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**HUMANITARIAN HEALTH ASSISTANCE  
IN UKRAINE:**

**A Mid-Course Review**

Cooperative Agreement No. CCN-0001-A-00-4048-00 with the  
Program for Appropriate Technology in Health (PATH)

USAID/ENI/HR/HP

August 1995

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## I. EXECUTIVE SUMMARY

The Agency for International Development and the Program for Appropriate Technology in Health (PATH) entered into a cooperative agreement (CA) in June 1994 "to provide humanitarian health assistance to Ukraine in areas of diphtheria epidemic, juvenile diabetes, and hepatitis B infection." The original life of program total was \$11.34 million.

This "in-house" review, stipulated in the CA and conducted in May-June 1995, examines program progress and recommends some mid-course corrections and amending the CA. This review finds that the roles and responsibilities of PATH have evolved and expanded well beyond what was defined in the cooperative agreement. In general, PATH has met or exceeded most program expectations as outlined in the CA. In addition, although program implementation has been delayed for various reasons, mostly outside PATH's control, program impact, beyond what was anticipated in the CA, is already discernable and achievement of program objectives is anticipated.

This review recommends that:

- The CA should be amended to recognize PATH's evolved roles and responsibilities and extended by approximately six months to assure completion of program objectives (including a procurement of an additional 10 million doses of Td);
- PATH should give priority attention to developing an approach to track the distribution and use of USAID-financed Td toxoid;
- PATH's field-base program management should be strengthened; and
- USAID/Ukraine should negotiate a Memorandum of Implementation with the Ukrainian MOH which sets forth MOH, USAID, and PATH roles and responsibilities under this program, and which emphasizes the importance of adhering to the agreed upon diphtheria control strategy;

The following are findings on specific program components.

Diphtheria - While the epidemic continues, to date this program has:

- Safely delivered slightly more than 11 million doses of Td toxoid, making USAID the largest single donor to the diphtheria control program<sup>1</sup>;

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<sup>1</sup> Deliveries to Ukraine through May 1995 actually totalled 13.8 million doses. Due to MOH delays in updating information, this review was able to examine data only through March 1995.

- Contributed to the definition of a new diphtheria control strategy, in collaboration with the Ministry of Health, the U.S. Centers for Disease Control (CDC), UNICEF, and the World Health Organization (WHO), and other donors (International Federation of Red Cross/Red Crescent Societies, and Canada);
- Introduced new approaches and technologies for maintaining and monitoring the national vaccine cold chain;
- Encouraged the MOH to reduce the list of contraindications to vaccination and increase the number of persons vaccinated;
- Collaborated with the MOH and CDC to demonstrate the techniques and value of serological studies and immunization coverage surveys;
- Encouraged the MOH to review and revise existing policies and clinical practices related to the diagnosis and treatment of diphtheria;
- Demonstrated the value of a more open flow of epidemiological and program information within the Ministry and among the Ministry and the donor community; and
- Promoted the importance of information, education and communication (IE&C) campaigns as a useful tool in informing and prompting local communities to engage in useful public health practices.

Diabetes in Children - Insulin deliveries are now underway. To date the program has:

- Developed a reliable registry/data base containing the names of diabetic children throughout Ukraine;
- Developed and implemented a reliable delivery system and appropriate methods to monitor insulin distribution; and
- Initiated training and information programs to improve clinical and home-based monitoring and management of diabetes in children.

Bloodborne Infection Control - The implementation of this component was delayed until program objectives were defined and detailed workplans were prepared. An extension of the CA will allow the recently defined objectives to be realized.

## II. REVIEW BACKGROUND, PURPOSE AND METHODOLOGY

The Agency for International Development and PATH entered into a cooperative agreement (CA) in June 1994 "to provide humanitarian health assistance to Ukraine in areas of diphtheria epidemic, juvenile diabetes, and hepatitis B infection." The CA anticipated that an independent "mid-activity review" would take place between nine and twelve months after signing of the CA. That review was to: determine what changes to the activity design, if any, were needed; assess the efficiency of implementation; detect misappropriation of commodity, if any; and determine whether additional time and resources are required to complete implementation of any component of the activity. Funding was allocated to conduct an "independent" review.

In fact, this review was conducted by USAID "in-house" personnel because: it was widely believed that additional USAID support needed to be committed as soon as possible to continue the attack on the diphtheria epidemic still raging in Ukraine; a detailed, hands-on discussion and assessment by the project managers was overdue and required for good project management; and contracting for "independent" evaluators would have resulted in substantial time delays. The review took place during the month of May 1995. All day meetings were held at PATH headquarters in Seattle, May 3 and 4, 1995. Participating in those meetings for USAID were Robert Jimenez, ENI/HR/EHA and Alexis Shelokov and Paul Holmes, both from ENI/HR/HP. Detailed discussions and reviews took place in Kiev, Ukraine May 16 through June 1, 1995. In addition to Shelokov and Holmes, John Tomaro of G/PHN/HN participated in those discussions. Except as otherwise indicated, this review considered information available through May 31, 1995.

During the course of this review, informal discussions were held with approximately twenty-five representatives of PATH, the Ministry of Health of Ukraine, USAID/Ukraine, and USAID/Washington. Time was not sufficient to interview program beneficiaries, i.e., people who may have attended PATH workshops, care providers or people immunized. A full list of contacts is found in Attachment A. While no formal questionnaires or interview guidelines were used, a list of topics was provided to PATH and USAID/W representatives. The list was taken directly from either the Cooperative Agreement or the three component Implementation Plans (see Attachment B). Throughout the exercise, reviewers tried to keep the focus forward looking, collaborative and constructive.

It should be noted at the outset that, the intent was for this review to have been finalized in advance of PATH preparing its proposal to amend the CA. Unfortunately, obligation deadlines mandated that PATH prepare its proposal in advance of the review being completed. However, the substance of all the findings, conclusions and recommendations contained in this review were verbally discussed with PATH prior to preparation of their proposal.

### III. OVERALL PROGRESS AND STATUS

#### A. Origin

Cooperative Agreement No. CCN-0001-A-00-4048-00 with the Program for Appropriate Technology in Health (PATH) was signed on June 9, 1994 (effective as of April 29, 1994), following a competitive selection process. It's estimated completion date was April 30, 1996 and it was fully obligated at its planned life-of-project funding level of \$11,340,000. The CA is funded under the NIS Special Initiatives Project (110-0001).

The program responds to an emergency request from the Government of Ukraine for assistance on three immediate medical problems: a diphtheria epidemic, lack of insulin for insulin dependent children (juveniles), and transmission of hepatitis B among health workers. Because of the urgent nature of the request, as well as to encourage and reward progress on political issues of importance to the U.S., A.I.D.'s primary interest at that time was to get people and commodities to Ukraine as quickly as possible. Accordingly, the activity was rapidly designed, competed and negotiated.

The stated objectives of the agreement were clearly humanitarian and relatively short-term in nature. From the CA ...:

"The objectives of this humanitarian activity are in general terms:

- 1) To introduce sufficient quantities of vaccine into the Ukrainian immunization system in time to influence the 1994/1995 diphtheria cycle and provide antitoxin, antibiotics and testing materials;
- 2) To provide a one-year supply of insulin to 6,000 insulin dependent juveniles; and
- 3) To have a reduction in the rate of hepatitis B virus (HBV) infection among health care workers.

Specifics covering the proposed measurable outputs are to be detailed in the implementation plans submitted by the recipient following the signing of the cooperative agreement."

At the time, capacity building and sustainability were not considered high priorities for the CA: sustainability was to be addressed through a second activity dealing with local production of essential drugs, which would be designed and implemented to run concurrently with but unlinked to the CA.

In addition, at the time the CA was signed, the understanding of the dynamics of the diphtheria epidemic in Ukraine (and throughout the NIS) was incomplete. While USAID did

undertake a rapid assessment of the problem and designed a response in collaboration with the Ministry of Health of Ukraine, little was documented about the severity of the problem, efficacy of the control strategy, institutional capacities of the Ukrainian MOH, or availability of critical commodities.

B. Progress and Performance

1. DIPHTHERIA

a. Objectives

PATH's "Project Implementation Plan: Diphtheria Immunization" was submitted to USAID on July 1, 1994, approximately the deadline set forth in the CA. The Diphtheria Implementation Plan did a good job of laying out how the commodity related tasks associated with the CA would be carried out. These elements included descriptions of vaccine storage capacity and the cold chain, procurement and delivery schedules, arrangements to assure safe and reliable transportation of vaccine to the oblast levels, and provisional antibiotic needs and treatment protocols.

The Implementation Plan did not address the criteria set forth in the CA in the area of immunization strategies and plans, including scheduling and other operational requirements for campaigns and other immunizations. PATH explicitly recognized this short-coming and noted that:

"The assessment team is not satisfied, however, that a truly thorough strategy has been formulated at the national, regional, and local levels. It is hoped and expected that a credible national strategy will emerge..... PATH will be guided by the principle that Ukrainian authorities alone must control and direct this diphtheria immunization campaign. From PATH's side, every effort will be made to provide the needed commodities and seek active collaboration with the Ukrainian counterparts in the sharing of information and data needed for the accountability of the project."

Accordingly, the major focus of the cooperative agreement has been the provision and accountability of 22 million doses of Td vaccine for adults, to help control the diphtheria epidemic, as well as a supply of antibiotics and antitoxin to treat those affected by the disease<sup>2</sup>. The accompanying "Progress Indicators", therefore, focused on delivery validation

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<sup>2</sup> Additionally, the agreement initially provided approximately \$1.38 million to procure DPT vaccine for children. When the Government of Canada decided to provide the DPT vaccine, the USAID/PATH procurement was withdrawn. The funds intended for those vaccines, therefore, are available for re-programming under the cooperative agreement.

and monitoring, cold chain monitoring and utilization. The "Impact Evaluation" indicators proposed were: comparison of projected deliveries to actual deliveries; review of MOH data on vaccine coverage; record and review of consumption of antitoxin, antibiotics and diagnostics; and comparison of baseline and subsequent incidence rates for diphtheria after immunization. The Implementation Plan further did not specify target dates or schedules.

b. Progress

The Diphtheria Epidemic in Ukraine - During the first five years of the diphtheria epidemic in Ukraine, the number of cases reported annually increased 36-fold: from an average of 82 cases (during the period 1986-89) to 2990 in 1994. Still, in 1994, Ukraine was the only NIS republic in which the year's total number of cases remained the same as in 1993.

However, the epidemic continues in 1995: there has been a marked increase in cases of diphtheria for January through April period as compared to the same months in 1994 (Jan - 41/174, Feb - 449/153, Mar - 498/123, Apr - 304/145). The preliminary figures for May (186/159) while still higher than 1994, suggest that the unseasonal increase in the number of cases is now over. The increases have been particularly noted in the rural areas, with more children affected than in the cities.

Because the numbers are aggregated for all of Ukraine, without relation to the intensity of immunization efforts by region, at this stage it is not possible to estimate what impact the vaccine has had. PATH believes that it is unlikely that the USAID/PATH program has had a significant impact on disease incidence so far (because up to the time of the April campaign, Ukravaccina dispersed the vaccines throughout the country and not solely in the ten most affected oblasts as originally intended). Reports on the number of diphtheria cases in the fall of 1995 should begin to exhibit differences between oblasts which have had mass campaigns and those which have not.

Assessment of Vaccine Storage and Cold Chain Capacity - In advance of the initial shipment of Td vaccine, PATH quickly and effectively conducted the required assessment of vaccine storage capacity in Ukraine. The system was pronounced "precarious but OK." PATH also has continued to monitor the cold chain on a regular basis. The PATH cold chain advisor is recognized by the MOH to be knowledgeable and his recommendations are regularly solicited and followed.

As a result of sound transportation arrangements and monitoring, PATH may have prevented some potentially serious vaccine problems. In addition to assuring the integrity of the cold chain in Ukraine, PATH has insisted on including TempTales<sup>3</sup> in all shipments. When one TempTale reading indicated that a shipment of Td may have been frozen in the hands of a U.S. freight forwarder, the manufacturer promptly replaced the entire shipment.

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<sup>3</sup>

Automatic temperature monitors.

## Delivery of Commodities

- Td Toxoid - Through this cooperative agreement, a total of 13.8 million doses of Td toxoid were delivered to Ukraine through May 1995<sup>4</sup>. These figures are approximately 2 million doses lower than the quantities originally anticipated because of production problems at Connaught. Whereas the original completion date for all vaccines shipments was June 30, 1995, the revised schedule extends shipments through November 1995. The inability of Connaught to ship according to schedule has constrained the ability of Ukraine to respond to the epidemic.
- Antibiotics, Antitoxin and Diagnostics - Through April 1995 and in comparison to the totals planned, the dollar-value percentage of other diphtheria commodities, already delivered were approximately:

	(% of total planned)	
Diagnostics	29%	including: Oxoid Hoyle medium and Pyrazinamidase test kits;
Treatment	38%	consisting primarily of antitoxin
Other supplies	51%	consisting primarily of labels and temperature monitors and serosurvey supplies

Much of the diagnostic material has not been ordered or shipped, pending additional discussions with the MOH regarding diagnostic and laboratory policies, practices and materials requirements. The MOH is currently conducting an enormous number of tests which appear to be wasteful of expensive materials as well as human resources. Treatment of patients is sometimes delayed until a diagnosis is confirmed by the tests. This approach is reasonable in a non-epidemic setting where the disease is not anticipated, but generally not in the middle of an epidemic. Moreover, one might further question the rationale of conducting extensive laboratory testing while following a mass immunization campaign strategy. PATH is continuing discussions with the MOH on diagnostics and may involve WHO/CDC in those discussions. PATH is also considering adding a training component on diagnostics, to be conducted in a workshop setting in the U.S. or elsewhere.

Since antibiotics and antitoxin are in such short supply throughout Ukraine, PATH has decided to withhold delivery until the MOH has developed a clear policy on antibiotic prophylaxis and has put in place a mechanism for controlling and monitoring use. This issue was first raised with the MOH more than six months ago and remains unresolved.

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<sup>4</sup> Due to MOH delays in updating information, this review was able to examine data only through March 1995. At that time the deliveries totalled 11.01 million doses.

The Strategy - The strategy to control the epidemic has evolved substantially since the Cooperative Agreement was negotiated and signed in April - June 1994. When PATH first started working in Ukraine the MOH was trying to vaccinate adults in "high-risk" groups. When the Diphtheria Implementation Plan was approved in July 1994, the control strategy shifted to provide two doses for all urban adults (ages 18-49) in the ten oblasts with highest incidence. It was estimated that approximately 22 million doses of Td toxoid would be required to implement this control strategy. This estimate formed the basis for the for Td toxoid requirement contained in the original cooperative agreement.

The current strategy, followed in principle by the MOH of Ukraine and based on the WHO strategy formulated in March 1995, calls for supplementary immunization of the adult population, considered currently susceptible. It calls for mass immunization of all adults ages 15 through 59 (who have not received Td immunizations since 1992) with a single dose of tetanus toxoid, with adults ages 30-39 receiving one additional dose, and adults ages 40-49 receiving two additional doses. This strategy, discussed in great detail in the Huger to Silva/Klement memorandum of June 7, 1995, results in a total Td toxoid requirement of approximately 52.5 million doses, including wastage. This strategy has been endorsed by the MOH, USAID, CDC, and WHO/UNICEF.

A review of the distribution records indicates that the original control strategy was never carried out by the MOH. The Td toxoid delivered to Ukravaccina was not distributed to administrative regions of highest incidence, but to nearly all administrative regions in the country. The MOH has indicated that the original strategy was too restrictive, politically unacceptable and unresponsive to the emerging pattern of the epidemic. More importantly, however, discussions with the MOH and a recent review of the documentation suggests that the MOH may be deviating from the most recent strategy.

The MOH did carry out a mass-immunization campaign in the southern oblasts in April 1995. Reportedly the MOH plans to carry out two additional mass immunization campaigns: one in the eastern oblasts in September/October 1995, and one in the West, possibly in April 1996. However, the MOH has yet to develop plans and timetables and specify the materials needed for implementing those campaigns or for carrying out the follow-on activities required to fulfill the agreed-upon strategy.

For instance, during this review, the team learned that the MOH planned to administer an additional dose of Td toxoid to all adults in the target population (regardless of age) resident in the southern administrative regions who were vaccinated during the April campaign. That plan, subsequently dropped, was based on the MOH's concern that the partial "herd immunity" resulting from one dose would not be sufficient to prevent transmission of the infection from the resident population to visitors expected during the summer months. While such an exception to the announced MOH/WHO/UNICEF strategy might have been justified, the proposal raised the concern that similar reasoning might be applied to other campaigns in other oblasts. Administering a second dose to the entire population of adults aged 15-59,

rather than to the two special cohorts (30-39 and 40-49), would require more toxoid than estimated for the epidemic.

Under the July 1994 agreements, the MOH was to be the implementer of any control strategy. PATH's primary role as described in the CA and Implementation Plan was to deliver and monitor the commodities. Just as the strategy has evolved, so PATH's activities have evolved to providing a greater degree of TA support, strategy, policy reform, etc. Examples include: more extensive than anticipated technical advice to the MOH on all aspects of the diphtheria control effort (especially by R. Doan and J. Maynard); helping to organize MOH workshops (on both diphtheria and blood-borne infection control); substantial logistical support to CDC for the seroconversion study and for the immunization coverage survey.

Monitoring for Utilization and Coverage - This component was designed to address an emergency situation: an epidemic which was out of control. The immediate priority for both PATH and the U.S. Government was to get Td vaccine into Ukraine as soon as possible. The initial tracking and monitoring systems were not adequate to trace the receipt and distribution of the vaccine. According to PATH, the MOH was initially sensitive to PATH's role and shipments started arriving before relationships with the MOH were fully developed. From September through December 1994, PATH struggled with the MOH to figure out what happened with the vaccine. In October 1994 PATH discovered that the first vaccine was not used until September 1994 (even though it had arrived in July). Until recently, Ukravaccina has delivered the vaccine broadly to the oblasts, according to traditional delivery patterns, rather than according to the original epidemic control strategy. As yet, however, there is little information regarding how the oblasts have used their vaccine.

At the time of this review, data on the receipt, distribution and use of the Td toxoid were incomplete. The review team spent innumerable hours trying to understand and reconcile PATH and MOH figures regarding what was delivered to Ukraine, what the immunization target groups were, what USAID/PATH vaccine was actually used and where, and what is still available. The only data instrument now available simply does not work. It needs to be noted here that there is absolutely no evidence (or even suggestion) that Td toxoid has been diverted or misused. Nevertheless, program implementation and accountability clearly demand that this information be accurate, reasonable and readily available to the MOH, USAID and PATH. The lack of credible information has hampered the ability to document progress made to date, and to anticipate future requirements.

Routine immunization of adults with the PATH/USAID-provided Td toxoid has been underway since September 1994. In fact, MOH figures indicate that through March 1995, approximately 6.3 million doses of this toxoid had been used in oblasts throughout the country (see Table 1, "Delivery and Utilization of PATH/USAID-provided Td Toxoid"). In addition, during the April campaign more than three million adults reportedly were vaccinated with a single dose of Td toxoid provided by PATH/USAID and IFRC/EU.

**Delivery and Utilization of PATH/USAID - provided Td Toxoid  
An Analysis by Administrative Region with Registered Cases in 1995 through March 31, 1995**

Admin. Region	Col. 1 Prior Target (1) March 94	Col. 2 Recent Target (2) 26 May 95	Col. 3 Difference Recent-Prior Targets	Col. 4 Total Distrib'd by MOH since Sept.94 (3)	Doses Given 1 dose	Col. 5 Doses Given thru March 95 2 doses	3 doses	Col. 6 Total Doses Given	Col. 7 Doses left in storage	Col. 8 Cases by Reg. since Jan. 95
<b>South</b>										
Rep. of Crimea	755,213	701,000	(54,213)	400,000	166,657	40,276	11,048	217,981	182,019	97
Zaporozhskaya	894,825	1,042,100	147,275	810,000	166,365	272,965	71,667	511,017	298,983	56
Nikolayevskaya	285,000	598,900	313,900	200,000	71,000	47,700	0	118,700	81,300	60
Odesskaya	145,581	485,100	339,519	300,000	103,884	18,697	21,811	144,392	155,608	70
Khersonskaya	85,000	291,300	206,300	200,000	51,933	67,305	0	119,238	80,762	71
Sevastopol City	305,000	28,200	(276,800)	440,000	4,963	200,693	72,289	277,945	162,055	30
Sub-total	2,470,619	3,146,600	675,981	2,350,000	564,802	647,636	176,835	1,389,273	960,727	384
<b>East</b>										
Dnepropetrovskaya	289,871	2,069,900	1,780,029	684,000	242,637	138,827	0	381,464	302,536	56
Donetskaya	820,000	2,527,600	1,707,600	714,000	346,136	242,510	0	588,646	125,354	144
Luganskaya	396,603	1,936,800	1,540,197	500,000	175,245	85,085	12,410	272,740	227,260	54
Kharkovskaya	510,185	123,700	(386,485)	650,000	145,502	107,675	81,367	334,564	315,436	56
Sumskaya	105,722	897,200	791,478	230,000	93,535	33,540	6,328	133,403	96,597	43
Sub-total	2,122,381	7,555,200	5,432,819	2,778,000	1,003,055	607,637	100,125	1,710,817	1,067,183	353
<b>West</b>										
Volynskaya	426,983	527,700	100,717	370,000	80,296	78,172	22,281	180,749	189,251	15
Zakarpatskaya	125,109	496,000	370,891	160,000	48,253	18,959	8,656	75,868	84,132	39
Ivano-Frankovskaya	360,000	169,300	(190,700)	310,000	73,009	57,603	62,217	192,829	117,171	14
Lvovskaya	342,000	1,005,000	663,000	380,000	185,040	88,720	40,020	313,780	66,220	40
Khmelnitskaya	230,764	294,000	63,236	230,000	26,277	36,544	92,215	155,036	74,964	13
Chernovitskaya	179,500	221,000	41,500	250,000	144,787	48,344	0	193,131	56,869	16
Ternopolskaya	891,274	484,900	(406,374)	250,000	38,660	38,991	19,453	97,304	152,696	8
Sub-total	2,555,630	3,197,900	642,270	1,950,000	596,522	367,333	244,642	1,208,697	741,303	130
<b>Center</b>										
Vinnitskaya	600,730	750,100	149,370	450,000	117,300	111,762	22,190	251,252	198,748	24
Zhitomirskaya	326,288	573,800	247,312	250,000	82,561	92,171	51,924	226,656	23,344	18
Kievskaya	267,600	1,248,200	978,600	380,000	104,400	101,900	34,900	241,200	138,800	18
Kirovogradskaya	255,000	703,100	448,100	140,000	52,932	17,747	8,776	79,455	60,545	23
Poltavskaya	573,700	70,300	(503,400)	460,000	17,317	199,971	106,635	323,923	136,077	13
Rovenskaya	540,747	321,800	(218,947)	240,000	60,418	76,738	71,465	208,621	31,379	3
Cherkasskaya	188,000	673,500	485,500	220,000	95,880	55,388	14,565	165,633	54,367	18
Chernigovskaya	701,360	592,000	(109,360)	250,000	48,697	38,948	41,378	129,023	120,977	34
Kiev City	441,073	1,574,200	1,133,127	642,000	59,885	31,228	39,961	131,074	510,926	132
Sub-total	3,894,498	6,504,800	2,610,302	3,032,000	639,190	725,853	391,794	1,756,837	1,275,163	223
Special Categories				367,000	103,734	100,246	65,479	269,459	97,541	
<b>TOTAL</b>	<b>11,043,128</b>	<b>20,404,500</b>	<b>9,361,372</b>	<b>10,477,000</b>	<b>2,907,303</b>	<b>2,448,705</b>	<b>973,075</b>	<b>6,335,083</b>	<b>4,141,917</b>	<b>1,090</b>
Note. Doses at Central Storage				610,000						
Total Doses Delivered				11,087,000						

Note (1). This target was based on the MOH/CDC interim strategy of providing each of 11 million adults in ten high incidence regions with two doses of Td toxoid.

Note (2). This target was based on the current MOH/WHO strategy of providing at least one dose with supplemental immunization of the two cohorts at high risk.

Note (3). In addition, IFRC/EU provided 2.5 million doses for the April campaign.

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The April campaign went better than many had expected, though tremendous regional differences in coverage and receptivity can be anticipated. Immunizations took place at polyclinics, schools, universities, factories, and even in homes. In some oblasts the campaign was extended well beyond the initial ten day period. The MOH appeared to mount a good organization and logistics seemed to go much better than some people had anticipated. In some locations, the campaign went extremely well. High coverage is anticipated in Odessa for instance, while coverage in Kiev is expected to be much lower. In Darnitsa, an industrial suburb of Kiev, fewer than one percent of the people who presented were turned away for contraindications.

Review of Data Provided by MOH on the Delivery and Use of the PATH/USAID-Provided Td Toxoid - The current epidemic in Ukraine and the NIS has been an unprecedented experience in the modern vaccine era. The succession of evolving strategies, proposed by international health experts at CDC and WHO, illustrate the difficulty of constructing a cost-effective approach to controlling the epidemic.

Table 1 is both (1) an initial analysis of the distribution and use of the Td toxoid provided by USAID/PATH through March 31, 1995 and a (2) proposed management tool and a revision of the instrument developed by PATH to document receipt, distribution and use of Td toxoid. The data presented in this table were taken from the "Report on the Use of Td Vaccine for Adults (received as humanitarian assistance from USAID/PATH)" for March 1995, developed by PATH, completed by the MOH, and delivered to PATH in May 1995.

Column 1 on Table 1 is the population target by administrative region based on the MOH/CDC interim strategy of providing each of 11 million adults in ten high incidence regions with two doses of the Td toxoid. This figure corresponds to the target scheduled to receive the PATH/USAID-provided Td toxoid, i.e., 11 million adults x 2 doses each = 22 million doses. The data on doses given, presented in Columns 5 and 6, suggest, however, that rather than concentrating on the "high-incidence" oblasts, the MOH selected the target population from all the administrative regions and administered a first, second or third dose as shown.

The target of 20.4 million adults that appears in Column 2 of Table 1 was recently provided by the MOH (May 1995). It is a portion of the total target population (34.4 million) scheduled to receive a first, second or third dose of the toxoid, according to the current MOH/WHO strategy of providing at least one dose of the toxoid to all adults aged 15 to 59 who have not been vaccinated since 1992, with supplementary immunization for select high-risk cohorts. The population figures in Column 2 may correspond to the PATH/USAID-provided donation of 22 million doses of Td toxoid, an amount sufficient to vaccinate (a) 17 million adults with one dose of the toxoid and (b) 5 million adults in the age cohorts 30-39 and 40-49 with a second or third dose.

The data on PATH/USAID-provided doses distributed, which appear in Column 4 of Table 1, indicate that more than 10 million doses had been dispatched to the administrative regions

by the end of March 1995. Approximately 70 percent of the doses distributed have been used (6.3 million - Column 6) and approximately 30% (2.7 million - Column 7) remain in regional stores. Slightly more than 5% (0.6 million doses) of the 11 million doses of Td toxoid provided by PATH/USAID were at Obukhov, Ukrvaccina's central storage facility.<sup>5</sup>

Column 8 of Table 1 presents the number of cases of diphtheria by administrative region for the period January through March 1995. While the total shown (1,090 cases) differs from the data presented in Figure 2 (1,364 cases), the figures presumably will be reconciled.

Column 8 also indicates that the City of Kiev and the southern and eastern regions recently registered the highest numbers of cases, consistent with the decision of the MOH to launch mass immunization campaigns first in Kiev and the south (carried out in April 1995) and then in the eastern administrative regions of Ukraine (planned for September 1995).

#### Other Diphtheria Issues

- **IE&C** - PATH and the MOH reached different conclusions about the response of health care workers and the general public to the April campaign. The MOH asserted that, with few exceptions, central and oblast level officials and workers had a high level of interest and commitment. In contrast, PATH observed that communications efforts were insufficient. There is even some question as to whether ads appeared in newspapers, and on radio or TV. PATH believes there is a clear need for more motivation at the level of the general public, from agents such as school principals and factory work teams. PATH further believes that health workers, many of whom are more concerned about other diseases such as tuberculosis, need to be motivated.
- **PUBLICITY** - There is a general perception at PATH, as well as USAID/Ukraine and USAID/W that USAID and the U.S. Government have not been adequately recognized or appreciated in Ukraine. The U.S./PATH role has been overlooked or minimized in at least one press conference and several written articles or documents. While the CA did not call for PATH to play a role in this area, PATH, USAID and the U.S. Embassy need to be more alert for opportunities for positive publicity and need to collaborate and coordinate more closely when opportunities arise.
- **COVERAGE AND IMMUNOGENICITY SURVEYS** - Two geographically distinct sites were initially selected for the immunogenicity survey -- Odessa and suburban Kiev/Darnitsa. The samples for the study in Odessa have been successfully collected. Initial findings are expected to be available in August. Unfortunately, the study in Darnitsa had to be dropped because of local political considerations. Hopefully, another comparable site in a factory setting near Kiev will soon become available.

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<sup>5</sup> According to the MOH data provided, the total received and distributed through March 31, 1995 11,087,000 as compared to actual PATH deliveries of 11,010,000.

- **SWISS SERUM INSTITUTE (SSI) VACCINE** - Early in 1995, PATH became aware of rumored allergic reactions to a SSI vaccine lot administered in September or October 1994. When PATH inquired, the MOH minimized the issue and discouraged active follow-up. Since then, several unsuccessful attempts were made by PATH and USAID representatives to obtain additional details of the alleged reactions. Under the circumstances, USAID requested PATH to prepare a memo to the file, but to take no further action until the existence and the nature of the rumored problem are clarified. (In fact, MOH has never reported to PATH any adverse reactions to any of the USAID/PATH-supplied vaccines.)
- **KHARKIV PRODUCTION** - PATH currently has no additional information on the status of possible Td production at Kharkiv, though reports that some Russian Td toxoid was supplied in bulk and filled at the facility are apparently accurate. PATH is considering a visit to find out the real status.

c. Prospects for Impact

The current epidemic of diphtheria in Russia and Ukraine is unprecedented in the vaccine era. Consequently, approaches to control, such as immunization strategy or regimens of treatment, must be continually reviewed and revised. It is not possible, at this point, to predict precisely how the implementation of the current strategy will affect the incidence of diphtheria in Ukraine, when the epidemic will be brought under control, or the extent of the resources required to achieve control. Nevertheless, substantial impact from other aspects of the PATH activity (some of it unanticipated) may now be projected.

**STRATEGY** - With the experience of the epidemic, and increased trust of PATH, CDC and other actors, the approach which the MOH is taking to the diphtheria epidemic has already changed greatly, to a point where there is now substantial agreement by all parties. However, the "best" strategy is expected to remain a dynamic implementation issue.

**COLD CHAIN** - PATH assessments and monitoring and limited monitoring equipment has helped assure that the USAID-funded Td toxoid has been delivered safely to oblast cold storage. As a direct result of PATH's emphasis on the integrity of the cold chain and resulting vaccine safety and efficacy, MOH and Ukravaccina officials at all levels are much more aware of the importance of the cold chain and are diligently and effectively monitoring it. The MOH has taken steps to correct deficiencies noted.

**CONTRAINDICATIONS** - In the past, an extensive list of contraindications to vaccination meant that many people were not immunized. The recent experience in Darnitsa suggests that PATH and CDC may have influenced the MOH to change practices with regard to administering the toxoid.

**COVERAGE SURVEYS** - The program has convinced MOH to initiate coverage survey techniques for the first time. The MOH has already said that if the upcoming survey proves useful, they would like to utilize them on a regular basis.

**IMMUNOGENICITY STUDY** - The findings of the immunogenicity study conducted by CDC, with support from PATH and the USAID/CDC PASA, will be used by the MOH to refine their adult vaccination policy in Ukraine. These results will also be useful for diphtheria control throughout the NIS.

**INFORMATION FLOW** - There is already good evidence of greater openness and transparency regarding the flow of information within the Ministry. While it was initially difficult for PATH to obtain information from the MOH, the ministry is currently much more cooperative, and there is absolutely no suggestion that they are withholding or intentionally manipulating data.

**RELATIONSHIPS** - PATH appears to have a "close and collegial relationship" with the MOH. In its dealings with the MOH and USAID, PATH has generally felt free to be creative and to use initiative.

**IEC** - There appears to be greater MOH receptivity to the concept of IEC and its role in addressing the diphtheria epidemic. This receptivity could lead to increased emphasis on this concept during the remaining period of the CA.

d. Findings/Conclusions and Recommendations

**FINDING:** PATH has generally met or exceeded the level of performance specified in the RFA and in the initial Implementation Plan, particularly with respect to: the procurement of vaccines and related materials; vaccine storage and cold chain; followed by a plan for procurement and delivery of imported vaccines and other commodities.

**FINDING:** There appears to remain a difference in opinion between PATH and the MOH regarding MOH and public support for the immunization campaign and, hence the need for additional IE&C (social mobilization) programs.

**RECOMMENDATION:** PATH and the MOH should agree on IE&C activities to be undertaken during the remaining months of program implementation.

**FINDING:** Commodity procurement and deliveries have been handled efficiently, responsibly and in a timely manner. In the two cases where delays have occurred (Td toxoid production and delivery of antibiotics) delays have either been beyond PATH's control, or warranted because of legitimate concern about loss of commodity due to inadequate MOH controls. Given the emergency and humanitarian nature of this activity, PATH was correct in placing top priority on Td procurement and delivery. PATH has acted prudently in withholding purchase and shipment of antibiotics and antitoxin. However, discussions with the MOH need to be concluded rapidly so that

either procurement can continue or funds for those commodities can be reprogrammed.

**RECOMMENDATION:** PATH and the MOH should set a deadline for resolving this issue. If agreement cannot be reached, the funds allocated for this procurement could be lost or reprogrammed.

**FINDING:** PATH activities have evolved well beyond the primarily logistics role they accepted in the Implementation Plan.

**RECOMMENDATION:** The CA should be modified to more accurately reflect PATH's more active role in a broader range of implementation activities.

**FINDING:** PATH has not developed a monitoring tool capable of tracing rapidly and accurately the receipt, distribution and use of the USAID/PATH-provided Td toxoid. This shortcoming has hampered PATH and USAID's ability to document progress made to date, and to anticipate future requirements.

**RECOMMENDATION:** PATH must develop, test, and use an effective monitoring and data instrument and keep the MOH and USAID advised of any deviation from the agreed upon strategy. The draft instrument, presented in Table 5, might be a useful start.

**FINDING:** There is an apparent disconnect between the current epidemic control strategy and the MOH toxoid distribution and immunization programs. While the current MOH practices may be medically and politically defensible for individuals or particular regions, such practices risk undermining the overall control strategy.

**RECOMMENDATION:** That USAID/Ukraine conclude, as rapidly as possible, a Memorandum of Implementation with the MOH. This document should set forth the responsibilities of the MOH, USAID, and PATH under this program, and emphasize the importance of adhering to the agreed upon strategy.

## 2. DIABETES IN CHILDREN<sup>6</sup>

### a. Objectives

The Cooperative Agreement called for PATH to submit a diabetes component implementation plan by September 15, 1994 which would describe how PATH intended to implement the component. The "Project Implementation Plan: Juvenile Diabetes Mellitus" was submitted to USAID on October 17, 1994. The Plan was based on a September 1994 visit by a PATH diabetes assessment team and generally conformed to the requirements set forth in the CA. It explicitly recognized the difficulty in collecting essential information and offered the disclaimer, "Thus, the potential validity of the team's observations may be limited..." Nevertheless, the Implementation Plan did a generally good job of describing the situation among diabetic children in Ukraine and, describing the steps recommended to procure and deliver specific quantities of insulin and related diabetes management supplies to approximately 5,200 children below the age of 15.<sup>7</sup> Though never explicitly stated, those recommendations, de facto, became the objectives of the diabetes component.

Like the diphtheria component, the Plan was particularly strong in outlining procurement and logistical elements. The Implementation Plan also appropriately highlighted the potential risk of losing high-value/readily-marketable insulin and the importance of effective and secure delivery and accountability systems. Finally, the Plan correctly identified the non-sustainable, one-shot nature of this component. Aside from a skeletal timeline covering the period from September 1994 through January 1995, however, the Plan did not include scheduling. Nor did it include a list of explicit indicators and measurable outputs, by which component progress could be measured. There is no indication that USAID ever sought to correct this oversight.

### b. Progress

As of May 31, 1995:

- A trial distribution (representing four months supply of insulin, Keton strips, lancets, needles and syringes) had been completed in three oblasts. The trial shipment and distribution went quite well, but still experienced a loss of approximately 4%.
- The transfer and tracking systems have been revised, as a result of that loss. There are now transfer forms for each in-country transfer stage: a) Center to oblast; b)

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<sup>6</sup> Referred to as "Juvenile Diabetes" in the CA and Implementation Plan. "Diabetes in children" is now used to conform to more current terminology.

<sup>7</sup> Please note that this estimate (based on limited information provided by the Kiev Institute for Endocrinology and Metabolism) is different from the 6,000 children under the age of 14 which was the target group described in the CA.

Oblast to rayon; and c) Rayon to patient (with spot-checking all along the route). In addition, a final patient data base has been provided by the MOH, helping to assure that the insulin actually goes to the target children.

- Deliveries of four-month supplies to the remaining oblasts was scheduled for June 1995. (All deliveries of the full one-year supply to participating children is expected to be completed prior to the end of 1995).
- Medical staff in each oblast have been trained and familiarized with U-100 dosage administration and diabetes monitoring. Lilly has done a good job with its portion of the education campaign. The MOH has been careful to keep the names and addresses of the target children confidential.
- PATH conducted several visits to the homes of children with diabetes confirming that the status of insulin dependent children in Ukraine is bad. Recurring problems noted include: shortages of syringes and needles; improper home storage of insulin; inadequate monitoring of health and insulin dosages; and a lack of dietetic products for diabetics.

Progress in this component has been a bit slower than initially anticipated in part because of the higher priority PATH and USAID gave to the diphtheria component. The major delays, however, have been due primarily to the difficulty in designing and establishing a reliable and secure system for distributing and monitoring the insulin shipped under this CA. Given the serious shortage of insulin in the country, all shipments are at risk of loss or diversion unless great care is taken.

#### c. Prospects for Impact

There is every reason to believe that the CA's primary objectives of this component (delivery of a one-year's supply of insulin to diabetic-dependent children in Ukraine) will be achieved. While this USAID-funded component will help for one year, PATH and USAID are still frustrated that the component is not sustainable, and that the children may be left without further dependable and affordable sources of insulin. Nevertheless, this program component is poised to have a far reaching impact on diabetic children.

**DELIVERY AND MONITORING SYSTEMS** - The registry of diabetic children in Ukraine, as well as the infrastructure and monitoring systems and instruments developed under this component may be continued by the Ministry of Health.

**DISEASE MANAGEMENT** - The activities to train medical practitioners and to make disease management handbooks and other educational material available to families of diabetic children should contribute towards improved diets and more regular and cost-effective disease management practices.

d. Findings/Conclusions and Recommendations

FINDING: While component implementation has been somewhat slower than hoped, PATH has given proper attention to assuring that appropriate distribution and monitoring systems are in place.

FINDING: Recognizing the humanitarian assistance origins of this component, AID/Washington and the Mission nevertheless share PATH's concern about its unsustainable character.

RECOMMENDATION: PATH may wish to explore low-cost activities which might enhance the sustainability of this component, or at least mitigate the negative impact when the USAID support ends.

3. BLOODBORNE INFECTION CONTROL

a. Objectives

The Cooperative Agreement mis-labeled this component of the program "Control of Hepatitis B Among Health Care Workers," but, via the component description, then revised the focus to clearly place the emphasis on a broader range of bloodborne infections. The Agreement read:

"This component of the humanitarian health assistance activity will consist of a program that will educate health care workers about the epidemiology and transmission of blood-borne pathogens, especially HBV, in the occupational setting. The program will provide training to trainers and develop didactic materials to be used in an education campaign.... In addition this component will include the procurement and provision of a reasonable supply of American-made" [materials to protect health care workers].

The CA further stated that "If funds were available, it would be desirable to immunize all Ukrainian infants at birth (with HBV)... However, at present, the high cost of the hepatitis B vaccine does not allow its inclusion in the Ukrainian national immunization plan." Therefore, AID decided not to procure HBV under this program.

As with the other components, the CA called for PATH to submit an implementation plan for the "hepatitis B" component by August 15, 1994 and set forth the information expected to be included in that Plan. The "Project Implementation Plan: Bloodborne Infection Control Among Health Care Workers" was submitted on time (August 31, 1994). The Plan provided an excellent assessment of current regulations, training, practices and attitudes concerning bloodborne infection control, but was non-specific about particular component activities, outputs, progress indicators or schedules. In addition, while correctly titled, the Plan placed weighty emphasis on hepatitis, while implicitly downplaying other bloodborne diseases.

The PATH assessment team found considerable Ukrainian interest in vaccine supplies, diagnostics and barrier supplies, but only mild interest about "universal precautions." Further, the Ukrainian disease-specific approach pulled the team in different directions and made a focus on universal precautions difficult. As a result, the only semi-specific proposals in the Plan were for "Physician Seminars" and an Information, Education and Communication seminar. The Plan also suggested "Possible Additional Activities" including revision of MOH orders, procurement and/or manufacture of barrier clothing and materials, pilot training and demonstration projects, and vaccination against hepatitis B. There is little evidence in file that USAID provided specific comments on the Implementation Plan.

b. Progress

As of May 31, 1995, PATH had reached agreement with USAID/Kiev and AIHA on the primary objectives for two BBIC demonstration programs at partnership hospitals in Odessa and Lviv. At that time, PATH and the hospitals were preparing project details.

Implementation of this component has been significantly delayed for a variety of reasons including:

- Lack of specificity in the original RFA, CA and Implementation Plan;
- Changes in personnel at the MOH, and MOH reluctance to view the component in terms of "universal precautions" as opposed to control of hepatitis B;
- USAID requests to delay the opening workshop until the content and audience could be better clarified; and
- The relatively higher priority PATH and USAID both gave to the other two program components.

An additional factor in the delay has been the issue of how PATH could develop a component focus that was both acceptable to USAID and responsive to the MOH. The Ministry, accustomed to approaching bloodborne infections on a pathogen by pathogen basis, was primarily interested in the problem of hepatitis B, for which the first line of defense worldwide is the HBV. By contrast, USAID was supportive of the "universal precautions" approach which seeks to protect workers from the full range of bloodborne diseases. In addition, USAID was concerned that if Ukraine began an HBV immunization program for healthcare workers, Ukraine might not be able to sustain it because of the high cost of HBV. In addition, USAID was concerned that the addition of HBV to Ukraine's children's immunization program might divert resources from other components of the program.

c. Prospects for Impact

Following PATH's May/June visits to the two AIHA hospitals in Odessa and Lviv and further discussions with USAID, the demonstration projects now have been carefully outlined. Project objectives, indicators of progress and success, and implementation plans have been agreed and activities will begin in September 1995. In the two demonstration

hospitals, the project activities will introduce cost effective practices to reduce the incidence of bloodborne infections. The projects will also capture and document that experience for future replication in other hospital settings in Ukraine. All activities would not have been completed by the original CA completion date of April 30, 1996, but should be completed by the end of September 1996.

d. Findings/Conclusions and Recommendations

**FINDING:** The lack of clarity on program objectives has been the primary impediment to faster progress in this component. Clear objectives have now been agreed by PATH, the MOH and USAID. An extension to the CA of approximately six months will be required to fully achieve program objectives.

C. Financial Situation

PATH's "Summary of Financial Information" through March 1995 shows the following:

ITEM	BUDGETED	PROJECTED <sup>8</sup>	EXPENDED	SURPLUS/ (DEFICIT)
COMMODITIES <sup>9</sup>				
Diphtheria	6,563,000	4,841,357	1,459,885	1,721,643
Diabetes	1,481,000	1,813,450	127,518	(332,450)
BBIC	1,096,000	1,096,000	0	
Subtotal	9,140,000	7,750,807	1,587,403	1,389,192
NON-COMMODITY	2,200,000	2,212,143	1,032,855	(12,143)
CA TOTAL	11,340,000	9,962,950	2,620,258	1,377,050

As the above table indicates, nearly half-way though the cooperative agreement period, actual commodity expenditures were only approximately 20 percent of the currently projected requirements (17 percent of the original budget). This low percentage is due primarily to four factors, each of which has been entirely or largely outside PATH's control:

<sup>8</sup> Through end of project.

<sup>9</sup> Includes freight.

- The CA initially provided approximately \$1.38 million to procure DPT vaccine for children. When the Government of Canada decided to provide the DPT vaccine, the USAID/PATH procurement was withdrawn. The funds intended for those vaccines, therefore, became available for re-programming.
- Due to production problems at Connaught, the delivery (and hence the expenditures) for Td procurement have been substantially slower than anticipated.
- Delivery of insulin has been slower than initially anticipated, because of the difficulty in putting a reliable and accountable delivery and monitoring system in place.
- The procurement of barrier materials for the bloodborne infection control program has been substantially delayed by the inability to clarify and specify component objectives.

By contrast, at approximately 47 percent of the amount budgeted, expenditures for non-commodity items (salaries & fringes, consulting services, travel & per diem, other direct and indirect costs) are about on schedule.

Viewed as a humanitarian program, whose primary objective was to get commodities to Ukraine as rapidly as possible, the non-commodity expenses to date have been high relative to the cost of the commodities delivered. As suggested above, however, in addition to the factors beyond PATH's control, the program has been much more personnel-intensive than initially anticipated. In the case of insulin for children with diabetes, PATH was correct in delaying procurement and delivery until appropriate systems were in place. As all conditions are now in place for rapid delivery (and expenditure) of commodities, this picture will change radically for the better over the next several months.

#### IV. ADMINISTRATIVE AND MANAGERIAL CONSIDERATIONS

##### A. PATH

PATH Seattle performs exceptionally well as a home office supporting the work in the field. PATH personnel and proven systems sustain high quality home office management, technical support, procurement support and administrative and logistic support. PATH has submitted monthly progress reports as well as quarterly progress reports and financial reports. Generally, these reports have been well prepared, substantive and timely. In addition, PATH has been flexible and responsive (sometimes on short notice) to special requests for information, meetings or problem resolution. The short-term U.S. technical specialists, provided either from PATH's own personnel or as consultants, have also performed well.

In the field, PATH has gained the respect of and has developed an excellent working relationship with the Ministry of Health. The Ministry has stated that they "could not have managed without this program." Amongst other things, PATH expertise has been absolutely

invaluable in reviewing and improving the vaccine cold chain and in developing a reliable and accountable system for delivery of insulin to children. Perhaps more importantly (and largely unanticipated in the cooperative agreement) PATH assistance has helped the MOH revisit such technical questions as diphtheria diagnosis and treatment, strategic planning, vaccine wastage, survey techniques, public mobilization, international procurement, diabetes disease management, and universal precautions for the control of bloodborne infections.

This said, there is still one area of PATH's performance which needs to be improved over the coming months: senior level, field-based project management. Two issues emerged over the course of this review which strongly suggested the need for more senior level PATH presence in Kiev. The first issue is the continuing absence of a useful tool or system for tracking exactly how and where the USAID financed Td vaccine is being used. The second is the need to continuously monitor and reexamine with the MOH and USAID such "big picture" questions as the strategy under which the MOH is utilizing the vaccine. Complementing these needs are the perceived needs for better day-to-day communications with the USAID mission in Kiev and the need to be alert for public relations opportunities.

#### B. USAID

USAID's initial program design, and procurement was handled professionally and very expeditiously. Given the relative lack of information available to USAID at the time, the program design has remained remarkably intact. Generally the communications between USAID/Washington and PATH and between USAID/Washington and the field have been good. There has, however, been concern that USAID's comments, particularly from the field, are sometimes late in coming and seldom in writing. While PATH believes that the situation has improved in recent months, and while PATH fully appreciates the heavy demands on USAID personnel (Washington and Kiev) it would appreciate more timely and more written responses to inquiries, proposals and reports.

#### C. MOH

The Ukrainian Ministry of Health generally has been an open and cooperative partner in program implementation. Despite occasional difficulties in getting important information (e.g. registry of diabetic children, and distribution of Td vaccine) officials and documents have usually been accessible. There have been few, if any incidents of withholding information and there has been no suggestion of misuse of program commodities. At the same time, the reviewers are concerned as to whether MOH inputs and involvement in the diphtheria program are sufficient to insure the most effective use of the USAID-financed vaccine and timely control of the epidemic.

Under the cooperative agreement between USAID and PATH, the Ministry of Health is explicitly responsible for control and direction of the diphtheria immunization campaign. PATH does have a Memorandum of Understanding with the Ministry which covers some of the logistics concerning commodity importation, packing, delivery, etc. There is, however,

no agreement between the MOH and USAID concerning this program. Nor is there any agreement which specifically spells out the Ministry's responsibilities, either in terms of the resources they will provide, or the program and strategy they will follow. As a result, while USAID's and PATH's roles and responsibilities are quite specific and explicit, the roles and responsibilities of the Ministry (the most important entity for bringing the diphtheria epidemic under control) are vague and ambiguous.

**RECOMMENDATION:** That USAID/Ukraine endeavor to negotiate with the MOH a Memorandum of Implementation which spells out the roles and responsibilities of the various parties in the diphtheria control effort, particularly the Ministry's responsibility for utilizing the vaccine in accordance with the agreed MOH/WHO/UNICEF strategy.

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*Attachment C***Memorandum****Date:** August 22, 1995**To:** Paul Holmes, CTO, USAID**From:** Roscius Doan, Project Director, PATH**Subject:** Comments on Draft of Mid-Term  
Evaluation Document**Distribution:** PATH/Seattle  
Ukraine Team  
John Pott, PATH/Kyiv  
Gordon Perkin

PATH has reviewed the draft of the mid-term assessment of our activity in Ukraine under USAID Cooperative Agreement No. CCN-0001-A-00-4048-00.

We are most appreciative of the open, collegial, and comprehensive manner in which this review was carried out. The format of this draft will serve as a framework for correction and improvement of this project in the weeks and months ahead.

The following comments are submitted in response to your request for feedback.

**DIPHTHERIA**

Page 9: Monitoring for Utilization and Coverage - The statement, "It was not until spring 1995 that PATH discovered that the first vaccine was not used until September [1994] (even though it had arrived in July)," is not correct. PATH reported to USAID in its October 1994 report (p. 2) that, "The Td vaccine provided by USAID/PATH has been in use only a short time. It is estimated that the first Td vaccine from this program was consumed in early September." In the December 1994 report (p. 3), PATH reported to USAID that a site visit to Ivano-Frankivsk oblast revealed that the Td vaccine in that oblast "entered general use only in October." The problem of the wide distribution of Td vaccine to oblasts other than those on the ten-oblast list was first discussed in general terms in the December 1994 report (p. 5), and documentation of the wide distribution by oblast was presented in the January 1995 report in Table D-2.

Pages 13 and 14: d. Findings/Conclusions and Recommendations - PATH supports the recommendations in this section. We intend to resolve the issue of whether or not to supply antibiotics for contact cases. We will improve monitoring of the Td vaccine receipt, distribution, and consumption. At this time, we understand that we are to take no initiative in the process of concluding a Memorandum of Implementation

Memorandum to Paul Holmes  
August 22, 1995  
Page 2

with the MOH but stand ready to advise and assist the USAID Mission in this process if requested.

#### DIABETES

No comments.

#### BLOODBORNE INFECTION CONTROL

Page 19: d. Findings/Conclusions and Recommendations - We have felt that the recent preparation of the program plan for this component has given direction to this activity. We are pleased to receive the extension of the cooperative agreement which will allow additional time for this work to be carried out.

#### ADMINISTRATIVE AND MANAGERIAL CONSIDERATIONS

Page 21: PATH agrees with the assessment that senior-level, field-based project management needed improvement. The formation of a Technical Assistance Group and the implementation of changes in the structure of the PATH/Kyiv office are recent responses to this concern.

If any amplification or clarification of these remarks would be helpful, do not hesitate to contact me. Best regards.

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