Reproductive Health Care Funding in Ukraine

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National Committee Member Profiles

The authors of this research, all members of the specially created National Committee for Reproductive Health Funding Assessment in Ukraine, are highly qualified specialists who have much experience in the reproductive health (RH) field.

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Natalia Mykolayivna Nizova, Doctor of Science (Medicine), professor, a committee member, professor of the obstetrics and gynecology department at Odessa State Medical University, and Dean of the post-graduate education school. She is a member of the Obstetrics and Gynecology expert commission of the Academy of Medical Sciences and MOH, a member of the MOH Coordinating Board on Post-Graduate Education, a member of the expert commission "Obstetrics and Gynecology" of the Academy of Medical Sciences and MOH, a member of the MOH Coordinating Board on post-graduate education, and national expert on FP problems. She has been involved in projects such as INRIEDO, AVSC Int., AIHA and POLICY in Ukraine. She is a research manager of the Women's Health Center and Regional Family Planning Center in Odessa and a coordinator of the oblast obstetric and gynecological service. She is head of the public organization "Health, Woman, Longevity". She is the author of more than 150 scientific publications dealing with present-day problems of obstetrics, gynecology and RH care, an editor of the first national manual on family planning and a co-author of the monograph "HIV infection in perinatology", first published in Ukraine. She has taken part in more than 20 International scientific conferences and congresses.

Volodimir Myroslavovytch Rudiy, a committee member, hygienist and epidemiologist by specialty, as well as a lawyer. Head of the Verkhovna Rada Secretariat on health care, mother and child protection. He has some 20 publications dealing with various issues of hygiene, public health care management and legislation. He took direct part in the formulation of almost all effective national laws that regulate social relations in this area, including 'Fundamentals of Ukraine's Health Care Legislation' and Ukrainian legislation 'On prevention of AIDS and Social Protection of Population'. He was involved in the implementation of the POLICY Project in Ukraine, and wrote the report 'Analysis of legal and statutory field in the area of family planning and RH in Ukraine'.

Executive Summary

Economic hardship in Ukraine makes it difficult for the public sector to pursue strategies for improving access to family planning (FP) and contraception, or improving the quality and provision of reproductive health (RH) care services. Instead, authorities tend to consider tactical expenditures and short-term objectives that, in the longer term, often prove expensive and detrimental. Given the current size of government deficits and the lower priority given to financing health care in general, it is hard to expect increases in state investment in RH care, or for that matter any other activity that is unlikely to impact directly on output in the short term. Estimates for 2000 indicate that health care accounts for only 2.9 percent of the gross domestic product (GDP), although this percentage rises to about 5 percent once out-of-pocket payments and other financial sources are considered. This compares with an average of around 8 to 9 percent in western countries.

We found little evidence to suggest that cost-benefit studies or policy evaluations had been undertaken in Ukraine, and that as a result policymaking and service planning tended to operate in a vacuum. Working on this project, we reached the conclusion that neither the necessary statistics nor any suitably developed methodology for deriving them currently exists. However, we were able to piece together a coherent picture of the current RH care system, which was sufficient for our purposes.

Our detailed conclusions and recommendations are contained in a separate chapter at the end of this report. We addressed the following key issues:

1. Current status of the RH care system and its adequacy for improving the present demographic situation.
2. Level of awareness among officials, institutes, and the medical research community about RH issues.
3. Principal risk groups to whom services should be targeted and the connections between them and providers.
4. Split between private and public financing in the RH care field, particularly the role of the informal sector.
5. Appropriate scenarios and policies for directing allocations to RH care services, given current resource levels, risk group size, and institutional context.
6. Improvements to the financing of RH care in order to improve access and equate services better to current needs.

Regarding the first issue, we agreed with the view that Ukraine is in the midst of a profound demographic crisis, which could potentially run out of control. Fertility levels in Ukraine in 1999 were about 8 births per 1,000 as compared to approximately twice that level 15 years ago; total fertility rate (TFR) is currently 1.0 and 1.6 for urban and rural areas, respectively. Mortality levels increased by 30 percent from 1990–1999 and are currently 14.6 deaths per 1,000. There is also a danger of an HIV/AIDS epidemic in Ukraine with cases growing faster than in any other European country. Life expectancy continues to shrink: according to 1999 data, it was 68.5 years for the entire population and 63.2 and 73.8 years for men and women, respectively. Maternal mortality ranges between 5.6 and 87.4 per 100,000 births

depending on region. The number of abortions is 1.2 times higher than the number of deliveries, and there are almost 0.5 million induced abortions every year in the country. Infant mortality was 12.8 per 1,000 live births in 1998. In addition, every third child has anomalies in its physical and psychic development.

At the same time, health and RH care providers in Ukraine have been unable to respond effectively as the public health care system suffers from a chronic lack of resources. RH-care funding in real terms is now several times smaller than it was eight years ago. The constitutional rights of citizens to free health care has not in practice protected either the public or physicians from the hardship of economic transition to a market economy.

Regarding the second issue, we found that, in general, Ukrainian government policy is consistent with the *Programme of Action* of the 1994 International Conference on Population and Development (ICPD). The *Programme of Action* has three main goals during next 20 years: decreasing infant and maternal mortality, and achieving universal access to RH services, including FP.

Policy toward RH acre is enshrined (directly or indirectly) in the Ukrainian Constitution and current legislation. Political decisions, which are adopted by different authorities, in the statements of president, in the program of the Cabinet of Ministers, speeches by the prime minister, Minister of Health, and in orders of authorities related to planning in this field.

In general, legislation is favorable toward RH care and toward the family in general. Under Article 3 of the Ukrainian Constitution, a citizen's life and health, honor, and security are given highest social priority. Article 50 guarantees the right of the citizen to an environment that is secure for life and for the compensation of losses caused by any violation of these rules. Under Article 14, the Ukrainian Government is responsible for security and stability, as well as for overcoming the effects of the Chernobyl disaster. Article 49 guarantees free medical services to every citizen of Ukraine. Legislation relating to safety at work and to environmental safety provides, in theory, a sufficient basis for protection. Customs and tax policies are generally also balanced and progressive, in the sense that they do not impose impediments to, for example, the importation of contraceptives[1]. However, the problem is that the enforcement of this legislation is not always efficient or effective.

A comprehensive description of RH care policy is contained in the national program, "Family Planning 1995–2000," and within the five-year program, "Reproductive Health 2001–2005." Despite this, a key difficulty is that health care in general and RH care in particular are not given the priority either in political or financial terms, which might be expected under current legislation and policy.

[1] V.Rudiy. Analysis of legislation in field of FP and RH care in Ukraine. The Futures Group Int., POLICY Project. ? ??, 1999. ? .28. M.Kohut, N.Lakiza-Sachuk. National-Level Decision Making on Reproductive Health Policy in Ukraine. The Futures Group Int., RTI, CEDRA. Kiev, 1999.-17p.M.Kohut, N.Lakiza-Sachuk. Key Informant Study: Policymakers' Knowledge of and Attitudes toward Reproductive Health in Ukraine. The Futures Group Int., RTI, CEDRA. Kiev, 1999.-19p.

As we have noted, the root cause is the social and economic crisis in Ukraine. Current economic policy is also a barrier to the development of private and mixed forms of health care, while the system of management is urgently in need of reform.

Regarding the third issue, we found that there were numerous groups at risk with overlapping needs and problems, although it was expedient to reduce this complexity to three female groups of population defined by age.

For purposes of this paper, for the calculation of RH care needs and associated financing, we defined three basic risk or target groups in the female population:

- **Girls aged 10–14—**prereproductive age, some of whom are already sexually active, at risk of becoming pregnant or acquiring sexually transmitted infections (STIs), or are using abortion and contraception techniques.
- **Women aged 15–49**—actively reproductive (i.e., becoming pregnant, bearing children, suffering from STIs and infertility, and using FP techniques).
- **Women over 50—**those additionally at risk from different kinds of cancer, requiring access to cancer screening and treatment facilities.

This is a simplification, since the groups are not mutually exclusive in terms of their RH care needs. For example, women under 50 may also have needs consisting of cancer treatment and screening services, but in the main these are assumed to be covered in the third risk group for the purposes of this paper.

We determined that the main services for these groups are the following: providing information on RH care services and promoting healthy lifestyles; sex education; psychological assistance; rehabilitation after stress situations (violence, etc.); services related to STIs (examination, treatment, etc.); providing contraceptives; infertility treatment and others related to RH; prophylactics and treatment of extragenital pathology; predelivery, delivery, postdelivery and obstetrics services; cancer screening, and cancer treatment.

The main RH care services providers are public and municipal hospitals and clinics; centers for RH care; centers for FP; schools; parents, friends; rehabilitation centers; private consulting centers and hospitals; and the mass media.

The main institutions involved in the distribution of public funds are the ministries of Health and Finance; the Cabinet of Ministers; Parliament; local authorities; professional medical associations; medical universities; and medical research centers.

Regarding the fourth issue, we found that health care financing is based on the principle of guaranteed free medical assistance, as well as through political regulation of other sources of health care financing (including legislation, tax policy, organization of budget process, etc.).

As already mentioned, RH care is officially funded through public sources. Funding from other sources is often prohibited. However, public funding covers only a small part of RH care needs. There is, for example, a large rise in illegal or semi–legal, out-of-pocket payments. Officially sanctioned alternatives to public sources of

funding are poorly developed, in the early stages of formation, and awaiting legal approval.

The main sources of RH care funding in Ukraine (in order of importance) are: local budgets; out-of-pocket payments; budgets for centrally funded programs; international technical assistance; funds provided by NGOs; charitable donations***;*** and insurance funds. Currently, the last three of these are considered to be small.

The main areas of expenditure from all sources are estimated to be, in approximate order, the following: (1) sex education (least expenditure); (2) HIV/AIDS; (3) cancer treatment; (4) cancer screening; (5) abortion services; (6) STI treatment; (7) maternity and obstetrics services; and (8) contraception (see also annex). The order for public expenditure is (1) cancer screening (least); (2) sex education; (3) cancer treatment; (4) HIV/AIDs; (5) contraception; (6) abortion services; (7) STI treatment; and (8) maternity services (most).

Regarding the fifth issue, we considered two possible directions of government policy: the first one, "Prevention and Promotion," calls for the prevention of diseases and promotion of healthy lifestyles; and the second, "Fighting Diseases," is directed to fighting diseases.

For "Prevention and Promotion," we assumed that government would give high priority to contraception, sex education, STI treatment, HIV/AIDS; and medium priority to maternity services, abortion services, cancer treatment, and cancer screening. Using IIASA's model of the RH care system developed for this project, we determined that contraceptive availability and usage should be increased from 300 to 400 per 1,000 risk group, and that the proportion of schoolchildren provided with sex education should be doubled. We argued that if the policy is successful, it should lead to decreasing the abortion rate by one-half. The need for prophylactics and treatment of HIV/AIDS would decline in three to four years by approximately 25 percent, as sexual behavior and attitudes to sex changed. The freeing up of resources would enable the ratio of services for cancer treatment to double, and screening for cancer to increase by 6 times—thus restoring it to levels under the old system.

For "Fighting Diseases," we assumed that government would give high priority to HIV/AIDS, STI treatment, cancer treatment, and cancer screening as in the previous scenario, whereas contraception, sex education, maternity services, and abortion services would be assigned only medium priority. The logic for this is that maternity services are in oversupply and were already so even before the recent dramatic falls in fertility. We also assumed that total out-of-pocket budget of RH care will slightly increase (from US$168 to US$175 million) due to economic growth.

The outcome of our simulations was that, under our assumptions, total public expenditures on RH care would decline from current US$64.7 million to US$57.3 million under the "Prevention and Promotion" scenario and to US $61.2 million under the "Health" scenario. Correspondingly, out-of-pocket payments will increase from US$103.2 million to US$117.7 million and US$113.8 million, respectively. In our opinion, it means that the Ukrainian government can potentially save some money by implementing one of these policies and investing the surplus in institutionalization of

the out-of-pocket payments system, through the development of a medical insurance market.

Regarding the sixth issue, improvements in the financing of RH care, we took the view that the main priority and ultimate goal should be to improve the demographic situation by giving a high priority to RH care.

The state should give remedying the serious demographic situation of the country highest priority by providing a stable and secure health care system and a safe environment. The main element of this policy is giving high priority to population's health, and especially RH, and using this as a basis for further renaissance of the Ukrainian nation.

We believe that the priorities should draw attention to the danger of abortion by the distribution of information; improve the availability of modern tools and methods for FP; improve the quality of cancer screening and cancer treatment; introduce gradually sex education in the curriculum of secondary and high schools; target information to risk groups concerning the dangers of STIs, especially HIV/AIDS, which has the fastest growth rate in Europe; reduce abortions; develop a new system for financing RH care with the goal of including of as many target groups as possible; improve enforcing existing laws in the field of RH care by, for example, imposing fines on companies and their management that violate the law; and finally, coordinate government, nongovernment, and commercial organizations involved in RH care.

It is assumed that these will increase contraceptive use and thus decrease abortions, STIs, and HIV/AIDS. Improvement of cancer screening services that detect cancer in its early stages would decrease the number of advanced, untreatable cases.

Under conditions of shrinking public funding and an increasing share of private funding in health care financing, the importance of the medical insurance market will increase. Through the proposed inclusion of medical social insurance in the Cabinet of Ministers of Ukraine Program of Activities,[2] the introduction of this source of financing into the health care system now seems possible. It will develop a multilevel approach for providing health care services and for RH care in particular. Accordingly, the state would guarantee some level of free medical assistance, while requests for additional services would be funded through both (local) public and private sources. Such a model would promote development of an accessible and efficient system of medical assistance, which is sensitive to local conditions and provides a safety net for those who cannot afford to pay. Section III provides further details of our conclusions and recommendations.

[2] Cabinet of Ministers of Ukraine Program of Activities, "Reforms for Prosperity," "Urjadovy Courier," March 15, 2000, N 47, p.4.

Definition of Reproductive Health
Adopted at the International Conference
On Population and Development,
Cairo, September 5-13, 1994

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases. (ICPD Programme of Action, *paragraph 7.2)*

I. Introduction

The U.S. Agency for International Development (USAID) financed the preparation of this report. The project was managed and coordinated by the International Institute for Applied Systems Analysis (IIASA) in collaboration with the POLICY Project, whose aim is to improve the political environment for programs in the area of family planning/reproductive health (FP/RH). Through the auspices of USAID, the POLICY Project seeks to generate improvements in the population's health status in selected oblasts within the framework of legislative, political, and economic reforms and FP/RH policy.

The 1994 International Conference on Population and Development (ICPD), known as the "Cairo Conference," provided the impetus for this research and the writing of this report. The outcome of the ICPD included an expanded definition of RH and a general declaration to ensure accessibility of RH services, including FP, by 2015. In 1999, at the Hague Forum, also known as ICPD+5, attention was directed for the first time to unique problems of RH facing countries with transitional economies, such as Ukraine.

Previous POLICY initiatives in the area of RH[3] have shown that top Ukrainian officials, who are the key decision makers in this field, are aware of the issues and

[3] Kohut, M. and N. Lakiza-Sachuk. 1999. *National-Level Decision Making on Reproductive Health Policy in Ukraine.* Kiev: The Futures Group Int., RTI, CEDRA.; Kohut, M. and N. Lakiza-Sachuk.

international policy developments and agreements. However, they believe because of for political and economic reasons that it is difficult to take all measures regarded as necessary.

Ukraine continues to decline economically, and the accompanying social transformations have created a chain reaction of social problems, for example, in the field of pensions. As a result, the health care sector in general and the RH sector in particular are not considered to be priority areas either in the broad political context or in terms of central and local government priorities. Many other branches of economy, including health care and RH, suffer from a similar lack of resources. Thus, RH funding is only one of the numerous issues claiming attention from ministerial departments and local government. We believe, however, that our analysis of the RH funding process and decision-making process should help focus attention on the RH care area and lead to beneficial improvements in RH and RH-care funding.

The strategic goal of this project is to promote wider access to RH care resources as proposed at the ICPD. The secondary goal is to raise decision-makers' level of knowledge and understanding of RH funding problems. Other lower level goals consist of the following:

1. Create and introduce a mechanism to forecast demand and needs in the area of RH, identify sources of funding, and discuss their advantages and disadvantages.
2. Identify data necessary to improve planning and financial decision-making in the area of RH.
3. Identify performance indicators, criteria for the monitoring and assessment of RH funding strategies.
4. Provide the POLICY project and other collaborating agencies with a wider network of people acquainted with and interested in issues of RH funding.
5. As regards RH financial aspects, ensure support for the work of the POLICY Project in Ukraine.

Between October 1999 and May 2000, the following process were adopted and tasks accomplished:

1. An advisory panel on RH funding issues was formed.
2. An executive secretary was appointed and provided with sufficient resources.
3. On the basis of regular meetings of the advisory panel and technical assistance from IIASA and The Futures Group International, the executive secretary prepared this national report.
4. A national roundtable was convened, during which members of the advisory panel and key players in the area of RH discussed the report and introduced certain changes and amendments. In all, 18 experts, officials, and observers participated, including a representative from the state press agency.

1999. *Key Informant Study: Policymakers' Knowledge of and Attitudes toward Reproductive Health in Ukraine.* Kiev: The Futures Group Int., RTI, CEDRA.

II. Methodology

The research included the collection and analysis of numerous statistics, information, and other relevant data, on and including the following:

- Macroeconomic indicators
- Population development indicators
- Health care financing
- FP services
- Obstetric services
- Abortion-based birth control
- Contraceptives
- Sexually transmitted infections (STIs) treatment, including HIV/AIDS
- Female cancer associated with RH

In the course our work, we were confronted with a string of problems connected with the process and methodology of information collection and analysis. First, government statistics agencies in Ukraine do not regularly collect much information concerning RH, especially pertaining to costs. This information had to be obtained by special request (e.g., from the Finance Ministry) or estimated. Second, important information about changes in financing through time was unavailable. Third, some data required estimation or expert judgment.

This report is therefore based on a range of informational sources obtained from representatives of all branches of government in Ukraine. In 1998–1999, the POLICY Project conducted the survey of the population's RH status and possibility of improvement in the political environment in Ukraine. The executive secretary of the national committee appointed to this project was also involved in that work[4].

The report also includes secondary analysis of results of the two sociological surveys conducted by the International Institute of Sociology in Ukraine, also with USAID support. Results of the surveys were made available. The first survey was "Family Planning–1996," and the second was "Reproductive Health–1998."

Some Aspects of the Social-demographic Situation

General Demographic Situation. Ukraine, which became an independent state in August 1991, had one of the largest populations in Europe (about 52 million.). The introduction of democratic principles has led to the foundation of a civic society (i.e., adherence to human rights, supremacy of law, and market reforms). However, too rapid a transformation of the political, economic, and social spheres of life has triggered a deep socioeconomic crisis affecting all levels of society.

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[4] Kohut, M. and N. Lakiza-Sachuk. 1999. *National-Level Decision Making on Reproductive Health Policy in Ukraine.* Kiev: The Futures Group Int., RTI, CEDRA.; Kohut, M. and N. Lakiza-Sachuk. 1999. *Key Informant Study: Policymakers' Knowledge of and Attitudes toward Reproductive Health in Ukraine.* Kiev: The Futures Group Int., RTI, CEDRA.

The unpreparedness of the bulk of population to absorb these changes, as well as a significant drop in the standard of living, resulted in a downward trend in population and health. It is evident that apart from the socioeconomic crisis, Ukraine is also going through a demographic crisis, which holds unpredictable consequences for the country's future.

The birth rate has fallen to 7.8 per 1,000, which is well below the rate needed to maintain a stable population. Ukraine has lost its family stability with many children. In addition, the declining standard of living and ecological problems aggravated by the Chernobyl accident have undoubtedly changed attitudes about family traditions and formation.

The mortality rate has intensified. From 1990–1999, the mortality rate rose by 30 percent, reaching presently 14.6 deaths per 1,000 population. Mortality caused by infectious and parasitic diseases is rising as well. TB, for example, is a real threat, with a morbidity rate two to nine times higher than in Poland, which already has one of the highest rates among developed countries. In addition, deaths caused by social stress, murder, and suicide are also growing.

Ukraine today is witnessing depopulation, with a fall of about 2 million since 1991. Some experts believe the birth rate has reached a crisis point, which if overstepped could be irreversible. By 1998, the number of elderly constituted more than one-fifth the total population for Ukraine; in rural areas, it was as high as one-third. If this trend continues, it will lead to additional economic and social problems.

During the 1990s, the number of marriages decreased drastically, from 9.3 to 5.9 per 1,000 (a fall of 36%). At the same time, the frequency of divorces remained at 1990 levels? 3.7–3.8 per 1,000. There is a growing incidence of informal marital relations, while the proportion of childless or one-child families is increasing. The number of children born out of wedlock as well as the number of single mothers is also growing, aggravating still further the problems of social and demographic development.

Negative changes affect the population both qualitatively and quantitatively. For example, the decline in the population's health status can be linked to the decline in life expectancy. According to 1999 data, life expectancy equals 68.5 years for the entire population, 63.2 and 73.8 years for men and women, respectively. In 1990, life expectancy in Ukraine was higher by 2 years, 70.5.

According to forecasts by the National Institute of Strategic Studies, if there is insufficient action to overcome the current socioeconomic crisis, implement socioeconomic reforms, curb inflation, or tackle mass unemployment and improve social protection, the population of Ukraine will decline to 42 to 44 million by 2020. Conversely, if there is a well-coordinated and effective socioeconomic development program, it might be possible to curb this decline to 46 to48 million.

RH Status of the Population. RH is one interconnected component of the general health status of the population. The decline in the population's general health has lead to a parallel decline in RH. For example, although the maternal mortality

rate, a basic RH indicator, has been decreasing in recent years, it is still higher than other European countries. Currently, depending on the oblast it ranges, from 5.6 to 87.4 per 100,000 neonates, a huge variation. The most frequent causes of death are hemorrhages, gestoses, and septic complications (i.e., conditions caused by general debility and associated diseases).

One of the key determinants of women's high mortality and morbidity rates is the large number of abortions, which presently remains the main birth control method in Ukraine. The number of abortions is 1.2 times as high as the number of births (by comparison, in Germany and France it is 0.25, and in Japan 0.06). One of the main reasons for this is the high cost of hormonal and intrauterine contraceptives (IUDs). Currently, there is little or no domestic production of these contraceptives; supplies have to be imported. Other reasons include the low level of information about hormonal contraceptives and IUDs, and about pregnancy and the prevention of pregnancy in general. This has not been helped by the often negative attitudes of some medical practitioners toward contraceptive methods.

Infertility, miscarriages, and high frequency of reproductive tract inflammatory diseases are some of the negative health outcomes resulting from large numbers of abortions, poor quality medical services, and low RH awareness. For example, secondary infertility appears in 60–80 percent of women (i.e., infertility following abortion). In five cases per 10,000, abortion results in death, which is a high by any standards.

Lack of appropriate sexual standards among segments of the population is another factor behind the high abortion rate. Although courses in valeology have been formally introduced in schools, they are not compulsory. It remains an optional subject to be taught mainly by teachers who have no formal subject training. On August 17, 1998, the Cabinet of Ministers issued a decree, entitled "On the regulation of provision of free and privileged prescription drugs." This decree provides that teenage girls, women who have either pregnancy contraindications, and/or women who are Chernobyl accident victims can receive contraceptives free of charge. However, information about the decree is not widely known.

In addition, lack of social and legal protection in the labor sector and insufficient control over occupational safety and health regulations are important causes for concern. At present, it is estimated that about one-half million Ukrainian women work in environments that fall below health and safety standards.

Infant mortality, another indicator identified in the ICPD *Programme of Action* is arousing concern as well. The rate is currently 12.8 per 1,000 live births. Approximately 47 percent of neonates dying during the perinatal period were premature. The main causes of perinatal mortality include intrauterine hypoxia and fetal asphyxia, congenital abnormalities, and birth traumas. The high rate of congenital abnormalities is of particular concern; currently, every third baby has physical or mental abnormalities.

The health status of adolescent girls is another problem area. Nearly 10 percent of girls ages 15–17 have chronic diseases of the urinogenital tract, menstrual

cycle disorders, or anemia—a deficiency disease. In addition, the incidence of STIs among children has also grown significantly.

Since 1995, there has been a rapid increase in the number of HIV/AIDS cases. From 1995–1998, the number of HIV-infected persons grew nearly 17-fold.[5] According to experts, there are 570,000 HIV-infected cases. Of particular concern is the fact that HIV/AIDS is spreading beyond the boundaries of usual risk groups, posing a threat to the entire population. Some argue that Ukraine is on the threshold of an AIDS epidemic, and the country has neither the technical expertise nor financial resources to deal with it.

RH Policy

Ukraine's RH polices is based on the ICPD *Programme of Action* and the achievement of its three goals during the next 20 years; namely, a decrease in infant and maternal mortality rates, universal access to the entire spectrum of treatment, and FP/RH services.

These policies are enshrined in the Ukrainian Constitution, in legislation directly or indirectly affecting RH care, and in political decisions made by relevant branches of government. They are also covered in presidential speeches and addresses, the Cabinet of Ministers' Program of Activity, speeches by the prime minister and Minister of Health, and in orders and directives issued by responsible bodies in the RH field.

The legislative field is generally favorable toward the RH issue in Ukraine. Article 3 of the constitution defines an individual's life, health, honor and dignity, inviolability, and safety as the highest among all social values. Article 50 guarantees each person the right to a safe environment for life and provides for compensation in the event or injury sustained as a result of violations of this right. Under Article 13, the government of Ukraine is responsible for safety, stability, and elimination of Chernobyl after-effects, whereas Article 49 guarantees free medical service to all citizens of Ukraine.

Occupational safety and environmental protection legislation creates the necessary basis for health and salety, while customs and tax policy are not limiting factors in terms of consumer access to various contraceptives[6]. Yet government enforcement of these laws is not always effective. In 1995-1999 the President of Ukraine issued about 20 Decrees concerning improvement of the status of children, youth and women.

The main objectives and goals in the RH field are set out in various national programs. Since Ukrainian independence, a number of national programs have been approved, which target or partly target improvements for the health status of the entire population as well as specific subgroups. They include, for example, "A long-term program of improvement of the status of women, family, mother and child

[5] Ibidem, p.10.
[6] Rudiy, V. 1999. *Legal and Regulatory Framework for Family Planning and Reproductive Health in Ukraine.* Kiev: The POLICY Project.

protection," a program for the resolution of disability problems, an immunoprophylaxis program, a national FP program, and a national program called "Children of Ukraine." In addition, RH policy is a central part of two current national programs: "Family Planning for 1995–2000," and "Reproductive Health" for 2001–2005.

However, it is clear that the socioeconomic crisis in the Ukraine is the main obstacle to implementing the ICPD *Programme of Action.* There has been a reduction in resources allocated to health care overall, in addition to the fact that FP/RH is already underfunded. Most national activities have been effectively shelved, and there have been no positive changes. And the situation is worsening.

Inappropriate economic policy is another obstacle in developing private and mixed forms of medical care provision. Owing to the economic crisis, medical institutions and facilities find themselves incapable of carrying through the necessary structural changes to ensure appropriate access to RH services.

Current Reproductive Health Care Status

Overview. Unlike most other sectors, health care in Ukraine is almost totally dependent upon public budgetary financing. The development and attraction of other sources of funding are constrained by lack of private sector interest and by the negative attitude of health administrators toward private health care in general. Budgetary financing alone is thus insufficient for normal interaction between the health care sector and other sectors operating in the market environment.

Ukraine's health care sector remains overregulated. It does not rely on market mechanisms, at least in a formal way. However, it experiences all the difficulties stemming from a poorly functioning market. According to some estimates, about two-thirds of revenues originate in the "shadow" sector. These financial flows by-pass the tax system, which restricts considerably the possibility of the government to increase its allocations to the health care sector or to control its development.

The so-called "shadow" sector also produces some unwelcome side effects. It encourages corruption among certain groups of physicians and prevents the impoverished from receiving health care services. In short, the market mechanism plays havoc with the health care system, through its failure to foster the development of medical technologies or improve the quality of medical services. Meanwhile, the public health care system continues to suffer from a chronic shortage of money. For example, in the last eight years funding has declined. Budgetary allocations now cover only a small portion of the sector's needs, and the situation continues to decline.

At the same time in certain sectors of the health economy, uncontrolled market forces are pervasive. Patients pay for necessary medicines and expendables, are responsible for food, bedding, and clothing, and for the remuneration of primary care providers. Illegal payments are rife. Required payments are high and most people in the Ukraine cannot afford them.[7]

[7] Perspective–2010. 1999. *Program of health care reorganization in Ukraine.* Kiev.

However, both patients and physicians have grown dissatisfied with the current state of affairs. On the one hand, the people's constitutional right to free medical aid has been totally ignored, and on the other hand, the health care economy is being exposed to unnecessary and unintended market fluctuations, which have perverse consequences.

Key Decision Makers. Key decision makers in RH funding are the Verkhovna Rada of Ukraine, the Cabinet of Ministers, and the ministries of Health, Finance, and Economics. The Verkhovna Rada, Ukraine's Parliament, is composed of 450 deputies. It is the legislative body of government whose constitutional majority adopts (approves) the state budget as well as making appropriate amendments to it. The parliamentary committee on health care and mother and child protection, as well as the supporting secretariat for that committee, are among the key people influencing RH policy.

Ukraine's president, as Head of the State, can issue decrees and directives as well as veto laws passed by the Verkhovna Rada. Statements made by the National Security and Defense Council on RH policy issues also tend to carry considerable weight. The executive branch also has a number of statutory and legal powers of a mandatory nature. The Cabinet of Ministers, the supreme executive body, for example, can adopt decrees and regulations that have a direct impact on RH. From an analysis of the decision-making process of the Cabinet of Ministers, it is clear that the most important members are the vice-prime-minister on social policy and the staff of the secretariat responsible for health care, women, and family issues.

At the Ministry of Health (MOH), the most influential players are the minister and the Head of the Main Department of Medical Care for Children and Mothers. The minister also issues decrees and can decide on the content of a decree as well as control its execution. The Minister of Health also develops technological policy in the area of RH and is responsible for organizational forms of medical care provision. Decrees are therefore a major tool for implementing decisions affecting the attainment of health care and management objectives.

Key Service Providers. At present, statistical and analytical expertise are fragmented. As a result, it is difficult to form a complete picture, although it is possible to piece together a rough one from different sources of information.

From the former Soviet system, Ukraine inherited a huge network of prenatal clinics and outpatient-policlinic facilities with prenatal clinics, women's departments and rooms (according to 1997 data, 2,006)[8] providing medico-prophylactic services in RH. According to official data, there are more than 13,000 obstetrician-gynecologists (Ob–Gyns), 197 oncologists-gynecologists (2.36 and 0.04 per 10,000, respectively), and 32,000 midwives working in RH. There are also more than 16,000 obstetric stations operated by midwives, and nearly 2,000 obstetric-gynecological rooms at central rayon hospitals and municipal policlinics.

[8] Rudiy, V. 1999. *Legal and Regulatory Framework for Family Planning and Reproductive Health in Ukraine.* Kiev: The POLICY Project.

In the private sector, there are 976 MOH-issued licenses entitling owners to practice gynecology (187 licenses belong to individuals and 789 belong to legal entities). Receipt of practice licenses in gynecology has certain restrictions, however. For example, owners are not allowed to provide prenatal care, treat pregnancy complications, or carry out surgical interventions, including abortions. These procedures are performed at accredited public and community-based medical facilities[9].

The role of the voluntary sector in the provision of FP/RH services has so far been small. The Red Cross is the largest and most influential of all the nongovernment organizations (NGOs). It has about 5.3 million members, of which about 2.6 million are active. Some 70 percent are women. At present, owing to financial difficulties, the Ukrainian Red Cross does not operate its own hospitals, ambulances, or pharmacies. However, there are no barriers to this in legislation.[10].

After the ICPD (and as part of the National Family Planning Program), 28 regional FP centers, which provide free service, were established. In the regions where they operate,the abortion rate is noticeably lower.

Organization of RH Care Funding

Ukraine's legislation states that medical care should be free at the point of use. In practice, the financing and payment for services are more complex. The main sources of funding and support for RH services in approximate order of significance are

1. Government and local budgets
2. Private funding
3. Under-the-table payments
4. Direct payments from patients
5. International technical assistance programs
6. Funds of public, religious, and charitable organizations
7. Charitable contributions
8. Insurance funds

Sources 1–5 account for most funding, whereas the rest are still small. Local governments have considerable control over allocations at the local level, with funds from local budgets exceeding national allocations many times over.

System of State-Budget Funding

The funding of national and local FP/RH activities is a component of the overall budgeting process, enshrined in the Ukrainian law, "On the budget system of Ukraine," which was adopted by the Verkhovna Rada, December 5, 1990 (and then enacted July 29, 1995, with subsequent amendments). Key decision makers are in the Verkhovna Rada and the ministries of Finance and Health, in that order.

[9] Ibid, ? .22.
[10] Ibid, ? .23.

Verkhovna Rada. The Verkhovna Rada determines the budgeting process, which feeds into RH allocations as follows:

1. The Verkhovna Rada Budgetary Committee, after taking in to account submissions by relevant parliamentary committees (including the Committee for Health Care and Mother and Child Protection), prepares and submits to the Verkhovna Rada a special draft act concerning key directions of national policy and expenditure for the next year, no later that May 20 of the current year.
2. The Verkhovna Rada then examines the draft, which it must approve no later that June 1 of the current year. Feeding into this process is a report from the Cabinet of Ministers on current year expenditures and economic forecasts for the next.
3. Following approval, the budget resolution is signed off by the Verkhovna Rada, promulgated according to the established procedure and relayed to the government. It provides a guide both for the government, which in accordance with Article 16 of the Constitution must draft the law on the national budget; and for Parliament, which examines the draft and other draft laws affecting budget revenues and allocations.
4. The budget resolution passed by the Verkhovna Rada then forms the basis with which the Cabinet of Ministers develops and submits to Parliament the law on the national budget for the next year.
5. Once the draft law is complete, the government submits it to the Verkhovna Rada. In accordance with Article 96 of Ukraine's Constitution, this submission must be no later than September 15 of the current year.
6. The Verkhovna Rada then considers the draft in accordance with the procedures laid down in regulations. Normally, the examination consists of two readings. Some provisions of the draft law requiring further discussion at the second reading will have a third reading.
7. Once passed by Parliament, the law on the national budget is referred to the president for ratification in accordance with Subsection 29 of Section 1 of Article 106. The president also has the right to veto the measure, as provided in Subsection 30 of Section 1 of the same article, in which case he refers the law back to Parliament with recommendations and suggestions. The Verkhovna Rada may fully or partially concur with the president's suggestions or overrule the veto, thus leaving the law unchanged. In either case, the law is submitted to the president again.
8. Having considered the socioeconomic development forecasts and tentative financial plans, tax, and revenue implications, executive members at the local level draw up their respective draft budgets and submit them to their oblast, city, town, or village councils by December 25.
9. Budgetary provision for the Autonomous Republic of the Crimea (ARC), and associated local budgets, are considered by standing committees of the Verkhovna Rada.
10. The Verkhovna Rada of the ARC gives its approval to the republican, oblast, city, and rayon budgets, which stipulate revenue, expenditure, and allocations by sector.
11. City, town, and village councils endorse the budgets, issuing allocations to each sector including health care.

12. If the Verkhovna Rada of the ARC and local councils fail to approve their budgets by December 30, the budget previously submitted for approval by the government of the ARC takes effect.

Ministry of Finance. The first stage of national-budget building begins in April/May with preliminary calculations from the Ministry of Finance based on first drafts of the unified and national budgets of Ukraine. During this work, the total for health care is considered both at national and local levels. In accordance with Article 49 of the Constitution, the government can top-slice funds for specific socioeconomic, medical and sanitary, and medico-prophylactic programs of the health care system. The scope of the budget covers funding for almost all services of medico-prophylactic facilities, including RH services.

The first stage of the process consists of determining the volumes of necessary funding, based on specific indicators of the whole network of medico-prophylactic institutions. RH funds are only one component of health care allocations and are not treated as a separate expenditure item. Only specifically designated central programs, including RH programs, are treated as separate items of expenditure. This is one reason why data on RH are scarce and why the committee had to obtain them through special data gathering exercises or by estimation.

In the second stage, the main budgetary office of the ministry of finance sets marginal expenditure volumes for each sector. These volumes are based on an analysis of the overall health care funding need, carried out by sectional funding departments of the Ministry of Finance, and also on the forecasts of then basic macro-indicators of social and economic development. In recent years, because of the economic situation marginal expenditure volumes have been lower than calculated needs. The difference in need and marginal expenditure volumes in the draft unified budget for 1999 and 2000 is show in Table 1.

Table 1
The differences between the need and marginal expenditure volumes for health care in Ukraine, 1999–2000 *(millions hrn.)*

	Overall need	*Marginal volumes*	*Divergence*
1999			
Health care expenditures–total	5,903.2	3,927.2	1,976.0
including:			
- national budget	690.5	580.6	109.9
- local budget	5,212.7	3,346.6	1,866.1
2000			
Health care expenditures–total	6,778.5	4,298.9	2,479.6
including:			
- national budget	889.2	615.9	273.3
- local budget	5,889.3	3,683.0	2,206.3

In the third stage, the above marginal expenditure volumes for the health care national budget are submitted to the Ministry of Finance and budget holders, who analyze and compare them with their own projections and needs; and on the basis of

this, initiate a series of consultations and analyses. They take the following into account: submissions by facilities (general hospital, special hospitals, maternity homes, etc.), by expense categories (salaries, food, medicines, etc.), and allocations to target programs and specific centralized activities; and then, submissions of budget holders. Budget holders are asked to review the expenditure priorities in the light of any shortfall, while ensuring that available resources are efficiently and effectively distributed. The MOH, alongside budget holders, formulate appropriate approaches to RH care, or where there is a similar need to channel resources for specific purposes.

In the fourth stage, the Ministry of Finance examines and analyzes budget holders' submissions, removing any anomalies and ensuring consistency. Recent years have shown that these revisions do not involve substantial changes to the overall budget. The draft budget is then submitted to the Verkhovna Rada for approval.

In the fifth stage, after the Verkhovna Rada has approved the national budget, budget holders confirm and distribute it to specific facilities, including those performing RH care functions. Individual health care facilities determine expenditure headings (salaries, patients' food, drugs, medical equipment, etc.). Heads of higher institutions endorse these estimates as well as expenditure budgets for centralized activities; in particular, for activities of the National Family Planning Program and HIV/AIDS and the Drug Addiction Prevention Program.

Drawing Up and Approval of the Republican Budget of the ARC and Local Budgets

Marginal expenditure volumes set by the Ministry of Finance and funded from the republican budget of the ARC, together with local budgets, are included in the calculation of the budgets of administrative–territorial units in accordance with the national budget law of Ukraine. After Parliament's approval, a similar procedure to establish the national budget is adopted.

System of Funding from Other Sources

Private Funding. Private funding is generated from the funds of individuals and groups of shareholding founders of private medical facilities, and is regulated by appropriate legislation. Prices for services vary according to the quality of care, skill levels of physicians, and nonmedical staff. The role of private funding in the area of RH in Ukraine is still small. There are about 1,000 private facilities licensed to provide gynecological services, although in practice very few people have access to them. As private medicine develops, this sector will become accessible to more, depending on license fees and other factors. Given the limited technical capacity of the public sector, the role of the private sector is expected to grow.

Patients' Direct Payments. These include official payments for services at private facilities and officially masked payments at public health care facilities (because the Constitution provides that the state is to provide free services for all population groups). A payment, for example, could be "for the development of the medical facility," or as contributions to the budget of public medical facilities (a hidden form of payment for services) at both public and private facilities.

Unofficial Payments for Services. In the absence of a sound strategy for the government's health reform, unofficial payments are becoming increasingly commonplace. "Shadow," or under-the-table, payments are a supplement to physician salaries, but contribute nothing in the way of investment, preventing the RH sector from receiving funds that are vital for its reform, modernization, and development. This situation also can lead to drastic social differentiation in terms of access to medical services and precludes RH services from being equally accessible to the bulk of the population.

International Technical Assistance Programs. International technical assistance**,** provided under state agreements, treaties and contracts with government structures, public agencies, and through collaboration with NGOs in Ukraine, is a significant factor in the implementation of decisions under ICPD and ICPD+5. For example, the USAID implemented medical training programs in FP in three oblasts and distributed FP devices amounting to more than $625 000.

The POLICY Project is involved in improving the political environment for RH by stepping up political support and broadening opportunities for officials to be involved in RH programs worldwide. For example, in Ukraine it provided methodological and technical assistance for the government's working group of experts in the final stages of the 1995–2000 program, and provided input to the National Reproductive Health Program for 2001–2005.

In 1998, as part of the Japaigo Project, training seminars for rayon hospital physicians were held in all Ukrainian oblasts. These seminars dealt with issues of RH protection, FP, information provision, and awareness building in the population. The Shering Company set up a training center for physicians of all specialties, including those practicing in RH. The UN Population Foundation implemented a project that included training of FP service workers, provision of contraceptives, and the supply of FP centers. The International Federation of Family Planning also implemented a project intended to influence and shape safe sexual behavior in young people.

Ukraine obtains FP devices also through other international projects or as part of humanitarian aid. However, there are no national statistics on the cost and quantity of contraceptives obtained in this way or from other sources. It is clear, however, that the volumes of technical assistance are large and come from various international sources.

As a recent international audit[11] showed, the main problems in using aid effectively include the absence of a coordinating body to coordinate efforts of international donors, variations in the needs of central and local health facilities and volumes assistance actually received, lack of training of some medical staff to promote and use RH devices (especially in rural areas), and short shelf life of devices.

Funds of Public, Religious, and Charitable Organizations

At present, these funds do not constitute a substantial part of the total amount of RH funding, possibly because of the absence of powerful financial sources and wealthy people who could facilitate their creation.

[11] Perry, S. 1999. *Contraceptive Audit for USAID/Kiev.* Kiev: MEDS, USAID.

Insurance Funds. These, generated from the system of national and social insurance funds and funds of private insurance companies, are supposed to cover medical care expenses from their own financial resources. Insurance premiums from institutions, enterprises under different forms of ownership, various allocations for specified health risks, and individual voluntary donations serve as financial sources for insurance funds. In Ukraine, the establishment of such funds has been announced as a component of the Cabinet of Ministers' Program of aAtivity for 2000–2004.[12]

Apart from the above-mentioned sources, it is possible to name the following as other possible (partly active or inactive in Ukraine) sources of RH care funding:

- Initiative foundations and initiative programs
- Accumulation programs
- Government medical loans

National RH Programs and Their Funding

Background. Since Ukrainian independence, a number of national programs have been approved. Their direct or indirect goal has been improve the health status of specific subpopulations or the population as a whole. They include "Family Planning," "AIDS and Drug-Addiction Prevention," and "Children of Ukraine."

The National Family Planning Program was approved on September 13, 1995, by decree issued by the Cabinet of Ministers, for the 1995–2000 period. The program was initiated because of the adverse trends in population development and health status, which were becoming increasingly apparent at the time:

- Drop in birthrate, increase in mortality leading to depopulation;
- Falling level of female RH;
- Deterioration in the health status of pregnant women;
- Increase in the level of women's reproductive tract diseases and STIs;
- High rate of reproductive losses owing to maternal and infant mortality.

The main objectives of the program were to

- Create a new FP service;
- Train medical, pedagogical and social workers to operate in the area of FP;
- Provide universal access to contraceptives;
- Build awareness in FP issues among the population, especially among adolescents;
- Develop and produce contraceptives in Ukraine;
- Expand research in the area of FP; and
- Develop international collaboration in the area of FP.

[12] Cabinet of Ministers of Ukraine Program of activities "Reforms for Prosperity". "Uriadovy Courier," March 15, 2000, # 47, p.4.

Status of Program Funding. In parallel with this initiative the overnment of the ARC, Kyiv and Sebastopol Oblasts' city–state administrations formulated territorial programs. The government's decree prescribes that funds be budgeted annually for activities of the National and Territorial Family Planning Programs, based on actual capacities. In this way, the supreme state executive body is able to direct funding for the national and local programs.

Approval of the National Family Planning Program preceded ratification of thenew Ukrainian Constitution, which established the procedure for creating such national programs. It states that the authority of such programs in areas of economic, scientific and technical, social, cultural development, and environmental protection is within the jurisdiction of the Verkhovna Rada (Article 85, Section 1, Subsection 6 of the Constitution). Furthermore, Subsection 4 of Article 116 of the Constitution states that this will be endorsed by the Cabinet of Ministers of Ukraine. For these reasons, the next national program of FP/RH protection may be expected to receive endorsement by Parliament.

Table 2
Estimated need and actual budgets, centralized RH programs, 1999–2000
(source Ministry of Finance) *('000s hrn)*

Activities	1999		2000	
	Need	*Approved from central budget*	*Need*	*Approved from central budget*
National Family Planning Program	940	800	1,095	800
AIDS and Drug Addiction Program	10,000	10,000	5,470	5470

Calculated on the basis of data presented by the Ministry of Finance

National programs are funded under the heading, "Target programs and specific centralized activities," from the marginal volume of health care allocations in the government budget, approved by the Ministry of Finance and key budget holders. Budget proposals from major stakeholders (including the MOH and Ministry of the Economy) are reviewed, analyzed, and revised by the Ministry of Finance for possible inconsistencies. Administrators of central health care facilities and programs draw up expenditure plans for centralized activities and programs.

Estimates of need for budget allocations to implement the National Family Planning Program and the AIDS and Drug Addiction Prevention Program for 1999–2000 are shown in Table 2, including amounts actually allocated from the central budget. Approximately 95–97 percent of overall expenditures are expected to be financed from local budgets. The above volumes of RH financing exclude expenditures on pharmaceuticals for outpatient treatment of specific categories of women patients, as well as payments for services provided at private clinics. Thus, the overwhelming amount of funds, allocated from local budgets, is assumed to be spent for the purposes designated. Table 3 provides detail for futures years based on current plans. There is a significant reduction in local budgets for 2000, but increased spending on this program by the state, reversing a practice in previous years.

Table 3
Funding for the National Family Planning Program Activities *('000s hrn)*

	Total	Including:	
		State budget	Local budgets
Overall need 95-98	2,792.1	638.7	2,153.4
Allocated	2,154.9	230.0	1,924.9
1999 need	3,100.0	940.0	2,160.0
2000 need	1,758.0	1,095.0	663.0

Calculated on the basis of data presented by the Ministry of Finance

National Program for the Improvement of Reproductive Health, 2001-2005. In late 1999, work began on a new national program and budget, which is supposed to be a continuation of existing and previous programs. Unlike the earlier Family Planning Program, however, it will be based on broader definition of RH, as defined at the 1994 ICPD, and will be designed to provide a more integrated approach based on legislative, social, economic, educational, and medical activities and initiatives. The intention is to promote a more caring state attitude to RH and help shape necessary reproductive behavior among the population. In accordance with budgeting procedures for 2001, the program and its budget should be formulated and agreed on by the end of July 2000.

Interrelations in the System "Target Groups, Services, Funding" (Network Diagram)

The interrelation between users and providers of RH services is a function of the system of provision and funding of these services. A network chart is provided here that links users to providers and sources of finance. Target risk groups (prospective consumers of services) are identified first, followed by a requisite package of services; then a system of service provision, associated sources of funding together with the organizations responsible for the provision of services are described (see network chart in Figure 1).

It is possible to identify several risk groups according to types of activity in target programs and bio-medical factors. For example, for STI/unwanted pregnancy prevention, provision of contraceptives on a prioritized and free of charge basis, the following risk groups were identified:

- Persons with extragenital pathology
- Women with reproductive tract diseases
- Drug users
- Alcoholics

- Persons affected by STIs
- Mentally sick
- Indigent and homeless
- Adolescents
- Women with more than two children[13]

Quantification of each target group gives rise to a number of methodological problems because official data are not available for each group and data that are available are incomplete. A difficulty is that some of the groups overlap; for instance, a person can be an alcoholic, STI-infected, and homeless.

Official data show that today in Ukraine there are 720,000 alcoholics, 56,000 drug addicts, and approximately 40,000 HIV-infected persons; however, how many belong to more then one group is not known. Other evidence suggests that actual number of such social groups may be much higher. Health statistics in Ukraine register the number of people in a social disease group according to the number of visits by patients based on a particular condition or through accidental detection of a disease in the course of treatment, but not as a result of screening.

For the purposes of our work, to calculate the need for RH services and appropriate funding, it is expedient to identify the following three groups of the female population:

- **Girls between 10–14**, of prereproductive age, a portion of whom are already sexually active, may become pregnant, get infected with STIs, resort to abortions or use contraception. The size of this group is indicative of the need for sexual education and psychological care for adolescents, and also the need for the provision of contraception on a target-oriented and free-of-charge basis.
- **Women between 15–49,** of active reproductive age, who become pregnant, bear children, contract STIs, may suffer from infertility, or be active users of FP methods. This group should be determined to estimate the country's need for contraceptives, as well as potential size of abortion services.
- **Women over 50,** who, apart from the problems mentioned in the previous groups, are most likely to suffer from various cancers, undergo regular cancer screening and treatment (if need be), and need prophylaxis for perimenopausal disorders. For example, their numbers provide some indication of those requiring cancer screening services.

Basic services required by these target groups include

- Information, healthy practices promotion;
- Sex education;
- Psychological care;
- Post-stress rehabilitation (rape, abuse, violence etc.);
- STI services (detection and treatment);
- Provision of contraceptives;
- Treatment for infertility and other reproductive disorders;

[13] Perry, S. 1999. *Contraceptive Audit for USAID/Kiev*. Kiev: MEDS, USAID.

- Prophylaxis of perimenopausal disorders;
- Rehabilitation of reproductive function;
- Services promoting RH (prevention and treatment of extragenital pathology, healthy practices);
- Prenatal, perinatal, postnatal, obstetric care; and
- Cancer screening.

In addition, key providers of these services include

- Public and municipal hospitals and clinics;
- RH centers;
- FP centers;
- Schools;
- Parents and friends;
- Rehabilitation centers;
- Private centers, prenatal clinics, and hospitals; and
- Mass media.

As already noted, the RH sector is almost totally funded from the state budget, while legislation limits the possibility of attracting other sources of funding, notwithstanding shadow payments. However, in the last eight years, financing levels have declined to one-seventh of previous levels. Thus, budgetary allocations cover only a small portion of needs.

Instead, approximately two-thirds of market turnover is absorbed by the shadow sector. This, in turn, limits government's control over health care reforms. The shadow sector breeds corruption among physicians and denies a portion of the population equal access to medical services, since it depends on the ability to pay. Despite the constitutional guarantees to free medical care, the reality is that many medical services have to be paid for by patients directly. Patients pay for necessary medicines and expendables, which helps to remunerate general practitioners. Under-the-table payments are also commonplace and their amounts often too large for patients to afford.

As Ukraine has no mandatory national insurance, no money comes from this source today, and revenues are based on taxation. Also, there is no system of prescription charges, as practiced in other countries. Writing out prescriptions is free at public facilities, while private physicians add them to the cost of treatment.

Depending on the provider and service environment, services provided to patients on a free-of-charge basis may include: sex education, information and healthy practices promotion; prenatal, perinatal, postnatal, obstetric care; post-stress rehabilitation, and psychological care. The charging basis for each service is as follows:

1. **Sex education**—a free service provided through school curricula, consultations with parents, and the media.

2. **Information and healthy practices promotion**—a free service provided through school curricula, radio, television, press, outdoor advertising, consultations with parents, and friends.
3. **Prenatal, perinatal, postnatal, and obstetric care—**according to the type of medical facility, patient's needs and capabilities, this care is free at women's clinics and central and municipal hospitals that provide a minimum package of services.
4. **Post-stress rehabilitation, psychological care—**payment depends on patient's needs and capabilities. It may be provided through public rehabilitation centers, at NGOs specializing in such services, free of charge; or at public and private clinics for, respectively, moderate or very high fee.
5. **Provision of contraceptives—**the bulk of sales of men and women's contraceptives is through pharmacies at cost; public or private clinics and FP centers also provide supplies. Contraceptives may also be provided as part of international technical assistance.
6. **Women's cancer screening**—a procedure that was formerly compulsory as well as free during annual preventive checkups with gynecologists. Today, it is optional, or as a result of physician referral. Such services are available at public hospitals, policlinics, and oncology centers and usually are provided on a free-of-charge basis, whereas private facilities charge a fee.
7. **STI services—**checkups and treatment is mostly on a fee-for-service basis. As private centers often have better resources than state-owned centers, government-paid physicians refer their patients for paid checkups and diagnoses to private facilities, then continue to treat patients on a free-of-charge basis thereafter; otherwise, private centers diagnose and treat patients for payment.
8. **Treatment of infertility and other RH disorders—**of utmost importance for RH, given the ecological situation in parts of Ukraine, and the level of abortion-based birth control. Only a small proportion of families can afford this.
9. **RH improvement—**prophylaxis and treatment of extragenital pathology, activities aimed at the improvement of the overall RH. Uptake depends on individual attitudes to health and on lifestyles. At present, these services are provided for a fee.

The main sources of funding and support for RH services in Ukraine include

- Government and local budgets;
- Private funding;
- Shadow payments;
- Funds of public, religious, and charitable organizations;
- Insurance funds;
- Charitable contributions; and
- International technical assistance programs.

The whole system of RH funding and the link between target groups, service providers, sources of finance and the institutional players is shown in the accompanying network diagram. Of interest is the complex set of relationships

between the service providers and sources of funds. Similarly, the overlapping responsibilities of the institutional players is another problem in establishing clear lines of responsibility.

Structure of Public-Private Provision-Financing of RH Services (Matrix)

The main sources of funding and support for RH services in the approximate order of their significance for overall volumes of RH sector funding are as follows:

1. Government and local budgets.
2. Private funding (formal or informal).
3. International technical assistance programs.
4. Funds of public, religious, and charitable organizations.
5. Charitable contributions.
6. Insurance funds.

Other possible sources of RH care financing also include

- **National health insurance**—its methodology and basis are being developed;
- **Initiative foundations and initiative programs**—undeveloped because of the lack of favorable legislation;
- **Additional voluntary health insurance**—undeveloped in the volatile market environment;
- **Budget reserves—**have not been designed under the conditions of unstable currency;
- **Government medical loans—**absent; and
- **Charitable programs—**exist in on a very small scale.

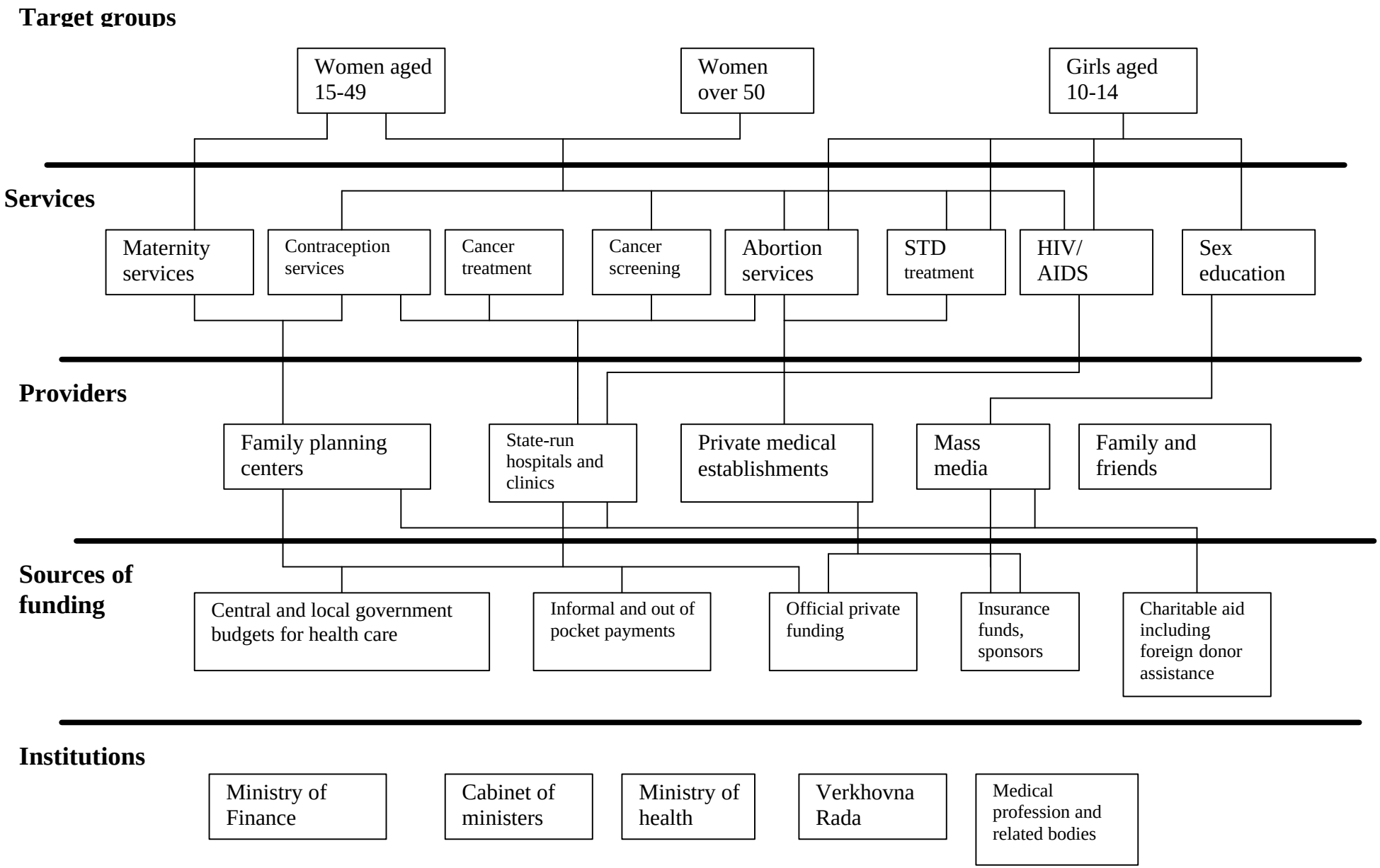


Figure 1: Network Diagram of the RH Care System (Interrelationship between Sources of Funds, Providers, and Target Groups)

Table 4
Relative Government and Private Financing Volumes in the Area of Reproductive Health (approximate) (%)

	Public and community hospitals		**Private hospitals**		**Total**
	Government funding	Private funding	Government funding	Private funding	
Contraceptives					
Hormonal	10	45	0	45	100
contraceptives	30	40	0	30	100
Intrauterine devices/	0	0	0	100	100
Weighted average	10	25	0	65	100
Procedures					
Mini-abortions	30	20	0	50	100
Abortions	40	60	0	0	100
Delivery	90	10	0	0	100
STI (treatment)	20	30	0	50	100
HIV\AIDS	30	70	0	0	100
Cancer/screening	50	50	0	0	100
Cancer/treatment	20	80	0	0	100

Table 4 shows the committee's rough estimates for the split in public-private funding for different services and interventions based on a combination of hard and soft evidence. From our analysis, it is possible to conclude that most RH services are provided through public health care facilities, although paid for by privately. Despite the fact that government allocations continue to decrease, the needs of the RH sector are increasingly met this way, although effective finance is from out-of-pocket payments. This funding follows two paths: (1) informal funding of physicians and public hospitals; and (2) creation of private medical facilities, which are totally financed by private means.

Without appropriate legislation and the proper institutional basis, the scope of private funding is limited (Ukraine's existing legislation directly prohibits private payments for the majority of RH services or their provision at private clinics). This attitude dates back to the era of the former Soviet Union, in which the traditional attitude toward health care as a sector was that it should be funded and controlled solely by the state. As we have shown, however, the reality is that the state is incapable of delivering services in these lines. As such, the government's policy toward health care and RH funding should be to formulate the necessary laws and enable the creation of appropriate institutions, which will provide much needed regulation for the health economy.

RH Development Scenarios and Use of Funds—Exploratory Simulations to Understand and Inform Directions of Change

The current sociopolitical and economic situation in Ukraine is unlikely to lead to significant improvements in RH, unless there are institutional reforms, more resources, and a realignment of priorities. We therefore considered in some detail the options, using a simple financial simulation model that incorporates data and estimates obtained during the course of our work. Our results are presented below.

The model seeks to translate priorities into budget allocations, which take into account unit costs of different services, size of the risk group, and allocative priorities. The outputs are a set of revised allocations and sources of funds, which are consistent with revised priorities. Users are then able to see what the consequences of their revised policies would be in terms of the overall availability of resources and the cost of services. The model includes the following set of RH services:

- Maternity services.
- Detection and treatment of HIV/AIDS.
- Abortion services.
- Cancer screening and cancer treatment.
- Treatment of STIs.
- Contraceptives provision.
- Sex education.

The model makes the following assumptions:

1. There are insufficient resources to meet all the needs of reproductive care, and utilization is constrained by available financial resources.
2. Experts are able to quantify an ideal level of use, corresponding to a given policy scenario, for each RH service. Scenario design reflects policy priorities and objectives.
3. Unit costs of providing each service are known.
4. Split between different types of financing (public and private) is known for each service.

The following assumptions represent input variables for the initial year:

- **Size of target group**—usually this is number of women in some age bracket.
- **Actual (existing) utilization rate**—number of target group members currently using the service, divided by size of target group.
- **Ideal utilization rate**—since the objectives are rarely rigorously specified in health matters and it is difficult to evaluate precisely the effectiveness of different medical and other interventions, the best way to handle this parameter is to consider it as a tool that experts debate, based on the best evidence available from their country and others.
- **Priority to achieving the ideal**—this parameter, reflecting the policymakers' subjective assessment, gives the proportion of ideal utilization, which should be obtained assuming that there are not enough resources to achieve the ideal levels of provision for all RH services. Mathematically, this priority parameter lies between 0 and 1; however, in

practice health care experts tend to understand statements like High, Medium, and Low, which can be translated, for example, into numbers such as 1, 0.75, and 0.5. Note that model results are sensitive to the priority parameters assigned. Also, it is not necessary for the ideal level to be higher than the existing level. Currently, the abortion rate in Ukraine is much higher than is desirable. Similarly, there is scope to reduce maternity provision following a fall in the birth rate.

- **Cost per member of the target population served**—average annual costs for a person using the service. For maternity services, abortions, cancer screening, and STIs, one treatment per year per patient is assumed.
- **Split between expenditure financed by the public sector and out-of-pocket expenditure.**

Based on the above information, the model calculates values of the following parameters for the initial point of time for each service and for the whole set of services:

- Ideal expenditure (cost per member of the target population served, times size of the target group, times ideal utilization rate, times priority parameter).
- Ideal public and private out-of-pocket expenditure (as ideal expenditure, times proportion of expenditure financed by corresponding source).
- Actual current expenditure (cost per member of the target population served, times size of target group, times actual current utilization level).
- Actual current public and private out-of-pocket expenditure (actual current expenditure, times proportion of expenditure financed by corresponding source).

The model then projects expenditure, by source of finance, for each RH service in the next year. It is assumed that total expenditure on all RH services combined is known. An adjustment parameter, or "budget factor," is calculated as total assumed expenditure divided by total ideal expenditure, and is used to calculate the following variables for each RH service:

- Predicted utilization rate (ideal utilization rate, times priority parameter times budget factor).
- Difference between predicted and current actual utilization.
- Difference between predicted and ideal utilization.
- Predicted utilization as percentage of current actual utilization.
- Predicted utilization as percentage of ideal utilization.
- Predicted expenditure (cost per member of target population served, times size of target group, times ideal utilization rate, times priority parameter times budget factor).
- Predicted public and private out-of-pocket expenditure (expenditure, times proportion of expenditure financed by corresponding source).
- Implied expenditure shortfall/surplus in comparison with ideal expenditure.

In addition, the final three variables are calculated for whole set of RH services combined.

The financial allocations of the model do not in themselves guarantee that a particular strategy will succeed. The model is intended to inform the debate, not to decide the outcome. There needs to be accompanying measures and policies—for example, to regulate the level of abortions—for a given strategy to succeed. Those measures and policies also need to take into account how the existing scale of informal out-of-pocket payments could be rechanelled and controlled to achieve specific policy objectives. Given their scale, this would not be a trivial exercise. Once familiar with the model, it is possible to conduct a variety of simulations; for example, changes in unit costs, changes on sources of finance, size of risk group, and so forth.

In the following, we keep the scenarios simple in order to illustrate the principles. We describe how members of the national committee approached the problem of scenario selection. First, committee members were explained the general principles behind the model and the kinds of analyses it can perform. Then, they agreed on the data inputs; for example, unit costs where these were not available from existing sources and on estimates for the total expenditure on RH. Standard official sources were used where possible, such as the Statistical Yearbooks and Demographic Yearbooks of Ukraine, published by the State Committee for Statistics of Ukraine. Other data were provided by the Ministry of Finance and by a survey, entitled "Family Planning—1996," which was made available by the Kiev International Institute for Sociology.

The committee agreed that it was important to take informal as well as formal expenditures into account, and the original model was modified for this purpose. The committee then discussed what would be reasonable scenarios given the present state of the economy and existing government policy. That the committee consisted of people with different backgrounds working in field of RH care, including representatives of different ministries, the medical establishment, and analysts, was helpful in that it provided a focus for debate and discussion from different standpoints. As a result, the basic directions suggested in these scenarios have a reasonable chance of being implemented.

During discussions, there was agreement that priority must be given to detection and treatment of HIV/AIDS under any scenario because of the worsening situation in recent years. Ukraine, for example, leads Europe in the growth of HIV. In other aspects, the committee concluded that government basically has two policy choices. The first policy choice might be devoted to prevention and promotion; that is, promoting healthy lifestyles through better FP and education, thus reducing abortions, HIV, and STIs. This policy would be applied in cities of southeast Ukraine, where HIV/AIDS and STIs are widespread. The second policy choice might be directed to fighting female cancers, which are on the increase because the female population is aging and because of the cessation of the national cancer screening system.

The idea is that these policies would be applied in regions of Ukraine with heavy environmental pollution. We called these two scenarios "Prevention and promotion" and "Fighting diseases" respectively. In the model, the two policies differ simply according to the priority assigned to each RH care service. For the "Prevention and promotion" scenario it was assumed that government would put high priority to contraception, sex education, STI treatment, and HIV/AIDS (i.e., the priority

parameter would be set equal to 1.0), and also high priority into maternity services, and into reducing abortion services. It was also assumed that whilst STI priority would remain high, more sex education and use of contraception would result in their decline and so the ideal level was set below current levels. Only medium priority would be assigned to cancer treatment and cancer screening (i.e., the priority parameter would be set equal to 0.75). The reasoning is that investing in contraception and sex education would lead over a period to a reduction in abortion rates, which are currently high and which are associated with infertility problems. Thus, the ideal level was set to what was believed to be attainable with this strategy. The reasoning for putting medium priority into cancer treatment and cancer screening is that it is not directly relevant to sexual and RH .

For the “Fighting diseases” scenario we assumed that government would put high priority to HIV/AIDS, STI treatment, cancer treatment and cancer screening, maternity and abortion services as before with the same ‘ideal levels’ as before, whereas contraception, and sex education would be assigned only middle priority. The general explanation is that government would be expected to invest more in detection and treatment of diseases rather than in anything else.

We assumed that the ideal level of contraceptive usage should be 400 per 1000 (compared to current level of 300) whereas the level of sex education in schools should be doubled. Also, we assumed that since level of detection of cancer and HIV/AIDS in Ukraine is very low, ideal levels of cancer and HIV/AIDS treatment needed to be higher than current levels by as 40 percent and 100 percent, respectively. For similar reasons, we assumed that ideal level of cancer screening utilization should higher (by a factor of six) than current levels. We assumed the public-private split in expenditure in each service area would remain constant at currently estimated levels.

Finally we considered 3-4 years would be needed to implement the above-discussed policies, over which the total (public + out-of-pocket) budget of RH care will slightly increase (from $168 to $175 million USD) due to economic growth. These assumptions and the rest of the data we input into the model are set out in the appendix. Similarly the detailed results are presented in the appendix. A simple way to summarize the results is in the form of graphs shown for each scenario in Figure 2 a & b, one for each scenario.

They show the percentage change between the current and predicted levels of utilization, following on from the revised allocations and given the RH policy scenario. There are a number of similarities but also some differences. As is seen sex education and FP would increase more under the 'Prevention and Promotion' scenario than under the 'Fighting Diseases' scenario. In either case the use of abortion services would fall by over half, and there would be a a smaller fall in STI treatment from present levels. However, treatment for HIV/AIDs would increase significantly under both scenarios. Cancer screening would increase significantly under either scenario particularly under ‘Fighting Diseases’. Cancer treatment would also benefit, although under the ‘Prevention and Promotion’ scenario it would remain more or less unchanged.

Because different services attract different levels of private and public funding these simulations suggest that public expenditure share could decline from the current $64.7 million to $60 million under the “Prevention and promotion” scenario and $64

million under the “Fighting diseases” scenario. However, corresponding, out-of-pocket financing would increase from $103.2 million to $114.9 million and $111 million, respectively. In our opinion, these results suggest that the government could save some money implementing one of these policies and that saving could be redirected to the *institutionalization* of the out-of-pocket payment system, including, for example, development of a proper medical insurance system and market.

Figure 2(a): Comparison of the % change between existing and predicted utilization under the 'Prevention and Promotion' Scenario.

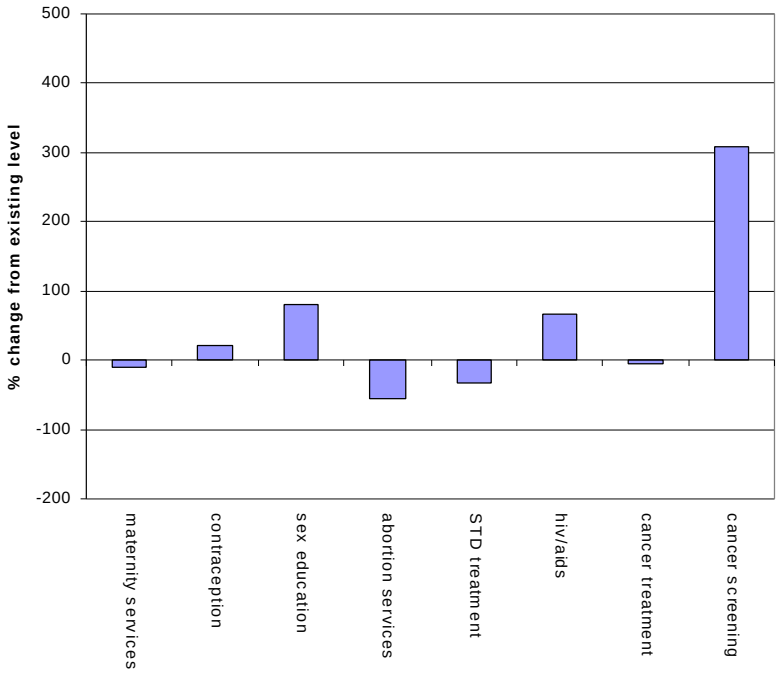
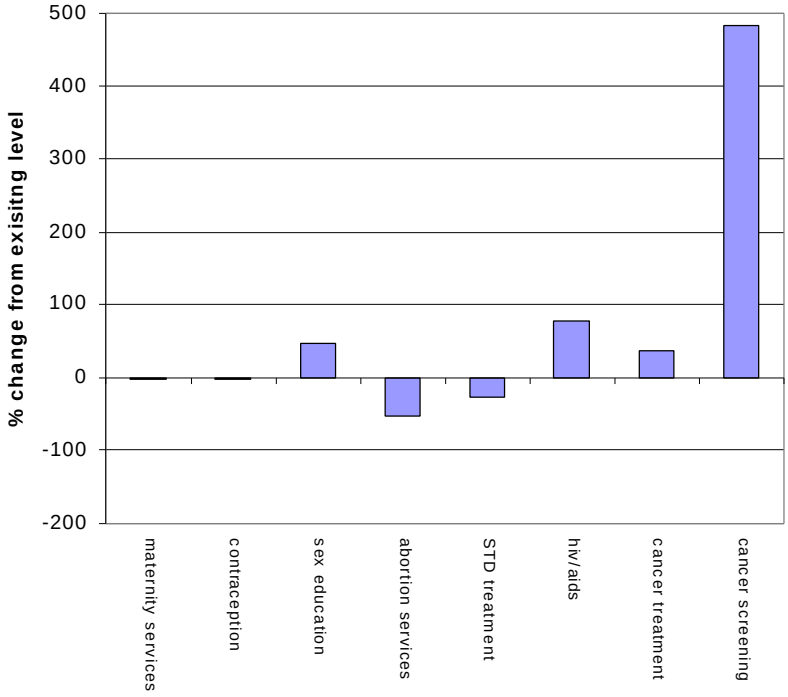


Figure 2(b): Comparison of the % change between existing and predicted utilization under the 'Fighting Diseases' Scenario.



III. Conclusions and Recommendations

In general health care funding is not a priority in Ukraine. The position of RH care is similar. Nevertheless, Ukraine's RH policy is consistent with the ICPD agenda and on the achievement of its three goals - decreasing infant and maternal mortality and universal access to FP/RH services. Although the ICPD agenda is understood in political circles and among decision-makers, the root cause of present difficulties is a lack of resources and funds. There are however a number of contributory causes including the organization and funding of health care where improvements are urgently needed and which could make a difference in the short-term.

For example the present distribution of resources in RH are inconsistent with requirements in different services areas. Thus Ukraine would still be relatively oversupplied with maternity services, even if fertility levels were to rise above their presently very low levels. Similarly the growth in unofficial out-of-pocket payments for services has widened inequalities and weakened management controls over the direction of development particularly in terms of investment and the ability of services to respond to needs. Decisions tend to be short-term and tactical rather than strategic and this applies at all levels of decision making. In short the present path of development is unlikely to lift Ukraine out of the present demographic impasse or the crisis in health care.

A number of specific improvements are needed. Whilst they do not in themselves guarantee a solution to these problems they should create a more responsive and effective framework for delivering services. The first and most important area of change is in the area of health service reform. The first priority should be to bring out of pocket payments into the mainstream of health care funding. The national committee agreed that the best way to do this would be to set up a social insurance fund, which would be voluntary in the first instance. Tax incentives should be considered to encourage as many people and employers as possible to join.

Proposals currently being considered by the Cabinet of Ministers suggest this recommendation should have a good chance of adoption. Revenues would be used to remove the incentives in the present system that give rise to such payments in the first place and to set up the appropriate institutions. However, it is important that any new institutions are efficient and effective and do not simply replicate existing bureaucracy. To achieve this however, there would need to be changes in current legislation on the issue of free access and a removal of any current limitations on existing private sector and NGO providers from offering these services.

Another priority area is to review and change the way resources are currently allocated. Currently the flexibility to make significant changes is constrained by the practice of allocating resources on the basis of inputs (beds, salaries etc) rather than on the basis of service needs and outcomes. The practice of allocating marginal extra resources through centrally initiated programs is right in spirit but experience suggest that unless the programs are backed with sufficient funds they will be ineffective. Changes to the way total resources are allocated would potentially improve matters by freeing up resources for central initiatives like the FP program. The committee believes regions and local authorities would welcome a fresh approach if it were

accompanied by financial and other incentives for improving the quality of patient care and throughput.

These changes would result in a multi-source system of health care funding which would be no more complex than the existing system but which would have the advantage of being transparent and properly regulated. According to this system the state would guarantee a specific volume of free medical care above which additional services will be provided by both public and private facilities for reimbursement or payment of a small fee – for example, for drug prescriptions. In the present financial and political climate this approach seems to be the most practicable and attainable.

The ultimate aim of policy however is to improve the demographic situation in the country and to improve the health status of the population, including the position of women. From the committee's work flow a number of specific recommendation s affecting key areas of RH care, some of which are directed at changes in behavior whilst others are more concerned with improving particular services.
These are:

- Improving the dissemination of information about FP devices and methods and making them more accessible. This will lead to a decrease in abortions and post-abortion complications such as cases of secondary infertility;
- Improving early cancer detection and treatment. Screening services have been allowed to decline and cases of female cancers are increasing. With further population aging the outlook is for more increase and early diagnosis and treatment will help keep down costs as well as improve health status. The committee believes a program should be established for training primary care specialists in cancer screening and detection techniques;
- Increasing the levels of service provision in other RH care specialties including gynecology, obstetrics and STIs;
- Introducing more sex education into school curricula to help prevent the spread of STIs, particularly HIV\AIDS (which as the national committee noted is becoming a major problem) lead to a decrease in unwanted pregnancies and abortions. The cost of introducing this recommendation, the committee believes, is relatively small compared to the beneficial effect it would have;
- Enforcing current legislation for example in the field of health and safety at work by the imposition of fines on employers. This would have wider benefits not only just for women at work;
- Establishing a mechanism for co-ordinating efforts in the field of RH on behalf of the many agencies and interest groups involved both in the Ukraine and overseas (for example donor agencies). This would provide a better focus for efforts to raise awareness and implement change whilst avoiding some of the present duplication;
- Improving the quality and quantity of official statistics in the RH field, including the flow of financial information, to facilitate better policy analysis and decision making. In addition the committee believes there should be a more responsive system of RH care planning so that RH services correspond more closely to needs at both local and national levels;
- Strengthening scientific support and research on RH in order to modernize present practices and outcomes.

As Ukraine currently does not currently have an integrated strategy for improving RH care, it is suggested that the National Program for Improvement in Reproductive Health for 2001-2005 may provide the best vehicle for implementing the committee's recommended program of change. The committee also noted that, as a result of decisions taken at ICPD+5, countries with transitional economies, such as Ukraine, should receive further technical assistance to help fund such programs. The government is therefore encouraged to engage in discussions with donor organizations to discuss with them the committee's findings and recommendations.

APPENDIXES: STATISTICAL TABLES

Refers section 2.1, Socio-demographic situation

Table 1. Population

Year	*Population*	*Born*	*Died*	*Balance*	*Migration*
1990	51838500	657202	629602	27650	78300
1991	51944400	630813	669960	-39084	151347
1992	52056600	596782	697110	-100264	287828
1993	52244100	557466	741660	-184125	54494
1994	52114400	521545	764669	-243043	-142876
1995	51728400	492861	792587	-299726	-94574
1996	51334100	467211	773717	-306502	-134094
1997	50893500	442581	754151	-311570	-82030
1998	50499900	419238	719954	-300716	-93584

Table 2. Fertility

Year	*Births*	*Born alive*	*Boys*	*Girls*	*Still births*	*Boys*	*Girls*
1990	658201	657202	338279	318923	5724	3153	2571
1991	631658	630813	323946	306867	5338	2992	2346
1992	597339	596782	306757	290028	4818	2655	2163
1993	557474	557466	286857	270610	3990	2238	1752
1994	521581	521545	268677	252868	3707	2008	1699
1995	493152	492861	253942	238919	3409	1898	1511
1996	467510	467211	241265	225946	3218	1744	1474
1997	442559	442581	227695	214886	2966	1585	1381
1998	418953	419238	215477	203761	2597	1420	1177

Table 3. Abortions

	1985	*1990*	*1991*	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*
Number of abortions, thousand	1179	1019	957	932	861	799	740	687	597	525
Per 1000 women at age 15-49 years	88.6	82.6	77.5	75.1	68.6	63.1	58.2	53.8	46.7	41.1
Per 100 births (including born dead)	154	155	152	156	154	153	150	147	135	125

Table 4. Complications of Pregnancy, Childbirth, and the Puerperium

	1990	*1995*	*1996*	*1997*	*1998*
Number, thousand	414	516	577	540	552
Per 100000 women at age 15-49 years	3358	4051	4515	4223	4319

Table 5. Marriages and divorces

Year	*Marriages*	*Divorces*
1990	482753	192835
1991	493067	200810
1992	394075	222630
1993	427882	218974
1994	399152	207577
1995	431731	198300
1996	307543	193030
1997	345013	188232
1998	310504	179688

Table 6. Mortality

	Deaths			*Infants deaths*		
Year	*Total*	*Men*	*Women*	*Total*	*Boys*	*Girls*
1990	629602	297584	332018	8525	4997	3528
1991	669960	319837	350123	8831	5103	3728
1992	697110	337485	359625	8429	4954	3475
1993	741660	356381	385281	8434	5046	3385
1994	764669	372087	392582	7683	4493	3190
1995	792587	396052	396535	7314	4243	3071
1996	773717	388707	388010	6779	3978	2801
1997	754151	375369	378782	6282	3733	2549
1998	719954	355009	364945	5423	3252	2171

Table 7. Mortality of women, by some causes of death, 1997

Cause	*Number*	*Per 100 000 women*
Breast cancer	7554	27.9
Cervix cancer	2471	9.1
Other malignant tumors of uterus	2389	8.8
Complications of pregnancy, childbirth, and the puerperium	111	0.4
Including		
Abortions	10	0.0
Haemorrhages during pregnancy and childbirth	18	0.1

Table 8. Incidence of female cancers by type

	Thousand				*Per 100, 000*			
	1995	*1996*	*1997*	*1998*	*1995*	*1996*	*1997*	*1998*
Breast	13.7	14.0	14.6	14.6	49.9	51.5	53.9	54.5
Cervix	10.6	10.6	11.1	11.1	38.7	38.9	41.0	41.2

Table 9. Infant mortality rates
(Child deaths at age under 1 year per 1000 born)

	1985	*1990*	*1991*	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*
Total	15.7	12.8	13.9	14.0	14.9	14.5	14.7	14.3	14.0	12.8
urban areas	15.7	12.5	13.5	13.8	14.7	14.1	14.3	14.4	14.2	12.9
rural areas	15.8	13.5	14.7	14.4	15.4	15.2	15.3	14.3	13.8	12.7

Table 10. Infant mortality, by major cause of death

	Thousand						*Per 10000 born*					
	1985	*1990*	*1995*	*1996*	*1997*	*1998*	*1985*	*1990*	*1995*	*1996*	*1997*	*1998*
All cases	12.1	8.5	7.3	6.8	6.3	5.4	157.4	128.4	146.8	143.4	140.4	128.1
Infectious and parasitic diseases	1.1	0.5	0.6	0.6	0.5	0.3	14.8	7.3	11.2	11.6	10.3	7.4
Diseases of the nervous system and sense organs	0.4	0.2	0.3	0.3	0.2	0.2	5.0	3.6	5.6	5.3	4.0	4.5
Diseases of the respiratory system	2.2	1.0	0.7	0.6	0.6	0.4	28.3	14.8	14.5	12.3	12.2	9.9
Diseases of the digestive system	0.2	0.1	0.1	0.1	0.0	0.0	2.3	1.2	1.7	1.8	0.9	1.0
Congenital anomalies	3.2	2.5	2.1	1.9	1.8	1.5	41.7	37.3	42.6	40.5	40.2	36.3
Certain conditions originating in the prenatal period	3.9	3.2	2.4	2.4	2.3	2.0	50.7	48.9	48.4	50.7	52.3	48.7
Accidents, murders and other external causes	0.6	0.4	0.5	0.4	0.4	0.4	7.4	6.3	9.1	8.3	8.4	9.1

Table 11. Infant mortality by age, 1997

	Number			*As percentage of total number*		
	Total	*Boys*	*Girls*	*total*	*Boys*	*Girls*
All cases	6282	3733	2549	100.0	100.0	100.0
Including at age:						
Under 1 month	3426	2098	1328	54.5	56.2	52.1
Including						
Under 1 day	508	292	216	8.1	7.8	8.5
1-6 days	1948	1239	709	31.0	33.2	27.8
7-27 days	929	539	390	14.8	14.4	15.3
1 month	579	334	245	9.2	8.9	9.6
2 months	476	272	204	7.6	7.3	8.0
3 months	417	230	187	6.6	6.2	7.3
4 months	319	188	131	5.1	5.0	5.1
5 months	274	153	121	4.4	4.1	4.8
6 months	195	118	77	3.1	3.2	3.0
7 months	148	88	60	2.4	2.4	2.4
8 months	156	82	74	2.5	2.2	2.9
9 months	122	69	53	1.9	1.8	2.1
10 months	92	54	38	1.5	1.4	1.5
11 months	78	47	31	1.2	1.3	1.2

Reproductive health care in Ukraine: economic environment and public financing

Refers to sections 2.2, Reproductive health care policy, and 2.3 Current RH care status

Italicized figures are estimates

Table 1. Basic macroeconomic indicators

Year	*1995*	*1996*	*1997*	*1998*	*1999*
GDP (bln hrn)	54.5	81.5	92.5	103.9	128.6
Annual inflation, %	181.7	39.7	10.1	20	19.2
UAH / USD rate	1.47	1.82	1.86	2.44	4.31

Table 2. General public health care financing data

Year	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*
public health care expenditure (mln UAH)	2599.9	3209.8	3996.8	3632	4363.4	*4446.2*
central budget, %	7.9	8.3	9.7	9.7	13.3	*13.9*
local budget, %	92.1	91.7	90.3	90.3	86.7	*86.1*
Hospital services, %	47	47.7	47.2	46	47.2	*47.2*
Policlinics, %	36.3	36.9	36.9	36.3	36.9	*36.9*
Staff, %	36.3	43.3	45	45.4	45.7	*45.7*
Medical supplies (drugs), %	12.1	9	6.6	6.8	8.3	*8.3*
other than staff and drugs, %	51.6	47.7	48.4	47.8	46	*46*
health care expenditure per capita	50.9	63.4	79.5	72.9	87.5	*90.1*
health care expenditure as % of GDP	4.3	4.0	4.0	3.5	3.5	*2.9*

Table 3. Financing of the National Family planning program

Year	*1995-1998*	*1999*	*2000*
Total, millions UAH	2154.9	850.5	*690.6*
Sources of finance:			
-central funds, %	10.7	3.4	*4.7*
-local funds (oblasts), %	89.3	96.6	*95.3*

Table 4. Public financing for abortion services

	1995	*1996*	*1997*	*1998*	*1999*	*2000*
Total, millions UAH	3.2	4	4.8	4	4.9	*5.6*
Sources of finance						
-central funds, %	*7.9*	*8.3*	*9.7*	*9.7*	*13.3*	*13.9*
-local funds (oblasts), %	*92.1*	*91.7*	*90.3*	*90.3*	*86.7*	*86.1*

Table 5. Public financing of gynecological diseases

Year	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*
Total annual expenditure, millionsUAH	106.4	137.1	165.5	146.9	183.6	*208.1*
sources of finance						
-central funds	7.9	8.3	9.7	9.7	13.3	*13.9*
-local funds (oblasts)	92.1	91.7	90.3	90.3	86.7	*86.1*

Source: Ministry of Finance of Ukraine

Refers to section 2.9, Reproductive health development scenarios and utilization of funds

INPUT DATA
Scenario "Fighting diseases"

Service	*Size of target group (millions)*	*Per 000 current utilization*	*Per 000 ideal utilization*	*Priority to achieving ideal*	*Annual cost per person served)*	*of which staff costs $*	*non- staff costs $*	*% service out-of-pocket*	*% publicly funded*
Maternity services	11.065	35.6	35.6	1	80	10	70	10	90
Contraception	11.065	300	400	0.75	20	1	19	90	10
Sex education	2.26	500	1000	0.75	1	1	0	0	100
Abortion services	11.065	46.7	23	1	50	20	30	60	40
STI treatment	41.088	24.20	18	1	30	10	20	60	40
HIV/AIDS	51.431	0.30	0.55	1	200	50	150	5	95
Cancer treatment	22.465	0.5	0.7	1	400	100	300	50	50
Cancer screening	22.465	50	300	1	5	2	3	80	20

Service	*Ideal expenditure ($millions)*	*Ideal (publicly funded)*	*Ideal (out-of-pocket funded)*	*% health service as whole*	*Current expenditure ($ million)*	*Current (publicly funded) $ million*	*Current (out-of-pocket funding) $m*
Maternity services	31.5	28.4	3.2	1.85	31.5	28.4	3.2
Contraception	66.4	6.6	59.8	3.91	66.4	6.6	59.8
Sex education	1.7	1.7	0.0	0.10	1.1	1.1	0.0
Abortion services	12.7	5.1	7.6	0.75	25.8	10.3	15.5
STI treatment	22.2	8.9	13.3	1.31	29.8	11.9	17.9
HIV/AIDS	5.7	5.4	0.3	0.33	3.1	2.9	0.2
Cancer treatment	6.3	3.1	3.1	0.37	4.5	2.2	2.2
Cancer screening	33.7	6.7	27.0	1.98	5.6	1.1	4.5
Total ($millions)	180.2	65.9	114.2	10.60	167.9	64.7	103.2

INPUT DATA
Scenario 'Prevention and promotion'

Service	*Size of target group (millions)*	*Per 000 current utilization*	*Per 000 ideal utlization*	*Priority to achieving ideal*	*Annual cost per person served $*	*of which staff costs $*	*non- staff costs $*	*% service out-of-pocket*	*% publicly funded*
Maternity services	11.065	35.6	35.6	1	80	10	70	10	90
Contraception	11.065	300	400	1	20	1	19	90	10
Sex education	2.26	500	1000	1	1	1	0	0	100
Abortion services	11.065	46.7	23	1	50	20	30	60	40
STI treatment	41.088	24.20	18	1	30	10	20	60	40
HIV/AIDS	51.431	0.30	0.55	1	200	50	150	5	95
Cancer treatment	22.465	0.5	0.7	0.75	400	100	300	50	50
Cancer screening	22.465	50	300	0.75	5	2	3	80	20

Service	*Ideal expenditure ($millions)*	*Ideal (publicly funded)*	*Ideal (out-of-pocket funded)*	*% health service as whole*	*Current expenditure ($ millions)*	*Current (publicly funded) $millions*	*Current (out-of-pocket funding)*
Maternity services	31.5	28.4	3.2	1.85	31.5	28.4	3.2
Contraception	88.5	8.9	79.7	5.21	66.4	6.6	59.8
Sex education	2.3	2.3	0.0	0.13	1.1	1.1	0.0
Abortion services	12.7	5.1	7.6	0.75	25.8	10.3	15.5
STI treatment	22.2	8.9	13.3	1.31	29.8	11.9	17.9
HIV/AIDS	5.7	5.4	0.3	0.33	3.1	2.9	0.2
Cancer treatment	4.7	2.4	2.4	0.28	4.5	2.2	2.2
Cancer screening	25.3	5.1	20.2	1.49	5.6	1.1	4.5
Total ($ millions)	180.2	65.9	114.2	10.60	167.9	64.7	103.2

OUTPUT DATA
Scenario 'Fighting diseases'

Expenditure: $175 million
Budget factor: 1.017

Service	*Predicted utilization per 000 risk group*	*Utilization - difference with current*	*Percent of ideal*	*Percent of current utilization*	*Predicted vs. ideal: shortfall (-) / excess (+)*	*Implied service expenditure ($ millions)*	*of which out of pocket ($ millions)*	*of which public ($ millions)*	*Difference with 'ideal' ($ millions)*	*% change current expenditure*
Maternity services	34.58	-1.0	97.14	97.14	1.0	30.611	3	28	-0.9	-2.9
Family planning	291.41	-8.6	72.85	97.14	108.6	64.490	58	6	-1.9	-2.9
Sex education	728.54	228.5	72.85	145.71	271.5	1.646	0	2	0.0	45.7
Abortion services	22.34	-24.4	97.14	47.84	0.7	12.361	7	5	-0.4	-52.2
STI treatment	17.48	-6.7	97.14	72.25	0.5	21.553	13	9	-0.6	-27.7
HIV/AIDS	0.53	0.2	97.14	177.50	0.0	5.496	0	5	-0.2	77.5
Cancer treatment	0.68	0.2	97.14	135.99	0.0	6.110	3	3	-0.2	36.0
Cancer screening	291.41	241.4	97.14	582.83	-8.6	32.733	26	7	-1.0	482.8
					Total	**175.0**	**111.0**	**64.0**	**-5.2**	**4.2**

OUTPUT DATA
Scenario "Prevention and promotion"

Expenditure: USD 175 mln
Budget factor: 0.947

Service	*Predicted utilization per 000 risk group*	*Utilization difference with current*	*Percent of ideal*	*Percent of current utilization*	*Predicted vs. ideal: shortfall (-) /surplus(+)*	*Implied service expenditure ($millions)*	*of which out of pocket ($ millions)*	*of which public ($ millions)*	*Difference with 'ideal' $ millions*	*% change current expenditure*
Maternity services	32.30	-3.3	90.74	90.74	3.3	28.596	3	26	-2.9	-9.3
Family planning	362.97	63.0	90.74	120.99	37.0	80.325	72	8	-8.2	21.0
Sex education	907.42	407.4	90.74	181.48	92.6	2.051	0	2	-0.2	81.5
Abortion services	20.87	-25.8	90.74	44.69	2.1	11.547	7	5	-1.2	-55.3
STI treatment	16.33	-7.9	90.74	67.49	1.7	20.133	12	8	-2.1	-32.5
HIV/AIDS	0.50	0.2	90.74	165.81	0.1	5.134	0	5	-0.5	65.8
Cancer treatment	0.48	0.0	68.06	95.28	-0.2	4.281	2	2	-0.4	-4.7
Cancer screening	204.17	154.2	68.06	408.34	-95.8	22.933	18	5	-2.3	308.3
					Total	**175.0**	**114.9**	**60.1**	**-17.9**	**4.2**