings from Field Visits
  - a. Poltava Findings
  - b. Kirovograd Findings
- Conclusions: Programming with PEA Findings
  - a. Key factors identified
  - b. Theory of Change
  - c. Constraints on USAID that may shape implementation
- Recommendations for USAID
  - a. Support for necessary systemic reform
  - b. Target health services and reform within the current system
- Annexes
  - a. Documents Reviewed
  - b. Persons Interviewed
  - c. PEA Methodology

## 1. Executive Summary

This report addresses why Ukraine has for years failed to adopt several reforms to its tuberculosis program despite a series of recommendations from international experts, including those included in National TB program reviews conducted in 2010 and 2015. The USAID Mission in Kiev asked for a political economy assessment (PEA) of the health system and options for USAID activity that would address issues identified in that assessment.

To conduct this assessment we adapted the Political Economy Assessment framework that is in development by USAID and conducted both desk research and field work during March 2015. An eight-person team comprised of both Mission and Washington-based experts conducted the research and contributed to this report. They were supported by past analyses for USAID and others, by leadership in the Kiev mission and by implementers of several existing USAID projects. In addition to serving the needs of the USAID Kiev Mission, this study also served as one of a series of pilot applications of the draft PEA framework.

The team reviewed a series of factors that explain the current health system in Ukraine. These include the overall progress of political and economic reform, the history and current relationships with Russia, the progress of institutional reforms in general and in the health sector, the web of incentives in the health system and the susceptibility to modernization in the system. The team interviewed experts and advocates, health workers and managers, donors and project implementers, both in Kiev and in the field, specifically in two oblasts: Poltava and Kirovograd.

**A complex problem:** The status quo for health services in Ukraine, including TB services, is very stable; it has been built over decades as a part of the Soviet “Semashko” system of health service delivery first introduced in the 1930’s. The status quo consists of interwoven and reform-resistant parts that provide reinforcing feedback to a wide range of health workers, administrators and policymakers. This has the effect of maintaining current redistributive outcomes: about<sup>1</sup> 40% of health spending in Ukraine’s constitutionally “free” health care is spent on informal payments from patients and poor people to drug companies and health workers. The result is more expensive and lower quality care overall and dramatic health inequality. Savings from a reformed system could finance a good deal of improved quality if the incentives were different. The inequality produced by the current system is reflected dramatically in a 2010 study documenting that on account of their inability to pay the informal fees, more than 60% of patients avoid care altogether - from hospitals and doctors both. Within the TB system specifically, while informal payments are not as common due at least in part to the marginalized social and economic status of TB-affected populations and their inability to make informal payments, access to pharmaceuticals during

---

<sup>1</sup> 2011 USAID Health Sector Assessment, p 28,

periods of drug stockouts has in multiple cases depended on the ability of the patient to make informal payments.

It would be impossible to understand why the health sector has resisted prior efforts at modernization without broader institutional arrangements in view. Similarly, it is impossible to consider even project-level efforts to improve health (or TB) services without an understanding of the how existing systems of political organization and action are intertwined with all levels of health (and TB) service provision. The main elements of the political and economic forces at work are well known and reported:

- Procurement of drugs and other consumables provide opportunity for enormous financial returns to oligarchs, who use these resources not only to enrich themselves but to engage in political and informal activities that maintain the existing political and health systems.
- Health workers – doctors and nurses – are appointed, assigned and promoted within a set of arrangements, formal and informal, that make the costs of change very high for many, many participants, even those who readily recognize the negative health outcome impacts of the current system.
- Health care is a state activity in Ukraine. Space for private sector innovators, or the growth of alternative models of finance and care are constrained to minor examples of companies contracting with private clinics or public facilities for health provision to employees.
- Because health care managers are responsible for managing inputs, not health outcomes, information systems and the resulting sets of financial incentives, formal and informal, have evolved without producing system-improving data.

The imperviousness of the status quo to seemingly sensible reforms depends on maintenance of a diverse set of poor public sector governance practices that affect many sectors, not only health.

- Lack of transparency about program and financial performance of programs, even while data exists within the health institutions.
- Limited effective role of vertical mechanisms of oversight, such as auditors, or law enforcement oversight of fraud, collusion or bribery.
- Weak horizontal controls as well: little parliamentary engagement in budget or program oversight and only anecdotal evidence of judicial engagement in protecting individual rights or adherence to administrative norms.
- Limited sustained indigenous civil society activism around public sector service provision. (Of course the events of February 2014 are the dramatic exception to this observation).

This suggests that the technical or medical practice changes needed to improve health outcomes depend in significant part on a series of essentially political reforms at both national, local and sector levels, many of which are outside what we normally think of as the “health system.”

**“Improved TB care depends mainly on broad health reform.”** This view was shared widely by virtually everyone with whom we spoke. This broad assertion does not mean that there are not dedicated health workers and facility managers who today care very much about their patients. We met many informed, focused and thoughtful individuals. Many had traveled abroad to observe other health systems; they understood WHO protocols and the consequences of Ukraine’s system weaknesses. We heard of innovations within the confines of the current system, and indeed donor programs are improving care where they are implemented. Yet even donor program effectiveness is constrained by the status quo. It is not only Ukrainian resources that end up being inefficiently utilized.

**Theory of change: Our review of both the specifics of TB care and the health systems within which it is embedded led us to suggest a different theory of change.**

**If future USAID programming 1) targets political and technical obstacles, leverages assets identified in this analysis, and invests in long-term systemic reforms; and 2) uses technical assistance as both a method to improve service delivery and to develop knowledge of health systems dysfunction; and 3) this approach is frequently revisited and adapted to changing political contexts; then USAID programming will be more effective in improving the functioning of Ukraine’s health systems, and this improved functioning will be visible in improved TB outcomes as well.**

## **Recommendations:**

This report makes a series of recommendations for USAID, as that is our assignment. Many of these steps are however also relevant to others in Ukraine, or from outside Ukraine, who seek to support improved health services, especially for Ukrainians suffering from, or who will become afflicted with, tuberculosis.

### **A. Support for necessary systemic reform of the health sector**

#### **Take advantage of the tide:**

- *Recommend: Embassy and USAID coordinate and establish health system reform as a US structural and government legitimacy-enhancing priority to accompany focus on security, energy, financial institutions.*
- *Recommend: USAID support the U.S. Ambassador with talking points for interactions with Ukrainian leadership, so that the priority of health from the*

*US perspective is raised at every opportunity.*

- *Recommend: Integrate with World Bank pilots in eight oblasts, supplying analytic support alongside their investment funds and their limited TA on payment systems.*
- *Recommend: USG raise how health is addressed in working groups on civil service reform, decentralization with Ukraine counterparts and allocate technical office and specialist staff in DRG and health, as appropriate, to monitor and suggest mechanisms for accomplishing.*
  
- *Recommend: Design upcoming decentralization support program to include resources and activity allocated to assuring the effects of decentralization are positive for health systems effectiveness.*
- *Recommend: Convene existing implementers in a “data-thon” to review their existing data and access to data that could document or demonstrate impacts of existing health systems norms and practices, and highlight areas of progress or lack of progress that can be used to show the benefits of various innovative practices and/or implications for wider reform efforts. Consider opportunities across the Mission and the USG to integrate this data into advocacy efforts related to reform.*

#### **Invest in disruptive forces:**

- *Recommend: : Support a health sub-cluster of the Reanimation coalition with periodic convenings, targeted support for publications, and a competition for CSO documentation of health effects of various health system characteristics.*
- *Recommend. Coordinate USAID health projects with CSO networks. Identify journalists; sponsor a film contest for creative use and exposition of data on health services.*
- *Recommend: Commission research and analysis of the limited examples of third party payer systems*
- *Recommend: Work with the Department of Defense to assess the costs and benefits of the parallel health system for military service members. Document any changes underway, or possible as pilots.*
- *Recommend: Commission a detailed review of health systems analysis possible with the evolving data from the E-TB Manager; extrapolate to possibilities with a wider utilization of the tool beyond TB. Target information and analyses of use to central and/or oblast level officials, utility of comparative performance data in a dashboard.*

#### **Engage and encourage necessary actors.**

- *Recommend: Develop detailed PEA-informed case studies of innovation and*

*award (through local CSO's) prizes to the "heroes" of health innovation.*

**Prepare for windows of opportunity before they open.**

- *Recommend: Find ways with USAID or other resources to assure that the details of reform are professionally thought through. If the Minister needs a health finance expert, locate and field such a person. Convene the other donors to assure that external advice is aligned and not duplicative, that insights are shared, and that agendas are coordinated. Other donors have their own constraints; the combination may not be easy or perfect, but is better aligned than not.*
- *Recommend: Convene a facilitated workshop of USAID and Ukrainian health care managers to discuss data needs of a reformed system and the gaps in current data routines.*

**B. At the same time, continue to earn the confidence of Ukrainians by targeting health services and reforms within the current system.**

- *Recommend: Expand M&E efforts to collect information relevant to deeper understanding of the PE issues identified in this report.*
- *Recommendation: Build an oblast-by-oblast inventory of patient groups, patient advocacy groups, CSO service providers, social networks interested in TB care. Delivery oblast and facility level data to them, with periodic convening of discussions with health systems staff as well, around developments seen in the data.*
- *Recommendation: Research the financial model and collective action strategy of existing CSO's who are supporting social services for patients, and develop menu of models of community support/social contracting for support services.*
- *Recommendation: Commission research on the health practices of the 60% of Ukrainian patients who forego health services altogether on account of the unaffordability of side payments.*
- *Recommend: Fund "know your rights" campaign for one or more CSOs. Conduct a competition for CSO ideas to assure care for those who cannot afford side payments. Collect and publicize successful efforts to defend rights to care using courts or other institutions.*
- *Recommend: The flexibility given to Poltava has, they assert, had beneficial effects on their level of care for TB patients. Document this and other examples of innovation to support provision of similar flexibility and patient-centered steps in other oblasts.*

**Integrate Political Economy into Health Office planning and programming.**

- *Recommend: Create a mission-level working group to report on a consolidated basis on steps to coordinate resources and activities on an expanded health strategy: maintain existing programs with a deeper extraction of reform-supporting knowledge, and an additional set of activities using the full range of the Mission's other resources to take advantage of the tide, invest in disruptive forces, engage necessary actors and be prepared for windows before they open.*
- *Recommend: Extend existing analyses and new project development efforts to include political economy analyses, testing in advance the range of factors, interests and openings upon which the proposed theory of change rests*
- *Recommend: Integrate Economic Growth experts into the health effort. For example: If 40% of health care in Ukraine is effectively privatized (through informal side payments) how can more predictable, affordable markets be advanced alongside the public health system? What is the enabling environment for a more regularized co-payment system? What institutional infrastructure needs to be developed alongside health payment reforms?*
- *Recommend: Convene discussion with Cross-Sectoral Programs Division in October 2015 to reflect on utility of this pilot and advise other missions or other applications of the PEA approach in the health sector.*

## **2. Question and Methodology**

### **a. Question**

This Political Economy Analysis was done at the request of the USAID Mission in Kyiv Ukraine. It is one of a series of pilots of a new political economy analytic framework developed by USAID's Cross Sectoral Programs Division in the Center of Excellence on Democracy, Human Rights and Governance in USAID/Washington.

The Ukraine Mission asked the team to analyze 1) the political and economic incentives that support preservation of the current tuberculosis (TB) health services program in Ukraine as well as 2) the level of knowledge of international best practices among TB decision makers, managers and health providers in Ukraine. As described below, Ukraine has failed to adopt several reforms to its tuberculosis program for years despite a series of recommendations from international experts, including those included in National TB program reviews conducted in 2010 and 2015. These recommendations included the following: 1) adoption of outpatient based therapy for almost all patients; 2) implementation of standardized regimens for treatment of both drug-sensitive and drug-resistant tuberculosis; 3) analysis and use of program data to improve rates of successful completion of TB treatment; and 4) improvement of drug procurement and distribution to eliminate stockouts of TB drugs. The Mission specifically was interested in better understanding why previous attempts at tuberculosis reform had failed, and how key actors can most effectively support efforts by national, regional and local governments to provide tuberculosis care and treatment in line with national protocols and the current evidence base. The political economy analysis (PEA) was undertaken to inform ongoing projects managed by the USAID Office of Health as well as the Government of Ukraine's forthcoming National Tuberculosis Program strategy.

### **b. Methodology**

The structure of the work and the field work was guided by a methodology drafted for USAID by Dr. Diana Cammack, building on the experience of other donors attempting to integrate political economy thinking into their programming. Prior efforts by the UK, the World Bank, the Netherlands and Sweden in particular helped inform the process and framework developed by USAID. That methodology (Annex C) provides both an analytic framework and a set of questions and tasks that were adapted for this study.

The USAID approach considers a range of factors that, together, form the political economy context for considering whether and how USAID might address problems of various sorts. In the instant case, the target is a series of health interventions; the USAID framework is intended to support a wider range of queries as well, to include broader country- and sector-

level challenges. The guidance thus requires adaptation of the framework to the country context, the sector challenges and the specifics of each problem being investigated. Background consultation with in-country stakeholders, review of existing health sector and TB program assessments and key informants was conducted in advance of travel to Ukraine and during the first three days of the work in Kyiv.

The PEA approach tasks the team to consider four factors – foundational conditions, institutional arrangements, developments that constitute the “here and now” and the dynamics of these factors that are relevant to the problem being considered. This review is to produce insights that take more effective account of the openings and actions that may not have been considered in a more “technical” approach to a development challenge being studied.

From March 10-24, 2015 a joint USAID/Washington and USAID/Ukraine team carried out field work to complete a political economy analysis to inform USAID Ukraine programming to support reform of tuberculosis care and treatment. Participants included Laura Pavlovic, Heela Rasool and Reena Shukla (USAID/Washington), Charles Cadwell (Urban Institute), Alla Vasilkova (Deloitte) and Dan Ryan and Erika Vitek (USAID/Ukraine).

In addition to working in Kyiv, the team traveled to Poltava and Kirovograd from March 15-19 to consider the current dynamics of tuberculosis care and treatment in these oblasts, the relationship between authorities and national level authorities with respect to policy making, resource allocation, procurement and decision making. USAID/Ukraine chose these two geographical areas for the field work because of USAID’s ongoing engagement in these regions, differences between the two oblasts in terms of levels of economic development, and the extent of international donor support and tuberculosis prevalence.

Prior to the field trips, the USAID/Washington team conducted a workshop in Kyiv for USAID/Ukraine team members, mission staff and implementing partners and key Government of Ukraine counterparts to introduce the PEA methodology and to draw upon stakeholder perspectives to gain a greater understanding of key country- and sector-level dynamics to help in further refining the PEA questions to be considered during the field research. The team also interviewed key international and national stakeholders and partners as well as civil society groups in Kyiv to gain a greater understanding of the overall national context for reform of tuberculosis care and treatment as well as the health sector in general.

During the field research, interviewees included oblast and rayon level health administrators, tuberculosis specialists, primary care providers, patients, and representatives of local civil society organizations, including local Red Cross chapters and various stakeholder groups, including groups working with tuberculosis patients, People Living with HIV/AIDS, patients engaged in substitution therapy, sex workers and anti-corruption activists. Annex B provides a list of people interviewed.

### **3. Background on Ukraine and Health Services**

The delivery of care to tuberculosis patients is but one victim of Ukraine's poor progress in overcoming its Soviet past. The design of programs and expectations for their success are colored deeply by a range of foundational, institutional and contemporary factors that exist at the country level and at the sector level. In the bleak portrait that follows also lie opportunities that can, with appropriate caution, be acted upon to improve health outcomes and TB outcomes.

*Foundational Country factors:*

The health system in Ukraine and the failure to modernize it are deeply intertwined with the history, economics and informal norms inherited from the Soviet Union. These interactions are not merely historical; Russian interests and interactions are the context within which much of life in Ukraine is planned and lived currently. Ukraine is Russia's Western neighbor, and though it was known as the Soviet Union's "breadbasket," it was also a major center of industrial production. Its population of 45.49 million has actually declined since 1991, when Ukraine's population was 52 million.<sup>2</sup> This decline has been due to low fertility rates<sup>3</sup> and declining, for a time, life expectancy, especially among men.<sup>4</sup> Economic, political and cultural connections with Russia have survived and influence developments in Ukraine in myriad ways as will be described below.

Of course Ukraine is also the EU's *Eastern* neighbor; significant parts of Ukraine were once Poland and many Ukrainians living in the western provinces are culturally and ethnically close to places now within the EU. Ukraine gave up its nuclear weapons in 1994 in anticipation of Western support and integration into the more prosperous West, if not also into NATO.<sup>5</sup> Significant majorities of citizens have consistently favored closer ties with the West.<sup>6</sup> Yet the health system, as will be described, is solidly anchored in its Soviet foundations.

The tension between these two systems of governance, economic management and national security has helped paralyze progress in Ukraine. Where Poland had per capita GDP less than Ukraine in 1991, Ukraine now has a per capita GDP of \$13,653.<sup>7</sup> - 60% lower than

---

<sup>2</sup> World Bank Development Indicators, 1991 and 2013, <http://data.worldbank.org/country/ukraine>

<sup>3</sup> Rekha Menon, "ECA Knowledge Brief: Combating Ukraine's Health Crisis: Lessons from Europe," The World Bank, last modified January 10, 2010, <http://go.worldbank.org/FBSNLMZV50>

<sup>4</sup> In 1990, life expectancy among Ukrainian men was 66 years, compared to 63 years in 2008. This represents a steeper decline than female life expectancy, which was 75 years in 1990 and 74 in 2008.

Information from: World Bank Development Indicators, 1990 and 2008.

<http://data.worldbank.org/country/ukraine>

<sup>5</sup> "Country Profiles: Ukraine: Nuclear," The Nuclear Threat Initiative (NTI), last modified November, 2014, <http://www.nti.org/country-profiles/ukraine/nuclear/>

<sup>6</sup> "Despite Concerns about Governance, Ukrainians Want to Remain One Country: Chapter Two: Ukraine: Russian Influence Unwelcome," Pew Research Center Global Attitudes & Trends, May 8, 2014, <http://www.pewglobal.org/2014/05/08/chapter-2-ukraine-russian-influence-unwelcome/>

<sup>7</sup> World Bank Development Indicators, 2013, <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD>

Poland's.<sup>8</sup> Russia has a higher estimated per capita GDP of \$14,611.7. Ukraine limps along with little improved prosperity—its 2013 per capita GDP was \$3,900.5 compared to its 1991 per capita GDP of \$1,489.7, and access to this limited growth has been widely unequal.<sup>9</sup> Ukrainians experience these poor outcomes in dozens of ways; their health system is a big example.

Russia: The complex relationship with Russia is manifest in many ways that precede the current armed conflict. Prior to the annexation of Crimea, 29.6% of Ukrainian citizens reported Russian as their primary language.<sup>10</sup> Ukraine's economy continues to be highly dependent on Russia. Not only is about two-thirds of Ukraine's natural gas supplied by Russia, the transport of gas through Ukraine to Western Europe provides important revenue to the Ukraine treasury.<sup>11</sup> Twenty-four percent of Ukraine's exports (prior to the current conflict) went to Russia, including a disproportionate share of Ukraine's manufactured exports, and 31% of its imports were from Russia.<sup>12</sup> No other single country has such a big role in Ukraine's external trade. Many of Ukraine's oligarchs depend on business with Russia for their continued dominance of particular firms or industrial sectors. And there are Russian interests with stakes in Ukrainian enterprises as well.<sup>13</sup> These continued ties with Russia mean that custody of the economy and other resources is contested not only militarily on the ground, but also in board rooms and voting booths.

The political instability and policy division that results from this history helps explain why major reform of a key part of the social safety net – health system reform- has been difficult to advance. Instability also constitutes a significant constraint going forward.

In the absence of post-Soviet institutional reform, Ukraine's economy came to be dominated by regionally-based business interests, each led by “oligarchs” at whom it is facile to point in explaining Ukraine's woes. The political contests between Presidents Yushchenko, Yanukovich and Poroshenko are often described as battles among oligarch groups, with one elite replacing another when power changes hands and redistributing political and economic spoils, but affecting little reform of any substance. Prior to Euro Mайдan, the deep cynicism among citizens that this has bred acts as a damper on deeper citizen engagement (in contrast to the narrower, committed civil society groups). On the other hand, abysmal performance and corruption by a series of governments has led to eruptions of citizen discontent: the Orange Revolution and the more recent Euro Mайдan being most notable. The question to be

---

<sup>8</sup> Remarks of David Lipton at the Peterson Institute April 10, 2015.

<sup>9</sup> World Bank Development Indicators, 1991 and 2013, <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD>

<sup>10</sup> “Linguistic composition of the population,” State Statistics Committee of Ukraine, 2001 census, <http://2001.ukrcensus.gov.ua/eng/results/general/language/>

<sup>11</sup> “Ukraine picks Shell, Chevron to develop shale gas fields,” Reuters, last modified May 11, 2012, <http://www.reuters.com/article/2012/05/11/shell-chevron-ukraine-idUSL5E8GBAE020120511>

<sup>12</sup> “Observatory of Economic Complexity: Ukraine Profile,” MIT Media Lab Macro Connections, accessed April 20, 2015, <https://atlas.media.mit.edu/en/profile/country/ukr/>

<sup>13</sup> Richard Balmforth and Natalia Zinets, “Ukraine challenges oligarchs’ grip on energy companies,” Reuters, April 7, 2015, <http://uk.reuters.com/article/2015/04/07/uk-ukraine-crisis-oligarchs-idUKKBN0MY1OG20150407>

answered by the Poroshenko government is whether the current moment is like prior shifts among the elites or whether long-overdue reforms, including of the health system, can be pushed through and institutionalized.

One unmeasured factor in this equation is the effect of the current conflict and economic downturn on various oligarchs. As their firms or markets are disrupted, will enough of them see their interests advanced by a more predictable, rule bound state that is more accountable to its citizens and less prone to mass protests and better able to integrate, indeed to compete, in international markets? Several oligarchs whose strength came from their interests in the Donbass, or Crimea have interests very different from those who see their future in integration with Western finance and investment systems. The weakness of the currency and the collapse of trade with Russia likely weaken all oligarchs, though some more than others. Whether this vacuum leads to consolidation of oligarch interests or to the assertion of a more rule-based application of state authority is a significant uncertainty affecting every Ukrainian, including planners and policymakers concerned with health systems and TB.

#### *Institutional Country Factors:*

A by-product of the consolidation of political and economic power has been weak development of horizontal and vertical institutions of constraint on government arbitrariness or opportunism by those in power with connections to economic actors. Parliament has not been a source of reform leadership or a force for more focused oversight on the effectiveness and efficiency of government programs, including health care. Various anticorruption bodies proposed or established have not yet proved effective. Ukraine has reliably ranked in the bottom fifth of international corruption rankings.<sup>14</sup> Patients exposed to demand for side payments from health workers or hospitals have little recourse. Overpayment for drugs that are purchased using irregular and non-transparent procurement processes taxes the health budget even while it leaves shortages and misallocations (more on this below).

In contrast to neighboring Poland, courts in Ukraine have not yet evolved into independent arbiters of the limits of state power vis-à-vis citizens, or as disinterested providers of dispute resolution among economic interests. This means that citizens and firms lack recourse for administrative abuses, that the state is a weapon to be used in commercial competition rather than a protector of market integrity. This has constrained innovation of many types, including in health care. Establishing any competitive model of health service delivery or an insurance mechanism requires an infrastructure of legal flexibility and dispute resolution that can lend predictability to all parties whose funds are at risk, or who might be expected to use the services. Even any public-private partnership rests in large part on the ability to contract for performance over an extended period. The paucity of reports of health service innovation that we observed or heard about partially a reflection of this undeveloped commercial institutional

---

<sup>14</sup> “Corruption Perceptions Index 2010 – 2014 Results,” Transparency International, accessed April 20, 2015, <http://www.transparency.org/research/cpi/overview>

infrastructure--though it is also the case that the growth of private service provision models has also been constrained by continued high levels of poverty, which would limit the ability of much of Ukraine's population to pay for services even if a private system were available.

*The "here and now":*

The 2004 Orange Revolution called for an internationally monitored vote that brought Viktor Yushchenko to power with a reform agenda.<sup>15</sup> The revolution resulted only in a change in elites and civil society groups; the Yushchenko administration was paralyzed by infighting between the President and Prime Minister Yulia Tymoshenko, and the nascent middle class and small-to medium sized enterprise sector did not have enough clout to sustain pressure for democratic reforms.<sup>16</sup> In 2010, a disgruntled electorate rejected Yushchenko at the polls; he failed to pass the second round. In the second round, Viktor Yanukovich, whom Yushchenko had defeated five years earlier, was elected President in an election widely seen as free and fair. His administration pushed to abolish the 2004 constitutional amendments limiting the power of the president (and strengthen that of the parliament), and he did much to recentralize power in the central government and in the presidency in particular. Government corruption, already a massive problem, increased further still and 2012 parliamentary elections were once again held to have been manipulated by the presidential administration. After having entered into discussions with the EU on an Association Agreement that would have substantially furthered the European integration of Ukraine, in November 2013 Yanukovich suddenly turned down this agreement in favor of an economic pact with Russia. This set into motion a series of large public protests against the president around the country (known as the "EuroMaidan"), where Yanukovich's opponents also strongly criticized the corrupt nature of his administration.

After Yanukovich instituted draconian anti-protest laws and used lethal force against the protestors during the first two months of 2014, many of Yanukovich's supporters abandoned the Party of Regions and he fled to Russia; the parliament soon voted to remove him from office. In the aftermath of his removal, Russia's annexation of Crimea has sparked armed conflict between Russia and Ukraine, which has further escalated with Russia's sustained support for a separatist movement in the east of the country.

The effect of massive government corruption--Yanukovich affiliates are estimated to have stolen up to \$100 billion during his regime--political disruption, and ongoing armed conflict has crippled the Ukrainian economy and caused massive currency devaluation, severely affecting the Government of Ukraine's ability to fund sectors outside of defense. Ukraine's per capita GDP is projected to be approximately \$1900, only 50% of that achieved in 2013.

---

<sup>15</sup> "The World Factbook: Ukraine," CIA, accessed April 20, 2015, <https://www.cia.gov/library/publications/the-world-factbook/geos/up.html>

<sup>16</sup> Andrew Wilson, "Ukraine: Political and Economic Lessons from Democratic Transitions," Council on Foreign Relations, last modified June 18, 2013, <http://www.cfr.org/democratization/ukraine/p30818>

As mentioned above the resulting economic downturn affects all sectors of Ukraine, including health care. The rising costs of gas affects all health facilities, which are required to fund the full cost of utilities as a mandatory budget line item. Uncertainty and rising cost of imported goods all press households as well, making the usual requirement of side payments all the more burdensome for many. The precise effect on access to services is not known. However one study found that 60% of patients in Ukraine, pre-crisis, did not seek treatment on account of their inability to make informal payments to doctors and hospitals.<sup>17</sup>

This situation has left the country in turmoil, but there are openings presented by the current crises as well.

- The conflict with Russia has created strong patriotic feelings across Ukraine and a renewed urgency to adopt reforms that will lead to Ukraine's integration into Europe. A presidential election in May of 2014 resulted in the election of Petro Poroshenko with 54.7% of the vote, and parliamentary elections in October 2014 brought in significant numbers of reform oriented politicians. This new parliament has ratified a new Prime Minister who has subsequently formed a new government, and a parliamentary vote reinstated the 2004 constitutional amendments, which had previously been removed under Yanukovich. The President is trimming the impunity of some autocrats.
- There is a new government and a new Minister of Health. The Minister of Health, imported from Georgia, is not tied into existing commercial interests, and has a vision for a series of bold reforms.
- President Poroshenko has stated that decentralization is a top priority for him. A well designed decentralization plan could help to dismantle the vertical power structures that have been the primary forms of political power since independence. Depending on the details of the decentralization adopted, many of the existing disincentives built so deeply into the health system can be eliminated or reduced, and local or oblast officials empowered and made accountable for delivery services. Furthermore, decentralization that encourages local variance and is based in locally driven initiatives will be critical politically in re-uniting Ukraine in the aftermath of the divisive conflict that continues in the east of the country.<sup>18</sup>
- The Rada has demonstrated that it can address some reform issues. The adoption of a law on international procurement of TB drugs is a notable example.
- Citizen groups are monitoring government performance and more actively engaging with Parliament, particularly in the post-Maidan era. The adoption of the Law on International Procurement is a recent example of the potential.

---

<sup>17</sup> Tambor, Marzena; Mielna Pavlova; Bren Recehl; Stanislaw Golinowska; Christoph Sowoda and Wim Groot, "The inability to pay for health services in Central and Eastern Europe: evidence from six countries," *European Journal of Public Health*, Vol 24, No. 3, 378-385 (2013)

<sup>18</sup> Dr. Sean R. Roberts and Dr. Oleksandr Fisun, "Local Governance and Decentralization Assessment: Implications of Proposed Reforms in Ukraine," USAID, September 3, 2014, <http://www.usaid.gov/sites/default/files/documents/1863/LOCAL%20GOVERNANCE%20ASSESSMENT%20FINAL.pdf>

- Ukraine's fiscal straits leave it dramatically open to suggestion from its international creditors, current and proposed, mainly the IMF. If the terms of on-going support are realistic and targeted at a narrow set of feasible structural reforms, this weakness can become strength in a health reform strategy.
- There are new sources of data on health service delivery, health outcomes and health spending, many within the reach of donors who have supported them. With data, advocates in Ukraine and those who support them can establish politically relevant facts that can motivate and steer attention to TB and wider health reforms.
- The World Bank and the Government are launching eight pilot programs to test and advance reforms of key health system components. These can shine a bright light on existing problems and the feasibility of specific changes in finance and management of health services.
- Some patient rights advocates have found recourse in courts to address lack of treatment, arbitrary denial of services, or demands for bribes. The anecdotes do not rise to the frequency needed to be data, but these reports suggest an opening.

None of these openings present a simple, or isolated, opportunity to change the context for health services in Ukraine. There is no existing coalition of non-governmental stakeholders coordinating strategy and efforts to hold government accountable. Health is but one of more than 20 priorities for the donor-supported Reanimation coalition of civil society groups. Indeed the one organized outside-of-government example we observed of collective action related to health reform was a protest outside the Kiev Administration building by health workers who were opposed to reform. While concerns about health poll as a high concern of Ukrainian citizens, mechanisms for focused collective action do not exist. Many of the recommendations at the end of this report respond to this observation.

#### *Ukrainian Health System and TB Services:*

The Ukrainian health system has preserved the fundamental features of the Soviet Semashko<sup>19</sup> system. The Semashko model was built as a multi-tiered system of care with a strongly differentiated network of service providers, where each of the five levels corresponded to the severity of the disease (district, central *rayon*, municipal, *oblast* and federal hospitals) and these were all connected by a sound referral system. This model made it possible to integrate the activities of other medical services and was very efficient in the economic sense at the time: low cost, health-care coverage could be universal and was rolled out to everyone free of charge. Over time the focus on input based budgeting led to a system that over-emphasizes tertiary and inpatient care relative to primary and preventive care.<sup>20</sup> Inflexible line-item budgeting left local health officials with almost no discretion to adapt to the needs of patients. Budget transfers to health facilities are made based on the number of beds in the facility, and within facilities line items for staff salaries and utility payments are required to be made first.

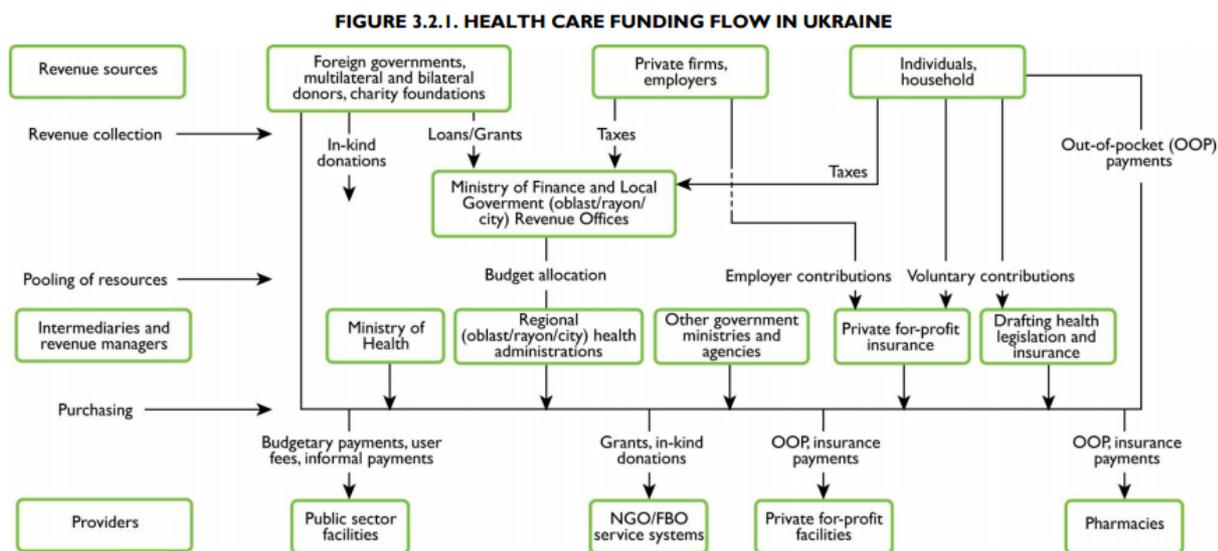
---

<sup>19</sup> Nikolai Semashko (1874-1949) People's Commissar of Public Health in the USSR 1918-1930.

<sup>20</sup> "Ukraine Health Systems Assessment," USAID, 2011, pg. 25.

Thus, the current budget and payment system is based upon strict input norms, leaving little flexibility to address the needs of patients, the quality of care or the changing health profile of the population; there are also decrees limiting the ability of chief physicians to hire certain types of personnel, a limitation that poses particular challenges for effective TB care and treatment, as will be discussed further below. Additionally, the incentives generated by the current input-based financing system have bloated Ukraine’s health infrastructure; the Ukrainian health system currently maintains 5.4 hospitals per 100,000 population, compared to 2.6 in the EU and 2.2 in Poland.<sup>21</sup> Further, the Semashko system did not provide effective financial incentives to medical personnel: jobs were guaranteed by the state (no unemployment); and salaries were extremely low.

Health facilities in Ukraine are now functionally subordinate to the Ministry of Health, but managerially and financially answerable to regional and local self-governments, which has constrained the implementation of the health policies developed by the Ministry of Health and fragmented health financing among multiple levels of government as well as among institutions and facilities at each of these levels. Despite this fragmentation, Ukraine’s health system remains an overwhelmingly public sector-dominated model. While private sector health care has begun to grow since 1991, with the exception of the pharmaceutical industry, the private sector remains a relatively insignificant part of the overall health system due to the cost of private care, a largely undeveloped private health insurance market, the absence of a system to enable public contracting of medical services to private practices, and a taxation system that discourages private practice.<sup>22</sup>



Source: HSA team  
 Note: OOP = out-of-pocket, FBO = faith-based organization

Health care expenditure in Ukraine is low by regional standards and has not increased

<sup>21</sup> “Ukraine Health Systems Assessment,” USAID, 2011, p.44.

<sup>22</sup> *ibid.* p 44.

significantly as a proportion of gross domestic product (GDP) since the mid-1990s; expenditure cannot match the constitutional guarantees of access to unlimited care. Out-of-pocket payments account for 42.8% of total health expenditure.<sup>23</sup>In reality, the state often does not provide sufficient funding. As a result, physician wages are extremely low, and set according to specialization and seniority rather than on a case-based system, informal payments are common and the quality of care has dropped substantially since the early 1990s, attributable at least in part to the lack of remuneration for effective care and treatment.<sup>24</sup> While many in the population strongly believe that health care must be free, widespread pressure for reform of the current patchwork of state based and informal payment systems is scant. Some reforms have been made in past 25 years but they are not comprehensive, and Ukraine still has not rationalized resources to identify cost efficiencies and incentivize results based program budgeting to address the needs of the population.

---

US-educated Alexander Kvitashvili, who reformed Georgia's healthcare system, was appointed health minister in December 2014, becoming Ukraine's fourth Minister of Health in two years. Kvitashvili came into office with the promise to reform healthcare management, optimize hospital networks, and to introduce initiatives on procurement of pharmaceuticals. He has identified transformation of the country's health system and the Ministry of Health from post-Soviet models to Western models that reflect best-practice medical norms and professional standards as an urgent priority. To push forward reforms, the Minister will need a strong team of deputies. In late December, the Cabinet dismissed then-first Deputy Minister Vasyl Lazoryshynets and appointed a respected trial lawyer, Oleksandra Pavlenko, as new First Deputy, which could represent the potential for future reform--or at the least a balancing of political interests.

In March 2015, a draft law on international procurement of pharmaceuticals related to HIV and TB was approved by the Cabinet of Ministers and passed through a first reading of Ukraine's Parliament (*Verkhovna Rada*). The draft law will allow for the transfer of national procurement of drugs and vaccines to international organizations such as WHO and UNICEF<sup>25</sup>. This is expected to reduce costs, improve the reliability of supply and remove one source of corruption for this set of drugs (though only about three percent of total pharmaceuticals used in the Ukraine health sector are procured at the national level, 100% of TB pharmaceuticals are procured at the national level),

#### *Informal Payments:*

“Under-the-table”, “envelope” payments, “bribes” and “corruption” became common labels for “gratitude” money to physicians and others in the healthcare system. Informal patient

---

<sup>23</sup> World Bank Development Indicators, 2013, <http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS>

<sup>24</sup> Tetiana Stepurko et al., “Informal payments for health care services: The case of Lithuania, Poland and Ukraine,” *Journal of Eurasian Studies* 6:1 (January 2015), pgs. 46-58, <http://www.sciencedirect.com/science/article/pii/S1879366514000244>

<sup>25</sup> “For the first time the medicine in Ukraine will be procured through international organizations,” *Patients in Ukraine*, February 9, 2015, <http://patients.org.ua/en/2015/02/09/for-the-first-time-the-medicine-for-ukraine-will-be-procured-through-international-organizations/>

payments include cash or in-kind supplements to the official payment for health care services including commodities, such as pharmaceuticals and materials. Previous studies have provided evidence on the variation of payment types (cash or in kind gifts given by patients or their families), timing (before, after or during service provision), subject (out- or in-patient service), purpose (obtaining better quality or access), and motivation (physician's request or patient's initiative). Informal patient payments include contributions to publicly-funded health care providers. Typically, the following patterns of under-the-table payments are observed: (a) expensive cash ex-ante payments paid for in-patient care, e.g. surgery or childbirth, which were expected by provider; (b) ex-post gifts in kind of a symbolic value given to out-patient care providers and initiated by the patient; (c) moderate payments initiated by the patient in order to improve health care service attributes and a variety of other combinations, or d) payments for pharmaceuticals not in supply at clinics but available at private pharmacies, sometime run by the very physicians do the referring. Although the existence of informal payments is publicly known, the specific informal transaction takes place in secret.<sup>26</sup> The “informal” system is in truth quite formal in that it is well established and widely applicable. While informants noted that informal payments were challenges for the health sector as a whole, the PEA team did not hear that payments were routinely solicited among TB patients, due at least in part to the socioeconomic status of these patients, as discussed further below. Nonetheless, the team did hear about the solicitation of payments for pharmaceuticals that are required to be provided free of charge during periods of stock outs.

Informal payments are expensive in Ukraine. A 2013 study found that for those who made payments, the costs represented 7.8% of median family income – a rate 2-4 times as high as patients in other Central and East European Countries.<sup>27</sup> More shocking findings from the same survey, which polled 1000 people in Ukraine, found that 60% of actual and potential users of the health system forewent services altogether on account of their inability to afford the side payments. This suggests that the challenge in Ukraine is not simply to improve the care of those who are in the health system, but to ensure the care of a potentially very large number who do not avail themselves of services at all, or only in crises. The inability to pay disproportionately affects women and young people’s use of primary care.<sup>28</sup>

#### *Tuberculosis in the Healthcare System:*

Ukraine is a World Health Organization (WHO) priority country in the European Region for tuberculosis (TB) control and is among the highest drug-resistant TB burden countries in the world. The WHO estimates that in 2013, TB incidence, prevalence and mortality rates were 96, 120, and 14 per 100,000 population respectively. Fourteen percent of the newly detected TB cases and 32% of the previously-treated TB cases have multi-drug resistant tuberculosis

---

<sup>26</sup> Tetiana Stepurko et al., <http://www.sciencedirect.com/science/article/pii/S1879366514000244>

<sup>27</sup> Tambor, Marzena; Mielna Pavlova; Bren Recehl; Stanislaw Golinowska; Christoph Sowoda and Wim Groot, “The inability to pay for health services in Central and Eastern Europe: evidence from six countries,” *European Journal of Public Health*, Vol 24, No. 3, 378-385 (2013)

<sup>28</sup> Id. pg. 383.

(MDR-TB), raising the number of new MDR-TB patients in need of treatment every year in the country to over 9,000. The majority of TB patients are male, over half are under 49 years of age, over 70% are unemployed, and the majority reside in urban areas. The incidence rate in penitentiary institutions is 3 to 4.5 times higher than the civilian sector. South-eastern Ukraine, which has a large number of penitentiary institutions, has higher incidence rates.<sup>29</sup> The burden of co-infection with TB and human immunodeficiency virus (HIV) is high (16/100,000 population) in 2013 and is disproportionately concentrated among socially marginalized populations including injecting drug users (IDUs), sex workers, and prison populations. TB-HIV co-infection can substantially influence mortality; approximately 40% of AIDS deaths in Ukraine are associated with TB.<sup>30</sup>

TB service in Ukraine is organized as a vertical system comprising a large network of specialized institutes, dispensaries, hospitals, outpatient clinics, sanatoria and rural operations. A deputy minister of health and the Ukrainian Center for Socially Dangerous Diseases of the Ministry of Health (UCDC) have the lead responsibility for TB. As of April 2015, the head of the UCDC became the national TB program (NTP) manager; prior to that, there was no NTP manager. The State Sanitary Epidemiological Service, a separate vertical structure, is responsible for data collection, surveillance and monitoring of Bacille Calmette–Guérin (BCG) vaccination.<sup>31</sup> TB services for the military, the prison system and Ukraine’s railways authority each have their own vertical organizations.

In 2014 there were 81 dispensaries (67 with inpatient facilities) and 33 adult TB hospitals with approximately 4085 dedicated TB beds, and two TB hospitals for children with 200 beds. But, as with the rest of the health system in the Ukraine, much of the infrastructure for TB control needs capital investment for rationalizing and upgrading. Some TB facilities, which lack basic amenities such as heating, create very poor working environments for health workers who have low salaries (about 50% less than the average salaries in other sectors). Although health workers in the TB control system receive a 30% increase in their salaries to compensate for working in a “risky” environment, the absence of any other incentives, such as ongoing training or housing support, means attracting a new generation of workers to the TB system is difficult. In 2014 approximately 355 health professionals contracted tuberculosis.<sup>32</sup>

#### *TB Diagnosis and Treatment:*

TB cases are identified by active and passive case-finding. Diagnosis still relies on mass screening of the population by X-ray, which is unreliable, and clinical evidence and sputum

---

<sup>29</sup> MEASURE Evaluation. Strengthening Tuberculosis Control in Ukraine. Impact Evaluation Baseline Survey, Ukraine 2014. Chapel Hill, NC: MEASURE Evaluation; 2015.

<sup>30</sup> Id.

<sup>31</sup> Rifat Atun and Igor Olynik, “Resistance to implementing policy change: the case of Ukraine,” *Bull World Health Organ*, 86:2 (February 2008), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647377/>

<sup>32</sup> Citation: MoH Annual Informational Bulletin, 2015

smear examination by direct microscopy in suspected cases. The continued practice diagnosis following an x-ray screening remains an issue; in addition, the practice of conducting sputum smear microscopy on a monthly basis creates a high volume of work for under-resourced laboratories, leading to poor-quality microscopy and low yield. General practitioners who work in polyclinics are responsible for screening and referring suspected cases to TB specialists at TB dispensaries, then to TB hospitals. This results in delays between detection and treatment, during which some patients drop out of the system.

Once diagnosed, WHO guidelines for TB care and treatment are not always implemented, especially during periods where there are drug stock-outs. Patients are treated using a variety of TB drugs, regimens and additional drugs to reduce side-effects or boost immunity, not all of which are consistent with WHO guidelines. As fixed-dose combinations are not used to rationalize the number of drugs taken, adherence is a problem. Over 90% of patients are admitted to hospital for the initial phase of treatment. While generally sputum smear-positive cases admitted for a period of 60–120 days, in Kirovograd the team was told that in some cases smear-positive patients with adequate housing and means may be released for outpatient care. During inpatient stay drug intake is not directly observed. Up to 5% of the admitted patients have surgical interventions to treat TB. Once discharged from hospital, patients are referred either to the network of TB dispensaries and clinics or to the primary health system for the continuation phase of treatment. TB patients are deemed cured when they have a negative sputum smear examination, when X-ray cavities have closed (or are static) and when general clinical parameters are stable. Most of these patients are monitored for a minimum of three years but some for longer periods of ten years or more, as are patients with inactive TB. These practices vary from internationally recommended practices.<sup>33</sup>

#### *Donor Engagement:*

USAID-supported projects have focused on expanding availability and improving quality of DOTS services for TB patients, while concurrently working at the policy level to create a service environment with fewer barriers to accessing high quality case detection and treatment. According to PATH, one of USAID's implementers, 50% of the population now has access to high quality TB care and case detection rates have increased to 73%, exceeding the minimum recommendations from WHO.<sup>3</sup> However, treatment success rates remain well below the 85% WHO recommendation and emerging MDR-TB and difficulty in treating TB/HIV co-infection have further complicated effective treatment.

At the national level, the lack of a common structure that bridges the various vertical reporting systems and program performance indicators makes data collection and analysis extremely difficult. USAID's supported e-TB Manager, a web-based tool based in UCDC for managing information needed by national TB programs, was highlighted as an improvement.

---

<sup>33</sup> Id.

The World Bank recently approved a \$214.73 million loan for the *Serving People, Improving Health Project* to support the implementation of reforms and improved service delivery in Ukraine's health sector. This project will focus on introducing new funding mechanisms with hospitals and enhancing primary and secondary prevention, early detection, and treatment of cardiovascular diseases and cancer in eight oblasts.<sup>34</sup>

Within USAID health is clearly an important program, with several programs addressing both HIV/AIDS and TB. However health reform is not a Mission priority. Individual experts have relationships with senior health officials, and are included in discussions of health reform, but those individuals have neither the time nor flexible resources to play an active role in supporting development of health reform strategy by Ukrainian reformers. Other USAID programs are not addressing health where it overlaps with their fields of activity. For example, projects dealing with Parliament, civil society, anti-corruption or local government all interact with issues faced in the health system. The obstacles to more effective cross-sector collaboration are not insurmountable, but are found in the momentum of project pipelines, competing priorities emerging from the country strategy, and perhaps, from uncertainty about specific opportunities for more effective coordination.

### **Questions for Field Visits:**

In the course of the workshop in Kyiv, the PEA team and a group of USAID project implementers and counterparts discussed a range of questions about current TB care, obstacles to improvement and openings for reform. These questions emerged from that discussion and guided the team's interviews with people visited in the field.

1. What are the current dynamics around TB care and treatment in the region?
  - a. How do you currently treat TB? Walk us through of how patient diagnosed and treated.
  - b. Do you have the staff to address TB needs? How many positions do you have? How many empty positions?
  - c. How do you fund treatment? From where do you receive funds? How do you receive them? How long do you have to spend them? How do you account for them? If you lack funding for things how do you deal with that?
  - d. How do you procure drugs? What do you do if you don't have drugs for treatment? Do you use the redistribution system?
  - e. How do you report TB diagnosis numbers? How do you use the data? Do you know if anyone else uses the data, and for what?
  - f. What are the challenges you face in applying protocols? How do you deal with these challenges?

---

<sup>34</sup> "World Bank Provides Support for a Healthier Ukraine," World Bank. March 4, 2015, <http://www.worldbank.org/en/news/press-release/2015/03/04/world-bank-provides-support-for-a-healthier-ukraine>

- g. What kind of ongoing training/mentorship are you receiving
  - h. What incentives can be provided within the current system to health professionals? Are doctors promoted for quality of care?
  - i. Are there any processes or institutions that do or could hold health sector accountable for effectiveness or quality of care?
2. What are the challenges and opportunities for improving TB care and treatment?
    - a. Have you heard about the proposed health care reforms being proposed in Kyiv? What do you think are the most important reforms that should be made to improve the quality of care?
    - b. Who do you think is interested in improving TB care and treatment? Who would oppose these reforms?
    - c. Why has the system proven so difficult to change, even as people say that reform of the health care system is a priority?
    - d. Do you think that there are opportunities in the current context to improve the TB care system? What are these opportunities?

#### 4. Findings from Field Visits

In addition to interviews of Kyiv-based organizations, the team visited a series of officials, health care workers, patient rights groups and patients in Poltava Oblast and Kirovograd Oblast. The following sections detail the outcomes of those interviews.

In general, we found that health professionals understand TB care protocols issued in 2014 that require that TB patients should be discharged from in-patient care once they are sputum-negative and transitioned to outpatient care. Several informants had visited TB facilities in other Western countries. The main gap that gives rise to low implementation of the WHO protocols lies in the resources, incentives and discretion available to deliver world-standard care.

##### *Poltava Findings:*

*Orientation:* Poltava is an oblast (sub-national administrative region) located in the center of Ukraine, approximately 210 miles from Kyiv. It is relatively wealthier oblast in Ukraine due to being a major processor of oil and natural gas. It also processes iron ore and is home to a large number of small and large industrial and agricultural organizations.

*Health overview:* The Oblast Department of Health is responsible for ensuring the administration of key Ministry of Health policies, standards and protocols at the sub-national level, including tuberculosis detection, treatment, and care. The Poltava Department of Health manages 54 separate legal facilities that provide health care, as well as specialized health treatment facilities, which includes specialized TB treatment facilities.

*Tuberculosis Overview:* Poltava Oblast has 3 TB dispensaries with 200 beds; two adults sanatoria with 220 beds; one pediatric sanatorium with 50 beds and 25 TB *cabinets* in other medical facilities. There were 786 new TB cases registered in Poltava in 2014 (compared with 878 in 2013). The TB incidence rate in 2014 was 54.9 per 100,000 (nationally – 54.9 %). Treatment outcome data among new smear-positive cases from cohort analysis in 2013 showed a 67.1% success rate, higher than the national rate of 62.6%; a death rate of 17.4 % compared to 15.5% nationally; a failure rate of 6.4 % (9.1% nationally); and a treatment interruption rate of 5.2 %, (7.9 % nationally).

While in Poltava, the team met with the Oblast Health Administrator (a former Deputy Minister of Health), the Oblast TB Program Director, the Kremenchuk Rayon Health Administrator, as well as a number of staff from the Poltava Oblast Health Department to gain an understanding of oblast health administration procedures, which included funding flows from the central to sub-national structures, decision-making on program priorities, and the level of discretionary authority that oblasts have to address public health priorities within their regions. Further, the team met with the Ukrainian Red Cross and Light of Hope, leading NGOs in Poltava that provide social support services to TB patients.

A number of key informants within the USAID/Ukraine health program, as well as USAID's health implementing partners and the UCDC cited Poltava has having a more successful transition to ambulatory care for treating tuberculosis patients in line with internationally recommended practice. Several enabling factors were identified for this adoption of primary care management of tuberculosis cases outlined below.

*The Importance of Politically Connected Champions to Bolstering the Role of the Primary Health Care Network in Treating TB:* The Poltava Health Department undertook an important decision in 2012 to delineate roles between primary and secondary care, setting aside oblast-level funds to support the implementation of primary health care services, including allocating 30% of oblast-level expenditures to support primary health in rural areas. These moves demonstrate a notable prioritization of primary health care within the Poltava oblast administration compared to other regions. Furthermore, the Oblast Health Administrator, a former Deputy Minister of Health, utilized his existing influential networks within the Oblast Administration to establish a "Gentlemen's' Agreement," which enabled Poltava to exercise discretionary authority to cut the number of beds in TB specialized facilities, and to maintain access to this funding and redirect it to operate health facilities within the oblast. As a result of this agreement, previous financial incentives to hospitalize TB patients in order to secure consistent funding levels based on the number of occupied hospital beds/health facility were disabled. Poltava was able to use the cost savings generated from cutting 200 beds in TB facilities (from 849 to 645 beds) to transition TB detection, treatment, and care to the primary health care network. It is important to note, however, that this agreement was made only for the current year; it was not clear whether similar arrangements would be possible in future years.

Recognizing the importance of changing long-existing popular perceptions of poor quality of care at primary health care facilities and over-reliance on assigning TB patents to tertiary facilities, Poltava also invested in a communications strategy aimed at reaching the public as well as health providers to build support for considering primary health care as the main entry point for health care services. Both the Oblast Health Administrator and TB Program Director attributed Poltava's successes to investing in a communications manager who conducted varied outreach activities to change long-standing norms.

*Investment in Social Support Networks:* The second factor contributing to Poltava's relative success has been recognition that social services need to be a part of successful TB treatment. Providing psychosocial care and support, as well as extending access to linkages for legal and nutrition support services for TB patients is critical to promoting adherence for the often arduous TB treatment regimen, particularly given the often socially marginalized profile of TB patients. In addition to funding made available for social services by the Global Fund, the Poltava Health Department also leveraged funding it had available within its budget to establish *social contracts* with the Ukrainian Red Cross and Light of Hope to provide a range of community-based support services, and has partnered with these NGOs to reduce barriers to care for TB patients. These activities included shelters for recently released prisoners with TB, economic empowerment training for beneficiaries given often high levels of unemployment among TB patients, and linkages with HIV and drug substitution therapy programs. In particular, both NGOs highlighted the critical role that social mobilization and support services play in bolstering patient adherence to TB treatment, namely nutritional support and psychosocial support visits from nurses. NGOs however expressed that giving the mounting number of internally displaced people in Poltava due to the war in Eastern Ukraine (an estimated population of 26,000), many challenges remain to provide services to vulnerable populations. Oblast health officials referenced Decree 33, which limits chief physicians' ability to hire certain types of personnel (such as social workers) as an obstacle that inhibits the expansion of social support services.

*Locally driven solutions to improve health:* At the regional level, respective sub-national line ministries can submit requests to Oblast Councils in order to secure additional resources to address resource shortfalls in regional programming. The Poltava Health Administration utilized this mechanism to secure \$100,000 to procure first-line TB drugs in 2014, during national-level stock-outs of first-line TB drugs. The Poltava Health Administrator indicated that in the past year, they secured an additional 34 million hryvnia from the oblast council, which was allocated towards creating a central dispatching unit for ambulances, as well as procuring diagnostic and oncology equipment. These commitments indicate that at least in Poltava the Oblast Council is a potential partner in identifying local resources to finance health priorities. We did not assess the fiscal capacity of other oblasts to undertake similar initiatives. It is worth noting that 2015 changes in the local tax law could provide additional opportunities for strengthening Poltava's TB program. This law enables local tax revenue to remain within the oblast budgets to fund regional priorities, such as the health sector.

### *Kirovograd Findings:*

*Orientation:* Kirovograd is an oblast (sub-national administrative region) located in the center of Ukraine, 185 miles southeast of Kyiv. The oblast has a population of approximately one million people, including 8,500 internally displaced persons (IDPs) from eastern Ukraine. Kirovograd's economy is largely agricultural, as well as food processing, mining, and some manufacturing. Kirovograd City, the oblast center and seat of government for the region, has a population of approximately 240,000 residents.

*Health Overview:* Kirovograd Oblast manages 122 medical institutions, including 37 hospitals; 12 dispensaries; 33 independent outpatient clinics; 6 dental clinics; 3 health centers; and 3 ambulance stations.<sup>35</sup> In total, the oblast maintained 8412 beds, or a ratio of 86 beds per 10,000 residents.<sup>36</sup> There were 32.5 physicians per 10,000 residents.<sup>37</sup> Only two-thirds of all physician positions were filled in Kirovograd oblast, with 17 rural clinics having no full-time physician at all.<sup>38</sup>

*Tuberculosis Overview:* In 2014, Kirovograd saw 774 new cases of TB, up from 763 in 2013. The TB incidence rate in 2014 was 78.9 per 100,000 population, 33% higher than the national rate of 59.5 per 100,000 for Ukraine. Treatment outcome data among new smear-positive cases in 2013 showed a 69.3% success rate, better than the national rate of 63.1%; a death rate of 12.5% compare to 15.5% nationally; a failure rate of 8.4% (9.1% nationally); and a treatment interruption rate of 7.7%, about equal to the national rate of 7.9%. To treat TB, the oblast has 1 oblast TB hospital, 4 TB dispensaries, and 18 TB clinics (one per Rayon).

*Awareness, Knowledge and Positive Attitude toward Reforms:* Among all stakeholders there was an evident awareness and knowledge of the new TB protocols, including outpatient protocols. Respondents also showed a positive attitude towards the protocols, noting that “Kirovograd is unique [in implementing out-patient care even before Kyiv introduced the protocols]”. As a result of the early implementation of out-patient care, respondents felt they had more experience and expertise in the approach. At one clinic, doctors recalled that a DOTS-like system was in place during the Soviet era, thus they were well acquainted with the approach. Officials also expressed an appreciation for greater health care reform, with Oblast-level officials stating “We cannot just focus on TB, but we need to focus on the holistic health care system reform designed to deliver results for patients, not just consume funds.”

Translating the positive attitude expressed by officials at the Oblast and local levels into concrete action was evident in several instances. In 2014, Rayons reportedly contributed

---

<sup>35</sup> Kirovograd Health Resources in 2014, <http://health.kr-admin.gov.ua/index.php/ofijna-informatsiya?task=view&id=060>

<sup>36</sup> Id.

<sup>37</sup> Id.

<sup>38</sup> Id.

10% more than was planned for TB budgets, showing level of commitment to fund the health sector. In 2012, the Oblast Administration used its own-source funding to procure x-ray and fluorography machines for every Rayon hospital to ensure standardized diagnosis of TB at the local level, demonstrating political will to prioritize and fund TB treatment.

*Ambulatory Care in Practice:* It was reported that the majority of non-MDR-TB patients in Kirovograd are not hospitalized, but undergo outpatient DOTS through local TB dispensaries. Even some smear positive and MDR-TB cases are treated as out-patients if they are healthy enough and can visit the TB facility regularly, we were told. At two facilities, the PEA team heard a stated preference not to hospitalize patients if (a) the patient's health condition allowed ambulatory care; and (b) the patient had access to stable accommodation. At the Kirovograd TB Hospital we were told that in 2014, only 54 smear-negative cases were kept as in-patients either in the TB hospital or sanatorium because they were homeless. Hospitals also reported working closely with the Red Cross, the Church and CSOs to secure accommodation for homeless patients as an alternative to inpatient care (see below).

*Role of Primary Health Care:* In Kirovograd, TB specialists customarily performed all TB care through the TB system. Since launching the shift towards ambulatory care, however, primary health care (PHC) providers have a greater role in diagnosis and treatment. Initial testing is done at the PHC level, which then refers to the TB system for confirmation and consultation. Being colleagues, TB doctors reported good communication and relationships with their PHC counterparts, which lent itself towards more coordinated outpatient care. Nonetheless, there were challenges, discussed below, in implementing this shift.

*Role of Community Health Workers (CHW), NGOs, and Social Workers in Treatment:* Government CHWs and NGO Social Workers are critical parts of the TB system. In terms of treatment, CHW and social workers identify at-risk patients, get patients in for testing and treatment, and generally help patients adhere to their treatment protocol. In some cases, CHWs may bring medications to housebound patients, or bring patients' sputum samples from home to the lab for testing. NGOs and the Church are also instrumental in finding accommodation for homeless patients, thereby removing one of the major barriers to outpatient care. For example, the local Church in Kirovograd runs a homeless shelter and has agreed with the TB dispensary to accommodate some TB patients who otherwise would have remained in hospitals or sanatoria. The Red Cross in Kirovograd is also providing food packages to patients, which they consider to be a positive incentive that has increased adherence. The Red Cross would like to increase the frequency of food packages, and expand from food to vouchers redeemable for non-food items. Overall, respondents felt that social workers, CHWs, the Church and NGOs were critical to providing holistic care and helping patients overcome the social barriers to adherence, though current funding could not keep pace with the demand for services. The PEA team was told that the food package distribution program was quite limited; the Global Fund was funding the distribution of food packages only for 136 MDR-TB patients, and the Network of People Living with HIV/AIDS were providing food package distribution only in Kirovograd city.

*Advocacy in Policy-Making, Budgeting and Oversight:* Several NGOs providing services to patients were also engaged in advocacy efforts. Social workers and legal assistants advocated on behalf of individual patients to help them access medical and social services, register for benefits, and navigate the TB bureaucracy. Local NGO service providers also engage regularly with TB system administrators and doctors on access to care issues. Collective advocacy at the Oblast level was also evident, with NGOs participating in, for example, the Oblast Government’s Health Council (which develops policy and budgetary recommendations). Some CSOs reported linkages to national-level affiliates, giving them a channel to inform national advocacy efforts. In regards to corruption, groups like Transparency International Ukraine are raising awareness generally about patients’ rights and how to avoid paying bribes to access health care.<sup>39</sup> In terms of inter-governmental advocacy, the Oblast government and TB doctors were consulted for comments on draft protocols and other proposed reforms, but lamented they would appreciate “better integration between those developing the protocols [in Kyiv] with those implementing them [in Kirovograd].”

*Creative Management of Drug Supply:* The central government manages the supply of first-line TB medications, and prohibits the Oblast or Rayons from procuring these drugs themselves. When there is a shortage or stock-out of medications, the Oblast or Rayon generally will request the central government to re-distribute drugs from another Oblast to Kirovograd. In 2014, when the central government drug procurement failed and the Oblast had no BCG vaccines, Kirovograd found a creative workaround to meet the very high demand for the vaccine from parents for their newborns: charitable foundations associated with health facilities procured the vaccine with “donations” collected from patients and provided the vaccine to the infants in need.<sup>40</sup> Oblast officials stated that if central government restrictions were removed then Oblast could better manage drug supply through local procurements with its own funding.

#### *Obstacles to Tuberculosis Reform Reported in Kirovograd*

*Economics:* Economic factors, including poverty, a low tax-base, the economic crisis, and corruption were all cited as obstacles to fully implementing tuberculosis and other reforms in Kirovograd. Although healthcare and TB were cited as policy priorities by the Oblast government, there is insufficient revenue to allocate funding for TB care given the Oblast’s revenue base and the economic crisis. This makes the Oblast heavily dependent on the central government, the Global Fund, NGOs and out-of-pocket payments (“donations” and private purchases) by patients to make ends meet in the event there are pharmaceutical stockouts. The economic crisis in Ukraine has led to staggering inflation and currency

---

<sup>39</sup> See, e.g., TI/Ukraine handout on navigating the healthcare system: <http://anticorruption.in.ua/instructions/ohorona-zdorovya>

<sup>40</sup> N.b. such charities are common in Ukraine and serve to cover unfunded needs, but also serve as a front for corruption; they solicit involuntary “donations” from patients, the proceeds of which are used for both legitimate expenses, such as medicines or vaccines, but primarily as bribes to doctors and those higher up the chain. For example, in Poltava City, 64% of such donations were unaccounted for.

devaluation, with a negative effect on TB care. For example, vendors do not want to lock into long-term supply contracts because of volatile price fluctuations in the market. Poverty in general, and among TB patients in particular, is another economic obstacle to adherence as patients struggle to secure housing, employment, or money for transportation, food, and medicines. Corruption, as in other sectors, further weakens health sector governance and accountability in general; however, corruption in the TB sector was reportedly less prevalent due in part to better enforcement of the government policy against informal payments within the HIV and TB sectors, but also due in part to the fact that patients were so poor they had no means to pay bribes or make “donations”; on the other hand poor patients suffered more because they could not pay out of pocket for second line drugs to treat MDR-TB. We did not independently verify this assertion.

*Personnel:* Several officials at the Oblast and local level cited the high number of staff vacancies as an obstacle to providing adequate care or implementing reforms. Kirovograd has some 300 vacancies for doctors across the Oblast that remain unfilled; in the TB system; out of 18 Rayons, 6 are without TB doctors. It was, however, observed that keeping unfilled positions on the budget could be a perverse incentive to divert those funds to doctors who were actually employed; as one informant noted, health personnel are entitled to fulfill the duties associated with an unfilled position and in turn receive 50% of the salary associated with that unfilled position. The lack of a medical school in Kirovograd meant that doctors must be recruited from outside the Oblast, which was difficult given the rural nature and low economic status of the oblast, lack of government accommodation, and other disincentives. In 2014, the Oblast attracted three new TB physicians; one of whom will likely stay as he married a local resident and now had family ties to the Oblast, but the other two were expected to leave for better offers in the near future. Without a medical school, it was also difficult to provide adequate professional development opportunities to health workers, such as cross-training PHC doctors in TB ambulatory care. The Oblast and Rayon/City administrators also cited central government restrictions that specify the number and kind of staff each health facility may hire (Order 129), which significantly limits the Chief Physician’s authority to allocate staff to meet actual health needs of the community. The risk of contracting TB is another disincentive for doctors to enter the TB System; Kirovograd has one of the highest rates of health care worker TB infection, 138.6 per 10,000 health care workers in 2014, compared to 84.8 for Ukraine nationally.

*Resistance to Ambulatory Care from the Primary Health Care System:* TB doctors and administrators remarked that they felt overworked, understaffed and under-resourced, and therefore they did not object to shifting outpatient care to primary care providers. They also noted, however, that PHC doctors were equally overworked and underpaid and therefore PHC doctors objected to being assigned increased responsibilities for TB care without additional incentives. TB doctors also noted that the lack of training in TB protocols among PHC doctors was another obstacle to full DOTS implementation in line with the new treatment protocols. Personal prejudices by PHC doctors against TB patients as being drug-

addicts, alcoholics, sex-workers, ex-convicts, homeless, or otherwise “undesirable” was another obstacle to getting PHC doctors to take on TB patients. Fear of TB infection and lack of effective controls on infection in PHC facilities was another disincentive among PHC doctors. Lastly, the perception that TB care is the sole responsibility of the TB system made it difficult to engage PHC doctors in outpatient care.

*Drug Security:* As noted above, drug security remained a significant obstacle to implementing TB care in general and out-patient care in particular. For example, from October 2013 through April 2014, there were no second line drugs available in Kirovograd, so the TB Dispensary could not accept new patients unless they could afford to pay out of pocket for medicines. Without second-line medications, TB patients suffer painful side-effects, which reduces their motivation to adhere to the treatment regimen. Local efforts to fix breaks in the supply chain are stymied by legal restrictions on what drugs may be procured by the Oblast or Rayon governments, as well as inflation and currency volatility. Attempts by the Oblast to use requirements contracts (also called “framework contracts”, or in USG terminology “indefinite delivery, indefinite quantity contracts”) to meet drug requirements are challenged by (a) lack of awareness among suppliers of how such contracting works; and (b) volatility in pricing. The BCG vaccine stock-out, cited above, is another example of how supply chain disruptions affect the care and cost of TB treatment and prevention.

*Weak Coordination & Collaboration:* While some coordination and collaboration was evident, such as between the Red Cross, NGOs and TB dispensaries, there were clear gaps in coordination. For example, while the government and NGOs are coordinating, the government is not funding NGOs to deliver social services (compared to Poltava, which had contracted the NGO Light of Hope to provide social services to vulnerable TB patients). In terms of inter-departmental coordination, Oblast health officials remarked that it was difficult to engage other Oblast departments, such as Social Affairs or Education, making it difficult to collaborate on social services for TB patients or public education campaigns on TB prevention.

*Advocacy & Collective Action:* NGOs were engaged in some advocacy and collective action at the local level in Kirovograd, and reported linkages to national counterparts; however, it seemed that much more could be done to mobilize, organize and push for full implementation of TB reforms. Patients in particular have very little collective voice themselves, relying on a small cadre of advocates to raise their concerns to policy-makers. Furthermore, the advocacy groups we met were focused largely on HIV-TB co-infected patients, leaving TB patients without HIV even less voice or representation; there was no apparent TB-specific coalition to represent the health and social priorities of TB sufferers broadly. Strong ties to national level TB reform efforts were also absent. Government officials told us they welcomed the input of advocacy groups as constructive in monitoring implementation and guiding new reforms.

## **5. Conclusions: Programming with PEA Findings**

**a. Key factors identified:**

**Our findings with respect to the health system echo many of the issues identified by prior health assessments such as the in-depth Health Systems Assessment conducted for USAID in 2011.** Our assignment was to dig more deeply into the systems of incentives that explain why so little has changed four years later, to ask, for every description of a health system weakness, “why is that so?” For the many experts we visited, the problems were all familiar, and indeed even the sources of inflexibility in the current system are well known to most. Our objective was to question what set of incentives or underlying conditions contribute to that inflexibility. The task was to quickly review relevant documents, supplement them with interviews in Kyiv and in two regions to inform judgments about the challenge facing Ukraine, and as well the challenges (opportunities) facing USAID.

In the material below we offer suggestions based on this 2 ½ week assessment. The conclusions thus reached build upon the work and insight of many others. We respect the considerable experience and perspective contributed by the many informants who contributed to our understanding. And we also recognize that there are several areas where designing actual program activities would require more gathering of evidence and building in systems of ongoing learning about evolving conditions in Ukraine.

**A complex problem:** The status quo for health services in Ukraine, including TB services, is very stable; it has been built over decades and consists of interwoven parts that provide reinforcing feedback to a wide range of health workers, administrators and policymakers. This has the effect of maintaining current re-distributional outcomes of the Semashko system: about<sup>41</sup> 40% of health spending in Ukraine’s constitutionally “free” health care is spent on transfers from patients and poor people to drug companies and health workers. The result is more expensive and lower quality care overall and dramatic health inequality. Savings from a reformed system could finance a good deal of improved quality if the incentives were different. The inequality produced by the current system is reflected dramatically in a 2010 study documenting that on account of their inability to pay the informal fees, more than 60% of patients avoid care altogether - from hospitals and doctors both.

The findings described earlier in this report describe an overarching problem in Ukraine that is hardly unique to the health sector - a lack of inclusive policymaking, of planning and budgeting and of implementation as well that results from broader political and institutional arrangements. It would be impossible to understand why the health sector has resisted prior efforts at modernization without having these arrangements in view. Similarly, it is impossible to consider even project-level efforts to improve health (or TB) services without an understanding of the how existing systems of political organization and action are

---

<sup>41</sup> 2011 USAID Health Sector Assessment, p 28,

intertwined with all levels of health (and TB) service provision. The main elements of the political and economic forces at work are well known and reported:

- Procurement of drugs and other consumables provide opportunity for enormous financial returns to oligarchs who use these resources not only to enrich themselves but to engage in political and informal activities that maintain the existing political and health systems.
- Health workers – doctors and nurses – are appointed, assigned and promoted within a set of arrangements, formal and informal, that make the costs of change very high for many, many participants, even those who readily recognize the negative health outcome impacts of the current system. Reports that some doctors must pay for their appointments assures that they have little choice but to continue their reliance on informal payments from patients.
- Health care is a state activity in Ukraine. Space for private sector innovators, or the growth of alternative models of finance and care are constrained to minor examples of companies contracting with private clinics or public facilities for health provision to employees.
- Because health care managers are responsible for managing inputs, not health outcomes, information systems and the resulting sets of financial incentives, formal and informal, have evolved without producing system-improving data.

The imperviousness of the status quo to seemingly sensible reforms depends on maintenance of a diverse set of poor public sector governance practices that affect many sectors, not only health.

- Lack of transparency about program and financial performance of programs, even while data exists within the health institutions.
- Limited effective role of vertical mechanisms of oversight, such as auditors, or law enforcement oversight of fraud, collusion or bribery.
- Weak horizontal controls as well: little parliamentary engagement in budget or program oversight and only anecdotal evidence of judicial engagement in protecting individual rights or adherence to administrative norms.
- Limited sustained indigenous civil society activism around public sector service provision. (Of course the events of February 2014 are the dramatic exception to this observation).

This list suggests that the technical or medical practice changes needed to improve health outcomes depend in significant part on a series of essentially political reforms at both national, local and sector levels, many of which are outside what we normally think of as the “health system.” Linear thinking about programs, such as “doctors lack training in x protocol,

so change the rule, train the doctors and evaluate their subsequent behavior” will not be sufficient for addressing the deep health and TB challenge in Ukraine. Our review found that health providers are aware of the protocols. Reforms that are political call on changes in complex systems where many important factors cannot be controlled and the entire path forward is not entirely clear at the outset. Our recommendations are made with awareness of these constraints in Ukraine, but also with the conclusion that there are openings in the current situation.

**“Improved TB care depends mainly on broad health reform.”** The need for progress on broad restructuring of the system of incentives was shared widely by the array of USAID program implementers with whom we spoke, as well as a variety of national civil society and service providing organizations. The USAID project implementers all work alongside clinicians and facility managers and have deeply informed perspectives. Their judgment impressed us: the priority action for improving TB outcomes was not simply a matter of more resources for their excellent projects, but required upsetting the Semashko system.

This broad assertion does not mean that there are not dedicated health workers and facility managers who today care very much about their patients. We met many informed, focused and thoughtful individuals. Many had traveled abroad to observe other health systems; they understood WHO protocols and the consequences of Ukraine’s system weaknesses. We heard of innovations within the confines of the current system, and indeed donor programs are improving care where they are implemented. Yet even donor program effectiveness is constrained by the collection of practices that we and others have labeled the “Semashko system.” It is not only Ukrainian resources that end up being inefficiently utilized.

The assertion that broad-based reform is necessary also does not mean that opportunities to improve current care should be ignored,

The recommendations below are aimed mainly at opportunities for USAID leadership and activity, but the strategy that underlies them is relevant to the actions of reformers within the Ukrainian government or of other donors interested in improved health outcomes in Ukraine.

**b. Theory of change:**

The revised theory of change that we suggest, based on our consultations with Mission staff, Ukrainians and other donors acknowledges the complex nature of the problem, and proposes a strategy that does not rely on a single logical framework, indeed that takes advantage of multiple entry points. One way to state this is:

**If future USAID programming 1) targets political and technical obstacles, leverages assets identified in this analysis, and invests in long-term systemic reforms; and 2) uses technical assistance as both a method to improve service delivery and to develop**

**knowledge of health systems dysfunction; and 3) this approach is frequently revisited and adapted to changing political contexts; then USAID programming will be more effective in improving the functioning of Ukraine's health systems, and this improved functioning will be visible in improved TB outcomes as well.**

**c. Constraints on USAID that may shape implementation**

There are many constraints on USAID acting flexibly: Congressional earmarks limit flexibility across program sectors. Funding constraints in particular skew the flexibility of spending that could be more responsive to Ukraine's needs and that could be used to address the broader health system obstacles to the accomplishment of disease-specific objectives, which focus mainly on improving care and treatment. USAID's own structure and procurement policies also limit nimbleness. Three and five year contracts with detailed scopes of work are not designed for responsive and effective adaptation. Contracts launched in 2013 were designed for implementation in a very different Ukraine. A contract launched today would still be challenged by the rapidly evolving policy environment. This suggests that part of a strategy going ahead involves changes in USAID culture and practices as well. Can a contract be designed to target an objective, but allow flexibility in activities, such that opportunities can be seized? For example, we learned that the new Minister of Health who is the author of the ambitious reform plan to end the stranglehold of the Semashko system, needs an expert in health finance to consult with. This key support is not expensive, yet there is no flexibility in any of USAID's 12 existing health sector projects to respond to this opportunity - even though all eleven programs would be more successful if the health system obstacles were reduced or eliminated.

Current Global Fund financing for Ukraine is set to end in 2017. Confidence that it would be extended varied among people we interviewed. If it is not renewed, the broad health system reforms are all the more important. But even if funds are allocated beyond 2017, sustainable impact depends on disruption and innovation within the current health delivery system.

An additional constraint is inherent in all multi-donor efforts. Giving more than lip service to "donor coordination" is always difficult. In the instant case, the World Bank is about to launch eight more oblast-level pilots, aimed at supporting changes in payment systems, information infrastructure, and regulatory reforms. While both USAID and the WB are in good communication, there are opportunities to significantly increase coordination around the learning and policy impact of these pilots. It is USAID, not the World Bank that has a program that provides technical assistance to Ukraine's health system; similarly, it is USAID that has a program in the Rada, a program to work with CSOs, a program targeting individual access to courts. Our task was not to review the relationship with the Bank in any detail; yet our casual observation is that there are opportunities going forward that would increase the impact of both programs.

Implicit in several of our suggestions are changes in USAID policy, practice and expectations. There are, across USAID, several examples of the types of innovation we suggest would be helpful. Not having conducted a separate political economy analysis of USAID itself, we do not proffer a strategy for sweeping reform. Suffice it to note that in the Kyiv mission, as well as elsewhere there are innovators figuring out ways to think and act more politically.

It is also important to note that a political economy analysis is most likely needed to inform the strategy and activities of in-country reform leaders. The openings for progress are their openings first. The leadership and activism, the learning and adapting that we believe are needed in Ukraine, have to, in the end, be Ukrainian. The ability of USAID to think and act politically is, in most cases, transmitted through the groups and the programs that USAID supports with its resources and technical expertise. As will be seen below, we also recognize that USAID can play a direct role in influencing policy makers and officials, with direct contact from Embassy and Mission staff. Here we simply note that USAID, and other donors, are most often indirect actors, where it is essential to understand the incentives of counterparts, but it is not always easy to affect those incentives. Doctors and nurses do not work for USAID any more than do members of the Rada. So thinking and acting politically requires detached but well-informed appreciation for the reality faced by Ukrainian counterparts.

#### **d. Recommendations:**

**For USAID, a more adaptive strategy is necessary.** A more adaptive approach will address a variety of openings in the complex superstructure that has proved so stable.

**Building an Adaptive Strategy, Integrating PEA into USAID programs:** There is much being written about “thinking politically” and “doing development differently”<sup>42</sup> that elaborates on the nature of this challenge. The essence of the emerging scholarship (and in some examples, the emerging practice) in this area is still very general, but clear. The literature suggests an approach, not a protocol or a check list; it suggests a flexible attack on complex and dynamic problems; with readiness to move quickly toward opportunities while recognizing that any effort takes place amidst wider trends in political and economic development in Ukraine. This approach has been highlighted in USAID’s Local Systems framework, and is being operationalized by staff working in various parts of the Agency on “thinking and working politically.”

---

<sup>42</sup> Carothers, Thomas and Diane de Gramont, *Development Aid Confronts Politics: The Almost Revolution*, Carnegie Endowment for International Peace, 2013., Carothers, Levy; Andrews, Matt, *The Limits of Institutional Reform in Development, Changing Rules for Realistic Solutions*, Cambridge University Press, 2013; Pritchett, Lant, Michael Woolcock and Matt Andrews, “Capability Traps? The Mechanisms of Persistent Implementation Failure,” Center for Global Development, Working Paper 234 (2010).

To integrate our findings into a more flexible health reform strategy, we recommend consideration of the following, organized in two overlapping clusters:

- A. Steps relevant to broad health reform support and
- B. Steps specific to the delivery of TB healthcare and pharmaceuticals.

## **A. Support for necessary systemic reform of the health sector**

### **1. Take advantage of the tide:**

The new government has health reform high on its agenda. Major decisions in Ukraine are made mostly in a top down fashion. For those working at the top:

- Does the Government of Ukraine know that health reform is a top US priority for Ukraine's development? Do the Ambassador and Mission Director have talking point to use in every contact with relevant Ukrainian political leaders?
  - *Recommend: Embassy and USAID coordinate and establish health system reform as a US structural and government legitimacy-enhancing priority to accompany focus on security, energy, financial institutions.*
  - *Recommend: USAID support Ambassador with talking points for interactions with Ukrainian leadership, so that the priority of health from the US perspective is raised at every opportunity.*
  - *Recommend: Integrate with World Bank pilots in eight oblasts, supplying analytic support alongside their investment funds and their limited TA on payment systems.*
- Health services are one of several sectors being addressed by the reformist government. If there is a working group on civil service reform, are health sector problems and opportunities a part of the discussion? How can USAID assure that they are?
  - *Recommend: USG raise this issue with Ukraine counterparts and allocate technical office and specialist staff in DRG and health, as appropriate, to monitor and suggest mechanisms for accomplishing.*
- Geopolitical events mean that Ukraine will decentralize from its current formal structure. Whether that decentralization is asymmetric, with some regions enjoying more or different autonomy than others is not yet clear. Few, if any, decentralization episodes in the world are motivated by a desire to improve services. Instead they occur in response to wider political crises. So while health is already notionally decentralized, in fact considerable discretion is still held at the central level. Pending discussions of new decentralization

policy could improve the autonomy, and accountability of local health leaders, allowing innovation and establishing stronger comparative performance regimes. Who are the health reform experts at the table where decentralization policies are being considered? In designing its own decentralization support program, can USAID target health as a key service to be improved by decentralization?

- *Recommend: Design upcoming decentralization support program to include resources and activity allocated to assuring the effects of decentralization are positive for health systems effectiveness, and not simply the fracturing of a big problem in a series of smaller ones, with the sum being greater than the prior total.*
- Success in implementing small reforms, such as international procurement of 3% of drugs (related to HIV and TB) should demonstrate results relatively quickly. Are the results being captured and used in the wider effort? Will the level of competition, the prices and quality achieved, the timeliness of delivery be tracked and reported to demonstrate the benefits of this reform and build support for widening the opening of drug procurement? Can USAID programs contribute to that outcome?
  - *Recommend: Convene existing implementers in a “data-thon” to review their existing data and access to data that could document or demonstrate impacts of existing health systems norms and practices, and highlight areas of progress or lack of progress that can be used to show the benefits of various innovative practices and/or implications for wider reform efforts. Consider opportunities across the Mission and the USG to integrate this data into advocacy efforts related to reform.*

## **2. Invest in disruptive forces:**

- Civil society engagement has proved important to the examples of progress we observed in Ukraine - in areas such as procurement reform. Can health system actors be re-animated to tackle issues in a more sequenced, and focused fashion? Can USAID use its convening power, or that of a partner think tank, to provide a forum for like-minded health interests to share strategies, ideas, information? Even while a donor cannot require that everyone row in the same direction, convening various actors periodically can increase the likelihood of that outcome.
  - *Recommend: Support a health sub-cluster of the Reanimation coalition with periodic convenings, targeted support for publications, and competition for CSO documentation of health effects of various health system characteristics.*

*Putting a human face on the statistics and packaging it to show effects on women, children, the aged, workers etc...*

- Citizen groups are tracking the overall reform effort, the press is covering it. Are they getting timely, reliable data and analysis of key health sector issues? Can USAID projects contribute to a health data dashboard that accumulates politically relevant health system information?
  - *Recommend: Coordinate USAID health projects with CSO networks. Identify journalists, sponsor a film contest for creative use and exposition of data on health services.*

There are other potential disruptors that may warrant USAID support or attention as well:

- What cost and reimbursement processes are being developed in the limited examples of private contracting with clinics for workers' health care? How are these affecting treatment and outcomes?
  - *Recommend: Commission research and analysis of the limited examples of third party payment contracts with health providers.*
- Defense ministry health is presumably under great stress currently, with dramatically higher care burdens. Are there opportunities to pilot new models of patient-centric finance and care? Could veteran and family groups be mobilized?
  - *Recommend: Work with the Department of Defense to assess the costs and benefits of the parallel health system for military service members. Document any changes underway, or possible as pilots.*
- Data: There exists considerable data on the Ukraine health system. Yet numerous studies have reported the many issues that result in much of this being of poor quality.<sup>43</sup> At the same time, developments such as the E-TB Manager supported by USAID is delivering patient and facility specific data of immense potential to inform policy makers and managers alike. It is already being used by some facility managers to better manage their work with patients. Combined with data on budgets, expenditures and staffing the data being generated for the UCDC is an asset in any wider reform effort, offering the potential to document the costs to patients that result from the current system and identify the progress made by various oblasts, rayons and facilities in improving care and reducing costs.
  - *Recommend: Commission a detailed review of health systems analysis possible with the evolving data from the E-TB Manager; extrapolate to*

---

<sup>43</sup> 2011 USAID Health Systems Assessment

*possibilities with a wider utilization of the tool beyond TB. Target information and analyses of use to central and/or oblast level officials, utility of comparative performance data in a dashboard.*

### **3. Engage and encourage necessary actors.**

There are other potential disruptors that may warrant USAID support.

- Doctors and nurses rely on the current system, yet their cooperation is essential in the end, both in designing new payment systems and building the case that there are alternatives to the poor status quo. Who are the examples of innovation within the existing confines, or disruptors who have had success outside the lines? How can they be protected or indeed lionized with attention or an award?
  - *Recommend: Develop detailed PEA-informed case studies of innovation and award (through local CSO's) prizes to the "heroes" of health innovation.*

### **4. Prepare for windows of opportunity before they open.<sup>44</sup>**

Health reform has been proposed before, only to come up short when one or more circumstances interrupt the implementation of the vision. The politics that maintain the status quo are powerful. A flexible USAID program would find ways to support the current initiative, but also envision a longer-term need to build the evidentiary base that will, in time, make it increasingly difficult for the defenders of "no change" to maintain that posture.

- The immediate reform agenda: The Minister of Health spoke of adoption of his reform program by the end of April 2015. We hope that he is successful, even if not on his original timeframe, though the few documents we have seen do not suggest that he has a detailed strategy for adopting the Constitutional, legislative and regulatory changes required. Nonetheless, this is an opening that warrants USAID support. If it is successful, it will enhance TB care outcomes, but also the health services for millions of other Ukrainians, with life-threatening health issues beyond HIV/AIDS and TB.
  - *Recommend: Find ways with USAID or other resources to assure that the details of reform are professionally thought through. If the Minister needs a health finance expert, locate and field such a person. Convene the other donors to assure that external advice is aligned and not duplicative, that insights are shared, and that agendas are coordinated. Other donors have*

---

<sup>44</sup> Kleinfeld, Rachel, "Improving Development Aid and Evaluation: Plan for Sailboats, Not Trains," Carnegie Endowment for International Peace, mimeo, 2015

*their own constraints; the combination may not be easy or perfect, but is better aligned than not.*

- Look beyond: If the reform is adopted, what support will be needed to implement? What expertise is already in USAID's portfolio? For example, E-TB Manager is a proven, effective electronic records system (TB patients fleeing conflict are able to have their cases picked up, with full past treatment information, by new oblast health administrators). There are lots of information systems extant or proposed for Ukraine; USAID has in country, on-the ground expertise to apply to the broader need. Similarly, USAID has experience working with social services that accompany HIV/AIDS care. As a shift to more primary health facility responsibility is implemented, integration of health and other social services will become more important. USAID and its implementers can contribute usefully to the plans for more integrated primary health care.
  - *Recommend: Convene a facilitated workshop of USAID and Ukrainian health care managers to discuss data needs of a reformed system and the gaps in current data routines.*

In the event major reform takes longer: USAID has expertise and a broad program of both health and DRG activities. The several activities suggested in items 1-3 above are all part of a more focused strategy that recognizes that current TB and HIV/AIDS programs will not achieve their full objectives without progress on the broader agenda. The steps suggested above draw on the expertise and front-line contact resident within USAID programs.

**B. At the same time, continue to earn the confidence of Ukrainians by targeting health services and reforms within the current system.**

While the current project work provides a strong base for generating data and insight about the broad health system, it is also the case that the programs benefit thousands of patients daily. Our recommendation is that this platform distinguishes USAID from other donors and assures that USAID's perspective is not overly Kyiv-based and that there is fine-grained information on the delivery end of the system.

- **Coordinate efforts to better understand what is working—and why.** USAID projects are working alongside oblast health administrators, dispensary managers and patient advocates, among others. We suggest that there are multiple uses for data that is collected in the course of these programs. Currently we are not aware of efforts to capture reform-relevant data or experiences from these projects. In particular, E-TB manager was highlighted by many as an opportunity to improve coordination and outcomes. In Kirovograd informants noted that E-TB manager was being used to analyze outcomes, plan procurement and consult with service providers; similarly, the UCDC cited it as a useful reference for improving care.

However, e-TB manager data is not currently being used as a means of fostering accountability for treatment outcomes. USAID and the World Bank have begun or will soon begin pilots of a variety of approaches that show promise for improving TB outcomes. It will be critical to coordinate among donors and the GOU to effectively assess the extent to which these pilot approaches—including the scale up of social support to TB patients and the reform of facility financing—are indeed affecting treatment success rates. Donors may also wish to follow the extent to which health providers and administrators themselves are tracking these outcome indicators, which could serve as a valuable proxy for the uptake of a more outcome-oriented model of health service provision. In addition to tracking outcomes (and GOU attention to these outcomes), it will be important to also reassess the incentive systems around TB care and treatment; to what extent are pilot activities effectively shifting provider and patient incentives toward ambulatory care and treatment? In addition to coordinating regular assessment of outcomes, USAID/Ukraine may also wish to annually reassess incentives related to TB care and treatment in the regions targeted by USAID and other donor programming

- *Recommend: Expand M&E efforts to collect information relevant to deeper understanding of the PE issues identified in this report.*

- **Consolidate the base.** As discussed above, many members of the medical establishment continue to have a strong vested interest in the current system of tuberculosis care and treatment, including tuberculosis specialists and facility managers whose current access to funding is dependent on maintaining a heavily in patient-centered model of care. While reform of Ukraine’s current health system is of paramount importance to enabling a shift in incentives toward an ambulatory tuberculosis care model, given the current incentive structures among health providers, the engagement of patients in the reform process is critical. While various stakeholder groups have an interest in improving tuberculosis care and treatment, including those living with TB patients, patients living with HIV/TB co-infection, prisoners’ rights groups, and homeless advocacy groups, in the regions the team visited it did not appear that these groups were coordinating to advocate for improved care or greater accountability within the health system. USAID/Ukraine should consider mapping civil society organizations with an interest in tuberculosis care and treatment in regions where they are supporting tuberculosis programming, both with a view to seeking opportunities to bolster the provision of social services (as discussed further below) and in order to engage service providers in advocating and monitoring adherence with ambulatory care protocols. The e-TB manager available on the Ukrainian CDC website provides an excellent source of data on regional and oblast level treatment outcomes.<sup>45</sup>

---

<sup>45</sup> See <http://ucdc.gov.ua/uk/statystyka/reestr-tb>.

- *Recommendation: Build an oblast-by-oblast inventory of patient groups, patient advocacy groups, CSO service providers, social networks interested in TB care. Delivery oblast and facility level data to them, with periodic convening of discussions with health systems staff as well, around developments seen in the data.*
- **Enhance patient adherence.** Given the current lack of effective incentives among health providers to fully shift to an ambulatory care model, patient support for outpatient care is critical, but the challenges inherent in effective tuberculosis treatment, as well as information gaps around patient rights with respect to treatment, weaken prospects for effective patient advocacy. Tuberculosis treatment regimens are notoriously difficult in terms of side effects and the need to precisely follow protocols; in addition, many tuberculosis patients require access to additional medical and social services. Above and beyond ensuring effective outpatient care of tuberculosis, the provision of integrated care is key; we noted that in the oblasts visited HIV care was provided in separate facilities that were often remote from the TB facilities that continued to provide the majority of DOTS services. USAID/Ukraine may also wish to consider options at the regional level to support other DOTS modalities, including the use of community health workers or nurses to provide treatment in remote locations. Civil society and health provider informants universally cited the important role the provision of food baskets to TB patients has had in incentivizing continued treatment, though it was the understanding of the team that currently Global Fund support for social service programming (including food baskets) is limited to their MDR-TB caseload. USAID/Ukraine should consider supporting the scale up of regional or local social contracting initiatives for social support services, such as those currently underway in Poltava.
- *Recommendation: Research the financial model and collective action strategy of existing CSO's who are supporting social services for patients, and develop menu of models of community support/social contracting for support services.*
  - *Recommendation: Commission research on the health practices of the 60% of Ukrainian patients who forego health services altogether on account of the unaffordability of side payments.*
- **Support Patient Rights Awareness.** In a number of interviews, informants noted that access to outpatient care for TB, as well as access to medicine in the event of stockouts, was dependent on the means of patients. Even in the absence of broader health sector reform, rights awareness initiatives can play a critical role in empowering patients to negotiate treatment as required by the current legal framework. Yet tuberculosis patients are particularly unlikely to be informed of

their rights to treatment. Ukrainian civil society organizations including Transparency International-Ukraine have prepared guidance for patients on their rights to healthcare.<sup>46</sup> USAID Ukraine may wish to consider supporting a tuberculosis-specific campaign in partnership with the civil society groups noted above, including a focus on rights related to DOTS, the right to free treatment under the law, and opportunities to request redistribution of medicines in the event of stockouts.

- *Recommend: Fund “know your rights” campaign for one or more CSOs. Conduct a competition for CSO ideas to assure care for those who cannot afford side payments. Collect and publicize successful efforts to defend rights to care using courts or other institutions.*
- **Promote and disseminate local reform initiatives.** PEA team members noted that recognition as a pilot region or as innovators appeared to positively incentivize reform-minded doctors and administrators at the regional level in both Poltava and Kirovograd. In both cases officials and physicians had indeed found flexibilities in the current system to advance ambulatory care models even in the absence of broader reform that appear worthy of wider consideration. USAID/Ukraine may want to identify opportunities to recognize and share promising practices that are leading to better treatment outcomes at the regional level; support could include modalities such as inter-regional exchange visits or innovation challenge grants.
  - *Recommend: The flexibility given to Poltava has, they assert, had beneficial effects on their level of care for TB patients. Document this and other examples of innovation to support provision of similar flexibility and patient-centered steps in other oblasts.*

### **Integrate Political Economy into Health Office planning and programming.**

This report is the result of a very quick 2 ½ week assessment. It builds on the expertise of health and democracy experts in the USAID Mission and from USAID headquarters. It draws on prior studies of health care in Ukraine and the region. And it is informed by interviews with dozens of people in Ukraine. It is however a snapshot. Health services in Ukraine are under great stress. The political, administrative and fiscal systems of Ukraine are in the process of changing, even if the direction of those changes is not so clear or uneven in its progress. This leads us to suggest a series of on-going steps that may help the mission confirm, consolidate and update our findings and improve upon our recommendations.

---

<sup>46</sup> See <http://anticorruption.in.ua/instructions/ohorona-zdorovya>.

- *Recommend: Create a mission-level working group to report on a consolidated basis on steps to coordinate resources and activities on an expanded health strategy: maintain existing programs with a deeper extraction of reform-supporting knowledge, and an additional set of activities using the full range of the Mission's other resources to take advantage of the tide, invest in disruptive forces, engage necessary actors and be prepared for windows before they open.*
- *Recommend: Extend existing analyses and new project development efforts to include political economy analyses, testing in advance the range of factors, interests and openings upon which the proposed theory of change rests. Not just what we want to do, but how and why will it be effective?*
- *Recommend: Integrate Economic Growth experts into the health effort. For example: If 40% of health care in Ukraine is effectively privatized (through informal side payments) how can more predictable, affordable markets be advanced alongside the public health system? What is the enabling environment for a more regularized co-payment system? What institutional infrastructure needs to be developed alongside health payment reforms?*
- *Recommend: Convene discussion with Cross-Sectoral Programs Division in October 2015 to reflect on utility of this pilot and advise other missions or other applications of the PEA approach in the health sector.*