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EXPLORING CARE FOR PEOPLE

LIVING WITH HIV AND KEY POPULATIONS IN UKRAINE DURING WAR:

Insights from Healthcare Providers working at Médecins du Monde and the Ukrainian Healthcare System, Policy Makers, and Key Populations

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List of abbreviations

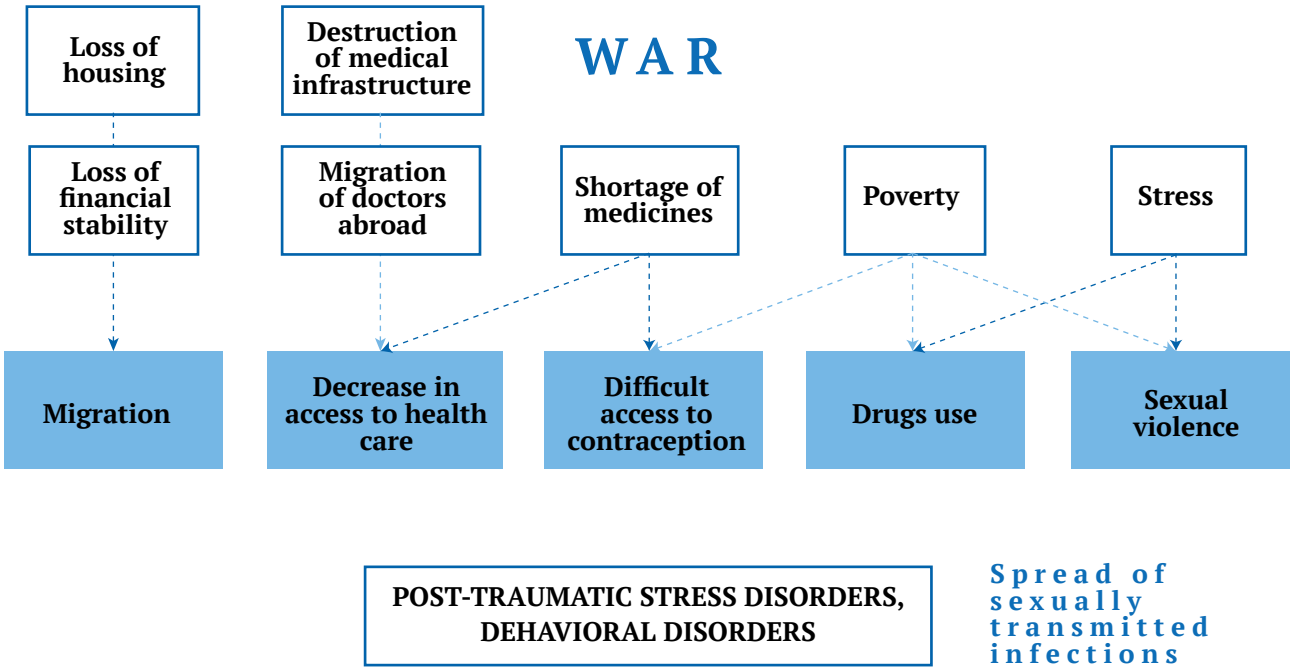
Abbreviation	Definition
AFEW-Ukraine	International Charitable Foundation "AIDS Foundation East-West"
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CBO	Community-based organization
FGD	Focus group discussion
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IDP	Internally displaced person
LGBT	Lesbian, gay, bisexual, and transgender people
MdM	Médecins du Monde (Doctors of the World)
MHPSS	Mental health and psychosocial support system
MSM	Men who have sex with men
MU	Mobile unit
NGO	Non-governmental organizations
PATH	Program for Appropriate Technology in Health, PATH
PLHIV	People Living with HIV
PMSACs	Primary medical and sanitary centres
PWID	People who inject drugs
SMT	Substitution maintenance treatment
SRH(R)	Sexual and reproductive health (and rights)
SSF	Swiss Solidarity Fund
STI	Sexual transmitted infection
USAID	United States Agency for International Development

01
INTRODUCTION

Since 2015, Médecins du Monde (MdM) has been operating in Ukraine and has offices in Dnipro, Zaporizhzhia, Vinnytsia, Kyiv, Kharkiv, and Chernivtsi. Since the full-scale invasion of Ukraine (2022), activities have been scaled-up with a primary focus on supporting primary healthcare systems disrupted by the war through mobile units (MUs). This project focuses on Vinnytsia Oblast (where MdM Germany operates), and Zaporizhia and Kharkiv Oblast (where MdM Spain operates).

Currently, MdM is not offering specific programs addressing HIV in Ukraine. With the ongoing war, there is a concern that HIV care services may be jeopardized, posing a threat to those affected (1). Figure 1, based on the systematic review *Impact of War-Associated Factors on the Spread of Sexually Transmitted Infections* (STIs) by Kvasnevska et al., provides an overview of the indicators influencing STI transmission during conflict (2). MdM, International Charitable Foundation "AIDS Foundation East-West" (*AFEW-Ukraine*), and the Swiss Solidarity Fund (SSF) are collaborating within this project to enhance sexual and reproductive health (SRH) services, including HIV response, for key populations living in Ukraine. To explore the experiences and needs of healthcare providers and key populations, qualitative in-depth interviews with healthcare providers (working for MdM and state clinics) were conducted by MdM the Netherlands, and focus group discussions (FGD) with key populations were conducted by *AFEW-Ukraine*. This report summarizes the gathered insights which will guide the development of SRH training for MdM staff and operating partners.

FIGURE 1:
War-associated factors on the spread of sexually transmitted infections (2)



02
Background

With an estimated HIV prevalence of 0.6% among its population in 2020, Ukraine faces a significant HIV burden, reporting the highest AIDS incidence in Europe and a substantial number of AIDS-related deaths over the past decade (1). Unlike many European countries where infections are more prevalent among men, Ukrainian men and women are almost equally affected (1). Key populations include people who inject drugs (PWID), who account for 38% of new HIV diagnoses, and men who have sex with men (MSM), whose numbers are increasing but likely underestimated (1).

Only 69% of Ukrainians living with HIV are aware of their status, and just 57% receive antiretroviral therapy (ART) (1). Achieving the UNAIDS 95-95-95 targets by 2025 seems unlikely, particularly with the ongoing war. In 2022, around 129,000 people were tested for HIV, dropping to 97,000 in 2023, with many diagnosed at advanced stages, indicating delays in healthcare-seeking behaviour (3).

Ministry of Health (MoH) guidelines recommend offering HIV diagnostics to key populations and vulnerable individuals, of which an overview can be found in table 1. Until recently, HIV diagnostics were primarily available at specialized HIV centres in larger cities. To improve access, the REACH 95 project (2021–2028), a collaboration between the MoH, USAID, and PATH, is decentralizing HIV services, enhancing targeted testing, and supporting primary care facilities in linking individuals to prevention, care, and treatment.

TABLE 1:
Key populations and vulnerable groups eligible for HIV testing according to MoH guidelines

CATEGORY	GROUP
Key populations	• Sexual partners of people living with HIV (within the last 12 months) • People who inject drugs (2+ episodes in the last 12 months) • Men who have sex with men (at least one sexual contact in the last 12 months) • People providing sexual services (at least two cases in the last 12 months) • Sexual partners of people who inject drugs (within the last 12 months) • People in penal institutions or remand facilities, and those released in the last 12 months • Transgender people
Vulnerable Groups	• Clients of people providing sexual services • People who use non-injectable substances • Sexual partners of men who have sex with men • People who have survived rape or sexual exploitation • Homeless adults • Migrants (internal and external), internally displaced persons • Children of migrants, orphans, children in difficult life situations • Military personnel and participants in hostilities

03 Methodology

Qualitative data methodology was employed to acquire comprehensive insights. A semi-structured interview guide was developed by research advisors from *AFEW-Ukraine* and MdM the Netherlands.

3.1. DATA COLLECTION AMONG HEALTHCARE PROVIDERS AND POLICYMAKERS

Data collection took place in two rounds of interviews. In total, twenty healthcare providers and policy makers were interviewed. The first round of interviews took place from February 16th to March 20th , the second round of interviews took place between April 30th to July 26th 2024.

During the first round of interviews, eleven in-depth interviews were conducted with medical doctors (working at MdM and a Primary Medical and Sanitary Centre (PMSAC)) and supervisors recruited by MdM program managers. During the second round of interviews, nine in-depth interviews were conducted with a midwife, mental health and psychosocial support professionals (MHPSS) and supervisors recruited by MdM program managers. Additionally, policymakers among which MdM program coordinators, program managers, and representatives of the MoH and WHO health cluster were interviewed. Characteristics of the respondents can be found in table 2.

All participants provided verbal consent to take part in the study. Interviews with policymakers were conducted in English. For healthcare workers, interviews were translated: the interviewer posed questions in English, which were then translated into Ukrainian by a translator fluent in both English and Ukrainian. Participants' responses, given in Ukrainian, were subsequently translated back into English. The interviewer transcribed all interviews in English within three days.

3.2. DATA COLLECTION AMONG KEY POPULATIONS

Data collection took place in person by the *AFEW-Ukraine* team and by 3 focal points in the project Oblasts in two rounds. The first round was conducted from March 13th to April 27th, 2024 and the second round - from 15th of July till the 1st of August. Data collection took more time than expected due to security reasons and specifics of reaching out to key populations during war situations. Qualitative data was collected by using individual, semi-structured interviews and guided FGDs with the key populations. The guides were developed by research advisors from *AFEW-Ukraine* and MdM. Overall, in the first round of interviews and focus groups, the team managed to conduct 2 interviews with adolescents from key populations and 17 FGDs in Kharkiv, Zaporizhzhia and Vinnytsia with a total number of 142 respondents (62 females and 80 males). In the second round 6 FGDs were conducted in Kharkiv and Zaporizhzhia with a total number of 52 respondents (33 females and 19 males). In total, 23 FGDs and 2 in-depth interviews with key populations were conducted with a total of 194 respondents. Respondents from key populations included LGBT/MSM (n = 53), PWID (n = 91), women living with HIV (n = 23), sex workers (n = 17), vulnerable women (n = 10). Characteristics of the respondents can be found in table 3.

3.3. DATA ANALYSIS

Data analysis was performed by a research advisor from MdM the Netherlands and the *AFEW-Ukraine* project team. All interviews and FGDs were recorded and transcribed with the given consent of the participants. All the replies were anonymous and impossible to trace. Recordings of interviews and FGDs collected by the *AFEW-Ukraine* team, were transcribed and then analysed. The key findings of that analysis were then translated into English, along with supporting quotes. The transcripts are available in the language of origin - Ukrainian.

Thematic analysis was employed, for which MdM the Netherlands used NVivo 14 Pro software. Transcripts were reviewed to gain familiarity with the data and further analysis was carried out using a coding system aligned with key themes regarding health needs and access to aid. Common themes and specific needs were identified, supported by participant quotes. The final code trees can be found in Appendix 1. Relevant quotes were chosen to exemplify the respondents' experiences.

TABLE 2:
Characteristics of healthcare provider and policymaker respondents

#	PROFILE	GEN-DER	MDM CHAPTER	PROJECT OBLAST	WORKING EXPERIENCE
1	MdM MD (family medicine)	Female	Spain	Zaporizhzhia	MD for 20 years, since 3 months working at MdM
2	MdM MD (family medicine)	Female	Spain	Zaporizhzhia	MD for 20 years, since 1 year working at MdM
3	MdM health officer/ supervisor	Female	Spain	Zaporizhzhia	–
4	MdM MHPSS supervisor	Female	Spain	Zaporizhzhia	MHPSS professional for 6 years, since 3 months working at MdM
5	MdM MHPSS manager	Female	Spain	Zaporizhzhia	Since 2 years working at MdM
6	MdM MD (family and emergency medicine)	Male	Spain	Kharkiv	MD for 5 years, since 1 year working at MdM + secondary position at Ukrainian health system
7	MdM MD (general doctor)	Male	Spain	Kharkiv	MD for 10 years, since 1 year working at MdM
8	8. Director PMSAC	Female	-	Kharkiv	MD for 25 years, since 7 years working as a director
9	PMSAC MD (family medicine)	Female	-	Kharkiv	MD for 17 years
10	MdM MHPSS professional	Female	Germany	Vinnytsia	MPHSS professional for 4 years, since 8 months working at MdM
11	MdM program manager	Female	Germany	Vinnytsia	MD for 11 years, since 14 months working at MdM + secondary position at Ukrainian health system
12	MdM MD (family medicine)	Female	Germany	Vinnytsia	Since 3 months working at MdM + secondary position at Ukrainian health system

#	PROFILE	GEN-DER	MDM CHAPTER	PROJECT OBLAST	WORKING EXPERIENCE
13	MdM MD (family medicine)	Female	Germany	Vinnytsia	Since 2 years working at MdM
14	MdM midwife/MD	Female	Germany	Vinnytsia	MD for 3 years, since 3 months working at MdM as a midwife
15	MdM program coordinator	Female	Germany	Vinnytsia, Dnipro, Donetsk	8 years of working experience in NGOs, since 9 months working at MdM
16	MdM program manager	Male	Spain	Country level	MD for 20+years, since 6 months working at MdM
17	Representative MoH Ukraine	Female	-	Country level	20 years of working experience in public health
18	Representative WHO health cluster	Female	-	Country level	-
19	Emergency Unit Project Manager	Male	Spain (HQ)	Country level	20 years of working experience in NGOs, since 5 years working at MdM
20	Medical coordinator	Female	Spain	Country level	MD for 15 years, since 5 years working at MdM

TABLE 3:
Characteristics of key population respondents

#	DATE	CITY/ OBLAST	TYPE OF DATA COL-LECTION	KEY POPULA-TION(S)	Num-ber of partici-pants	Female	Male	Age
					194	95	99	*16-59*
1	13.03.2024	Vinnytsia	Focus Group Discussion	LGBT/MSM	10	0	10	20-34
2	14.03.2024	Vinnytsia	Focus Group Discussion	PWID	6	0	6	35-46
3	14.03.2024	Vinnytsia	Focus Group Discussion	PWID	4	4	0	27-45
4	14.03.2024	Vinnytsia	Focus Group Discussion	PWID/SMT pa-tients	7	0	7	30-52
5	15.03.2024	Vinnytsia	Focus Group Discussion	PWID/SMT pa-tients	10	0	10	36-59
6	15.03.2024	Vinnytsia	Focus Group Discussion	Women living with HIV	5	5	0	35-48
7	15.03.2024	Vinnytsia	Focus Group Discussion	PWID/SMT patients	9	9	0	34-59
8	18.03.2024	Vinnytsia	Interview	Women living with HIV	1	1	0	18
9	27.03.2024	Zaporizhzhia	Focus Group Discussion	Vulnerable women	10	10	0	37-59

#	DATE	CITY/ OBLAST	TYPE OF DATA COLLECTION	KEY POPULATION(S)	Number of participants	Female	Male	Age
					194	95	99	*16-59*
10	24.03.2024	Kharkiv	Focus Group Discussion	LGBT/MSM	11	0	11	25-47
11	29.03.2024	Kharkiv	Focus Group Discussion	Sex workers	8	8	0	23-42
12	30.03.2024	Kharkiv	Focus Group Discussion	LGBT/MSM	7	0	7	19-24
13	31.03.2024	Kharkiv	Focus Group Discussion	LGBT/MSM	5	3	2	32-47
14	29.03.2024	Kharkiv	Focus Group Discussion	Women living with HIV	11	11	0	25-50
15	04.04.2024	Kharkiv	Interview	LGBT/MSM	1	0	1	16
16	05.04.2024	Zaporizhzhia	Focus Group Discussion	PWID	10	0	10	40-59
17	06.04.2024	Kharkiv	Focus Group Discussion	PWID	8	2	6	38-52
18	12.04.24	Zaporizhzhia	Focus Group Discussion	Sex workers	9	9	0	26-48
19	27.04.2024	Zaporizhzhia	Focus Group Discussion	LGBT/MSM	10	0	10	25-55
20	15.07.2024	Zaporizhzhia	Focus Group Discussion	PWID	9	9	0	28-50
21	22.07.2024	Zaporizhzhia	Focus Group Discussion	PWID	11	7	4	32-50
22	22.07.2024	Kharkiv	Focus Group Discussion	Women living with HIV	6	6	0	35-50
23	26.07.2024	Kharkiv	Focus Group Discussion	LGBT/MSM	9	4	5	21-52
24	27.07.2024	Kharkiv	Focus Group Discussion	PWID	7	0	7	35-48
25	01.08.2024	Zaporizhzhia	Focus Group Discussion	PWID	10	7	3	35-55

PLHIV – People Living with HIV

SMT – Substitution maintenance therapy

MSM – Men who have sex with men

HIV – human immunodeficiency virus

PWID – People who inject drugs

LGBT – lesbian, gay, bisexual, and transgender

Vulnerable women include all the women from key populations (PWID, PLHIV, Sex Workers, LGBT)

04
Findings: Insights gathered from healthcare providers

4.1.
HEALTH SYSTEM

4.1.1. Mobile Units

In all project Oblasts, healthcare delivery follows a consistent format. MdM provides primary healthcare through MUs. A fully staffed MU comprises a medical doctor, a MHPSS professional, a nurse, and a midwife. A partially staffed MU consists of the same team minus a medical doctor or midwife. Table 4 provides more details on the MUs in the three project Oblasts.

On a daily basis, the MUs visit villages in various Hromadas across the project Oblasts to deliver their services. The MUs from Vinnytsia and Zaporizhzhia cover 5 Hromadas, those from Kharkiv cover 9 Hromadas. Within these Hromadas, they reach out to remote villages where primary healthcare is not accessible due to long travel distances. The team delivers services through the MU and utilizes extra rooms provided within public spaces such as churches or community clubs when available. Additionally, the MUs support PMSACs. PMSACs vary in the scope of services they offer, ranging from basic primary health care to specialized care departments, day-care services, and inpatient care facilities. Given the challenges of limited staff and increasing demands, particularly with growing populations of internally displaced persons (IDPs), MUs assist in sustaining the operations of these IDP shelters. According to the respondents, the MUs have high demands.

> *...Not all locations have doctors. Yes, they have doctors, but they haven't medicines and they haven't some laboratory analysis, I mean some equipment. And in this case, we work like hell. Yes, we provide our help.*
>
> Quote from a medical supervisor (MdM)

Operating with a schedule, the MUs ensure villagers are informed of their arrival times and locations, which are made public through announcements on local channels. On an average day the MUs operate between 10:00 – 14:00 o'clock and see 20-25 patients, providing primary health care. For further diagnostics or specialized care, patients are referred to larger health facilities or hospitals in nearby cities. If a patient lacks the financial means for travel costs, MdM provides a budget to reduce the likelihood of them forgoing further follow-up care. While the MUs carry basic medicines available free of charge, more complex medications are prescribed and can be picked up at the nearest pharmacies.

Table 4:
Details on the MUs in the three project areas

PROJECT OBLAST	FULLY STAFFED MU	PARTIALLY STAFFED MU	TOTAL
Vinnytsia	2	1	3
Kharkiv	1	2	3
Zaporizhzhia	2	1	3
TOTAL	**5**	**4**	**9**

4.1.2. Challenges in accessing healthcare

According to the healthcare provider respondents, the primary challenge for patients in receiving the care they need is the long travel distances to healthcare providers, due to the relocation of their own physicians to West-Ukraine or abroad. This presents a significant barrier, particularly for elderly or disabled individuals who are unable to travel long distances, as well as for those lacking transportation or facing financial constraints, especially since public transport mostly is unavailable. While most physicians who have relocated continue to offer services via E-consulting, some cases require physical consultations for proper triage, and not all patients are able to access digital healthcare. This is where the MUs play a crucial role, reaching out to remote areas and providing assistance to those in need of care.

The MUs can digitally refer people to other first-line healthcare services, including PMSACs, for further diagnostics. When a referral to a medical specialist is necessary, the patient is referred to their primary physician with whom they have a declaration. This physician then digitally refers the patient to a medical specialist at a hospital, typically located in larger cities. According to all respondents, E-consultations and digital referrals to the healthcare system work very well. Additionally, the majority of respondents report that specialized healthcare is still operational in the areas where they operate. However, longer wait times are mentioned due to the relocation of many specialists and limited hospital capacity.

4.1.3. Challenges in healthcare delivery

According to the healthcare provider respondents, the biggest challenge in delivering care are the high demands and the limited (human) resources. Respondents working in Kharkiv and Zaporizhzhia also mention being challenged with unstable internet and sometimes lack of mobile connection.

> *If we talk about Vinnytsia Oblast, our healthcare system did not breakdown, it's only overloaded by IDPs. […]. In the east of our country it's a totally different situation because there's a lot of hospitals and other which are ruined.*
>
> Quote from the director of a PMSAC.

4.2. PATIENT PROFILE

4.2.1. Patient characteristics

The majority of patients visiting the MUs are individuals aged 60 and older, predominantly women, and frequently with disabilities. Given the proximity of Kharkiv and Zaporizhzhia to the frontline of the occupied territories, there has been a noticeable trend of young people relocating to West Ukraine or abroad. Consequently, elderly individuals have stayed behind, particularly those unable to travel long distances and are often unable to access primary healthcare services.

In the IDP shelters in Vinnytsia, the majority of patients belong to marginalized groups; those who remain in shelters are primarily individuals in disadvantaged positions. Also in Kharkiv, the number of IDPs is increasing.

> *In the previous times, when we were started and these shelters loaded for the first time, it was the multiple kinds of people. I mean genders, age professions and others. But, during this time, [those] who have ability to find the work and find the place to live like separate apartment. They leave these shelters and that's why now in the shelters live only people who have all disability, or they are elderly and have no possibility to work.*
>
> Quote from an MdM program coordinator.

4.2.2. Health issues

All medical doctors report that the majority of health issues patients present with are non-communicable diseases, such as cardiovascular disease and diabetes. In the shelters for IDPs, there are many young children living closely together, resulting in many patients presenting with flu-like symptoms.

The MHPSS program plays a significant role in the work of the MUs, as many patients come with anxiety issues, depression, and symptoms of sleep deprivation due to acute stress from the war.

4.3. SEXUAL AND REPRODUCTIVE HEALTH SERVICES

4.3.1. SRH service delivery

SRH services at the MUs are provided by midwives and include cervical and breast cancer screenings, contraceptive counselling, distribution of free condoms and oral (emergency) contraceptives, preconception counselling, postnatal support, guidance on menopausal symptoms, and assistance with basic gynaecological issues. For more specialised services, such as STI testing or contraceptive insertions, patients are referred to other clinics.

The SRH services are not promoted through posters or flyers, as some respondents believe this could have negative consequences. Due to the stigma surrounding the issue, some medical doctors worry that public advertising may discourage clients from seeking help, fearing judgement from others.

> *Usually patients would approach me and I will tell them about services I may provide. Sometimes, they would be quite ashamed of receiving all the services and I will start, for example, with the breast screening. So, people are less scared and the next time they come they may go for more screenings.*
>
> Quote from a midwife (MdM)

4.3.2. SRH care seeking behaviour of patients

Medical doctors have observed a low demand for SRH services among patients. Various explanations have been offered for this observation. The majority attribute it to the older age demographic of patients, suggesting that fewer individuals are in their fertile years. According to one informant, younger residents who still reside often prefer private healthcare clinics or utilise E-health services with their designated general practitioners for gynaecological care. Additionally, one informant suggests that SRH may not be prioritised by individuals living in war areas.

> *People mostly don't think about it [SRH], because it's frontline in 40 kilometres.. and they would think about something like that much later.*
>
> Quote from a medical doctor (MdM)

A respondent working for MdM as a midwife, along with several programme coordinators, noted that midwifery services are commonly perceived as being exclusively for pregnant women. However, clients visiting the MUs for general health issues are actively informed that SRH services are important for people of all ages. Most respondents believe that by promoting this message more consistently, a greater number of patients would seek out these services.

> *What I suggest is to have for different ages appropriate [information] material. Maybe this became more attractive to people that are old because there are a lot of them and they don't have access to the services because they don't know that the midwife can provide consultations, not only to give birth.*
>
> Quote from an MdM program coordinator

4.3.3. HIV diagnostics and care

Currently, the MUs do not offer HIV rapid tests or provide HIV care, these services are, according to the healthcare provider respondents, delivered in specialized HIV centres in the Oblasts' capital cities. As the MUs provide primary health care services, technically a person living with HIV could come to the MU for general- or psychological care. However, the great majority of the healthcare providers working at MdM reported that people living with HIV do not visit the MUs, only one staff member had experienced this. Patients requiring HIV testing are referred to specialized HIV centres. While it's not routinely recommended, a referral is made if a patient meets the criteria made by the MoH (table 1). However, none of the MdM staff have reported such criteria or received any requests for an HIV test from patients.

Most respondents believe offering HIV tests at the MUs would be beneficial, though some are sceptical about patient willingness due to privacy concerns. They also emphasized that patients must always have the legal right to decline an HIV test.

4.3.4. Relationship between mental health and SRH

Two MHPSS professionals highlight the connection between mental health and SRH. They observe that the impact of war on mental health has led to increased alcohol consumption, which may contribute to risky SRH behaviours. Additionally, they report a rise in cases of gender-based violence (GBV) by veterans returning home. Respondents report that violence against women by partners is normalised in society, with most people having experienced it at least once in their lives. They emphasise the need for awareness campaigns to challenge and reject this behaviour.

> *Yeah, we have some cases when the soldiers come back and the relatives suffer from GBV cases, from the... From their husbands, brothers and so on. We know cases when a soldier killed the neighbour... Another one killed his wife, and one killed himself and such cases in our in our region, Kharkiv region, there are so many cases.*
>
> Quote from a MHPSS supervisor (MdM)

A key concern is the taboo surrounding seeking mental health support, as many people, according to respondents, believe they don't need help from a psychologist. However, regularly returning to the same locations with the MUs allows the team to build trusting relationships, which leads to more people using their services.

4.4.
HIV (CARE) THROUGH THE LENS OF HEALTHCARE PROVIDERS

4.4.1. HIV prevalence

According to the majority of respondents, HIV incidence is on the rise in Ukraine. There's a belief among some respondents that the actual incidence might be higher due to underreporting, attributed to many individuals not having been tested yet. Multiple respondents note that HIV diagnosis often occurs when the immune system is already compromised, and individuals have symptoms of the infection.

> *I've read the statistics and during the last year there were like 12,000, but I think there are a lot more, like 3 or 4 times more. A lot of people don't get tested. A lot of people are IDPs who don't get access to tests. And regions that are close to hostilities, they receive only very limited medical care and they don't get tested as well.*
>
> Quote from a medical doctor (MdM)

4.4.2. Antiretroviral therapy

According to the respondents, antiretroviral therapy (ART) is available for all individuals living with HIV, provided free of charge by governmental healthcare services at specialized HIV centres. The respondents note that, despite the ongoing war, the accessibility of ART remains unaffected, although their observations are based on general knowledge rather than direct involvement in HIV care.

4.4.3. Transmission routes

Some respondents suggest that the increasing incidence of HIV may be attributed to reduced accessibility of ART within the military. Concerns arise over volunteer soldiers potentially foregoing HIV testing before joining the military at the start of the full scale invasion, leading to undiagnosed HIV infections and subsequent transmission within military and civilian populations. According to the respondents, this situation raises risks not only for fellow soldiers but also for soldiers' families upon their return from the frontline, as well as healthcare workers in frontline areas. Additionally, several respondents express concerns about HIV transmission via insufficiently sterilized instruments used in military hospitals or during dental procedures.

> *The main problem in Ukraine that this people which have HIV, they can be militaries for today. In this war, they can get some injuries. In armies, they don't have this antiretroviral therapy, and then they go to other doctors, you know, surgical, I mean, specialist and that's a big problem for our doctors.*
>
> Quote from an medical supervisor (MdM)

> *I think the risks have increased currently, but I don't think it's due to injection drugs or something of the civil population. Currently, we have a huge frontline and the constant shelling's are happening and that would create a high pressure on surgery units and like these cases of traumatization they would be far more threatening. And they can't say that risky behaviour has really increased. It's more about traumas and surgery, the number and quality. That is [why] closer to the frontline, units wouldn't usually have enough resources for quality of care, for sterilization of materials and so on.*

Quote from a medical doctor (MdM)

4.5. HEALTHCARE DELIVERY TO KEY POPULATIONS THROUGH THE LENS OF HEALTHCARE PROVIDERS

4.5.1. Key populations visiting the MUs

According to all healthcare providers working at MdM, individuals from key populations are not utilizing the services of the MUs. When asked to reflect on their experience working with key populations in their previous work, most medical doctors discussed their interactions with PWIDs. Only one medical doctor spontaneously mentioned MSM, and one informant mentioned sex workers. The LGBT community was not brought up by the medical doctors, except for the mentioned MSM subgroup.

> *There are the people who present their sexual services, men who..., junkies, uh, people who use drugs... Those people exist of course, but not among our patients. [...] When I was working in the institution, I was having over 2000 declarations, so of course, I was working with such people.*

Quote from a medical doctor (MdM)

4.5.2. Identifying key populations Medical doctors

Patients visiting the MUs often present with specific, often chronic health issues. Medical doctors explain that they prioritize addressing the issues that patients present with, also due to the limited time they have for a consultation. The majority of respondents note that as a result, an intake consultation on social behaviour and lifestyle factors is not routinely conducted, potentially leading to a failure to identify individuals from key populations. Two respondents working at a PMSAC also suggest that this may not always be standard practice within the Ukrainian healthcare system, especially in healthcare centres located in small villages as medical doctors often believe they should already know such issues from their patients. Additionally, respondents highlight that the absence of standardized social analysis at the MUs may be attributed to the predominantly elderly patient demographic, which, according to them, decreases the likelihood of them belonging to key populations.

Most respondents experience discussing HIV and identifying individuals belonging to key populations to be challenging. Several respondents express concerns that directly questioning patients about this could potentially strain the patient-provider relationship.

> *Well, it's hard to say [if individuals part of the key populations are visiting the MUs], like we wouldn't ask directly about that, not to offend a person, so you should be really careful.*
>
> Quote from a medical doctor (MdM)

The majority of respondents believe that the lack of specialized communication training for medical doctors is a significant contributing factor in feeling uncomfortable addressing the issue. However, some argue that there are abundant training opportunities available on this topic, but it ultimately depends on the healthcare provider's decision to specialize and their personal comfort level in addressing these sensitive issues. There is a consensus among some respondents that the government should incentivize and encourage healthcare workers to enhance their communication skills in this area.

> *Ah well, it's... Many of the healthcare workers they are not talking about that [HIV and key-populations], but it's needed. It's needed.. the people need to be trained, need to talk about that. But in general, there is a feeling that... There is a certain unwillingness to talk about it, but it should be addressed.*
>
> Quote from a medical doctor (MdM)

Midwife

The interviewed midwife reported to feel comfortable identifying key populations during her consultations, explaining that this a standard procedure during a SRH consult.

> *Of course I would ask people about their risk factors, their sex life, number of partners and so on and if something like that is figured out during the questions, of course I would redirect them. But that's the only case. Or if they tell me that they have unprotected sexual contact and they are not sure about their partner, then I will be able to refer them too.*
>
> Quote from a midwife (MdM)

4.5.3 The influence of legal factors on doctor-patient communication

Some respondents believe that the number of HIV-positive individuals and/or individuals belonging to key populations visiting the MUs is underestimated because staff members do not always ask the necessary questions to identify them. Several respondents mention privacy laws in Ukraine, which affect healthcare workers' ability to ascertain a patient's HIV status or lifestyle factors that may increase the risk of HIV infection. The underlying cause of this underreporting may be the (mis)interpretation of these laws by healthcare workers, leading them to avoid asking the required questions.

> *I think it the number of these people who come to you is higher, but we have no access to that information if the person don't say it by themselves. We have a law in Ukraine that we have no rights to demand this information.*
>
> Quote from an MdM program coordinator

Additionally, several respondents note that when healthcare workers inquire about lifestyle factors and employment status, the topic of sex work would be avoided due to its legal prohibition, making openly discussing this challenging.

4.5.4. The stigmatization of key populations in healthcare

According to most healthcare provider respondents, individuals living with HIV or those belonging to key populations do not encounter stigma in the healthcare sector. Multiple respondents claim that these groups are protected from stigma by laws prohibiting discrimination based on these factors. However, a few respondents suggest that despite these legal protections, individuals in these groups may sometimes be treated differently by healthcare professionals.

> *No, in healthcare system they don't. Because it's supported by law and people, such people, would usually know their rights, so they would be seen as usual persons and no despicability or anything. Or, maybe it is but doctors will not show it.*
>
> Quote from a medical doctor (MdM)

> *Like there are a lot of education and lessons included in schools about HIV and how it spreads, so people know that you can't get infected via conversation, but some people would sometimes avoid contact. It's not like the person with HIV would be isolated fully or anything in the medical institution, but again, people are a little cautious about that.*
>
> Quote from the director of a PMSAC

One respondent suggested that, while key populations are at higher risk of contracting HIV, focusing too heavily on targeting them could reinforce stigma. Instead, they recommended prioritizing the creation of a supportive and open environment during consultations, allowing individuals to access diagnostic services easily without drawing attention to their specific lifestyles.

4.5.5. The unconscious use of stigmatizing language by healthcare workers

During the interviews, the choice of words by some respondents subtly revealed prejudices about key populations. However, these respondents did not perceive themselves as stigmatizing these groups. This suggests a potential unconscious bias in the use of stigmatizing language among the respondents.

> *Like, it's not so about HIV itself, but everyone knows if a person has an **immoral lifestyle**, there is no real stigma, people are accepted like that, but sometimes they would minimize contacts and so one. There is definitely fear.*
>
> Quote from a medical doctor (PMSAC)

> *Only when I would suspect something. Like, usually during asking questions I would figure something out and also **it's visible from the look of the person**.*
>
> Quote from a medical doctor (PMSAC)

> *We are living in small towns so we would know most information about patients: who works where, who does what and, I would of course, know if there are **underprivileged people with low-income or an immoral lifestyle**, and if I have suspicion, I would just redirect them to testing like we have free HIV-tests.*
>
> Quote from a medical doctor (PMSAC)

4.5.6. Stigmatization within society

Over half of the healthcare provider respondents believe that people living with HIV and key populations face stigma and/or social exclusion within society. This stigma surrounding HIV often leads to feelings of shame and taboo, hindering open discussions about the topic. A few respondents suggest that, as a consequence of societal stigma, the subject of HIV may also be avoided within the healthcare sector, both by patients and medical staff. Furthermore, several respondents noted that society tends to perceive individuals who have been part of key populations with an elevated risk of HIV infection as unlikely to change. This perception can contribute to social isolation and unemployment, potentially exacerbating existing challenges.

4.6. COLLABORATION WITH COMMUNITY BASED ORGANIZATIONS SUPPORTING KEY POPULATIONS

The majority of healthcare provider respondents believe that community based organizations (CBOs) for key populations, such as support groups for people living with HIV, exist primarily in larger cities. However, none of the respondents could provide specific information about these organizations, including their names and methods of operation. Additionally, none of the respondents have received requests from patients to be connected with support groups or CBOs.

Most respondents are knowledgeable about existing medical programs offered to PWID. These programs are typically provided in PMSACs or specialized centres within the governmental health system. Narcologists are responsible for providing appropriate psychological and medical support, including distributing clean needles and implementing dexamethasone programs. According to the respondents, these programs have not been disrupted due to the war.

4.7. NEEDS OF HEALTHCARE PROVIDERS

4.7.1. Early HIV detection

The majority of the respondents believe that providing training to healthcare providers to enhance their understanding of HIV care and the needs of key populations would be highly valuable. They suggest that such training could aid in the early recognition of individuals infected with HIV, thus improving health outcomes and public health. Most respondents do not consider it an immediate priority, as they are not currently involved in delivering HIV care or interacting with patients who are part of key populations. Moreover, they face numerous challenges in providing care in war areas, remote settings, and with limited resources.

4.7.2. Communication and counselling training

According to one informant, the avoidance of the topic of HIV by healthcare workers is not due to a lack of training but rather because it is emotionally charged and challenging to address. This underscores the need for healthcare workers to receive additional tools and training on how to sensitively broach the topic. In addition to improving their skills in discussing HIV, most respondents express a desire to learn how to create a supportive environment where patients feel comfortable opening up.

> *...We have to do this in a way that this person does not psychologically close off. That this person understands that this is not a judgement and that they can have a life and with the right treatment they will not be a danger to others.*
>
> Quote from a MDM program manager

MHPSS professionals feel comfortable addressing sensitive issues, as it is part of their daily work. However, they all report the need for additional training in identifying key populations and enhancing communication skills in this area, as it requires a different expertise.

4.7.3. Conditions to start offering HIV rapid tests at MUs

The majority of respondents consider it beneficial to offer HIV diagnostics to patients visiting the MUs, provided that patients always have the option to refuse the test and that their privacy is ensured. However, ensuring patient privacy poses a potential challenge for the MUs, particularly during consultations conducted in open spaces where other healthcare workers or patients may overhear. Furthermore, respondents emphasized the necessity of having a protocol in place to ensure that individuals who test positive on HIV rapid tests can be promptly referred to specialized centres for further diagnostics and treatment.

05 Findings: Insights gathered from policymakers

Most MdM program coordinators/managers support the idea of offering HIV rapid tests through the MUs. While one coordinator sees this as an urgent need, others suggest it should be implemented only after a needs assessment. If implemented, key conditions must be met: staff must be trained in pre- and post-test counselling, patient privacy maintained, and clear referral pathways established for patients who test positive.

A challenge is the current strain on human resources, as doctors working in the MUs are already facing high demands. Additional personnel would be needed to handle this extra task. Two program coordinators believe it may be more effective to focus on capacity building within Ukraine's primary healthcare system, as this responsibility falls to them.

> *Now we unfortunately don't have our resources to provide it [HIV rapid tests] in the field because the number of patients during one MU visit can be up to 40 persons. So, our staff, usually like a little bit overloaded with patients in the location. And, my opinion, we need to strengthen local health system to provide such type of examination, because it's fully their responsibilities.*
>
> Quote from a medical coordinator (MdM)

This view is echoed by the representative of the MoH. Currently, the PATH program, in collaboration with the MoH and supported by USAID, is working to decentralize HIV services and integrate them into primary healthcare. This initiative aims to close service gaps by training general practitioners to handle HIV testing and counselling, aligning with the goal of improving access and reducing stigma.

Some MdM coordinators worry that once MdM phases out its programs, a new gap in healthcare delivery may emerge. They argue that supporting existing NGOs already providing these services, and with established points of entry to key populations, is a more sustainable approach that avoids duplication of effort. The most frequently mentioned organisation is '100% Life,' Ukraine's largest patient-led HIV organisation, active in 25 regions. In contrast, the MoH and a WHO health cluster representative recommend making HIV tests available at as many locations as possible, ensuring individuals can get tested as soon as they are ready, without needing external referrals.

> *If a person with HIV lives near frontline or in very rural area where now we have a problem with public transport, it [HIV diagnostics and care] can be not accessible. So, I mean that these centres [HIV centres in bigger cities] are working, it's everything OK, they have budgets, they have everything that they need, they have humanitarian support, but people don't have a possibility to come to this centre from rural area. Of course it depends on the situation, on territory, on oblast, but we have these physical barrier to access.*
>
> Quote from representative of WHO health cluster

According to the WHO health cluster representative, who specializes in collaboration between Ukraine's health system and NGOs, organizations like '100% Life' could take over when MdM phases out its activities.

> *I think that all interventions that you enjoy, international, national starting they can be phased into this '100% Life', because they are super experienced, they have good building programmes, they know how to do everything. They have mobile units.*
>
> Quote from representative of WHO health cluster

Although the MoH reports no shortage of HIV rapid tests, they are often not (yet) offered in first-line care settings, where patients frequently visit, largely because healthcare providers may feel uncomfortable addressing the topic. The MoH representative also emphasizes the importance of health literacy, urging individuals to take personal responsibility in seeking health resources.

> *There are millions of different places where rapid tests are available. It's like, it's your responsibility. It's about your health, so you should make the right decision. You'll protect yourself and your relatives. I believe that test should be available everywhere.*
>
> Quote from the MoH representative

MdM is currently addressing this issue by offering information sessions provided by health promotors to improve health literacy. MdM program coordinators suggest that their SRH services could reach a broader audience if people understood that SRH services are relevant for all ages and genders.

> *I think that we need to make more effort and find an appropriate way to discuss about the topic [SRH]. That's why I'm considering the option of age-appropriate material for this target group [women of all ages].*
>
> Quote from a medical coordinator (MdM)

06
Findings: Insights gathered from key populations

6.1. HEALTHCARE SEEKING BEHAVIOUR

There were no significant differences in the findings based on the respondents' locations. However, variations, including gender-based differences, were observed between key populations. In terms of receiving medical services, women living with HIV mainly go to state clinics and they are sufficiently informed about guaranteed medical services, while representatives of LGBT community prefer to go to private clinics and/or to doctors, recommended through the community networks. Men who use drugs refer to medical services less than other key populations and have less trust in psychological help. Turning to private hospitals sometimes is necessary but financially very difficult for most of the respondents regardless of the region.

6.2. ACCESS TO CARE

6.2.1. General accessibility

Respondents complained that getting an appointment with a family doctor became much more difficult due to a shortage of doctors. Even though in their interviews MDs at PMSACs said that clinics are not allowed to refuse patients these days, representatives of key populations still reported having a problem with signing declarations, because almost all family doctors have recruited the required number of patients. Some of the patients lost their official documents and cannot access state medical services until they restore them. Challenges are also observed in the requirement to obtain a referral from a family doctor before seeking consultation from a specialized secondary-level physician. All of the respondents mentioned long queues for specialized doctors e.g., gastroenterologist, endocrinologist, and cardiologist.

> *I consulted a gastroenterologist. It was such a problem, it was very difficult to get an appointment with this doctor because he only sees patients a couple of times a month. And it's queues, it's a very long wait. Waiting for your turn, waiting for your date and while you wait for it, you don't know what will happen to you.*
>
> Quote from a female, PWHIV, 25 y.o., Kharkiv

> *And at the moment there is a very acute shortage of specialized doctors. There seem to be enough family doctors, but there are not enough specialized ones. Either they moved to other regions or even abroad. That's why there are fewer of them and it's very difficult to get to them, there are very long queues. It is completely unrealistic to get an appointment with an endocrinologist.*
>
> Quote from a female, LGBT, 43 y.o., Kharkiv

PWIDs and SMT patients program in Vinnytsia reported that the doctors at the state clinics ask to pay them money for consultations. Most male patients confirmed that they do not trust their doctors. They also do not seek psychological help. Overall, the psychological services reported to be available, and in general most respondents are informed about them, but do not believe in their effectiveness.

Regarding the system of medical referrals, registration through "Helsi", the most popular medical information system for healthcare institutions and medical portal for patients in Ukraine, seems to work satisfactorily for most of respondents. While during their interviews MDs said that E-consultation goes smoothly most of the times, the patients among key population reported different experiences. Many of the respondents in Kharkiv noted that it takes a long time to get an electronic referral and make an appointment with a doctor, and this process is complicated by constant air alarms and lack of electricity. In Zaporizhzhia LGBT community respondents noted that you cannot get an appointment with some of the doctors online at all.

> *Because there is no online registration, it is impossible to get an appointment. You have to come to the registry office there at 5 in the morning to wait in the queue, stand there until 7 in the morning before the queue opens. And then you go to the registry window and find out that there were only 5 coupons, they already had been issued. And they cannot issue anything for tomorrow, so you need to come and repeat that again tomorrow.*
>
> Quote from a male, LGBT/MSM, 42 y.o., Zaporizhzhia

Also, respondents reported that some guaranteed services are not enough to cover their needs (e.g., MRI once a year). Some people also mentioned that hospitals are now, due to the help of humanitarian projects, better equipped with the necessary medicines.

In the second round of FGDs, some respondents noted that over the past 3 months, they had a positive experience of receiving medical consultations in state medical institutions. Some family doctors provided consultations, including remotely. However, there is still a problem with obtaining urgent medical tests - in public clinics there is a long waiting time, in private institutions - it is expensive. The lack of highly specialized doctors causes additional waiting time. One member of the FGD described a case where, due to a long waiting time for an appointment, he stopped the examinations and treatment. Finally, lack of documents becomes an obstacle when receiving services.

> *And because of this I didn't even want to, they sent me to a neurologist, I thought - with these people I might not live to see doctors. That's why I didn't continue seeing doctors. First of all, it's just asking for time off from work, wasting time. I already ask for time off from work – I sit with the children, so. So I stopped trying.*
>
> Quote from a male, PWID, 36 y.o., Zaporizhzhia

6.2.2. Affordability

Many medical services are very expensive and sometimes financially unaffordable for most of the respondents, especially medical examinations and dental services.

> *I believe that one of the big problems in the medicine of our country is diagnostics. We are very bad with diagnostics, availability and reliability. A lot of results depend on the diagnosis. Unfortunately, diagnosis in our country is expensive. She is worth a lot of money. That is, we cannot come to the clinic and get examined for free. We can get a free doctor's consultation, but almost all diagnostics cost very serious money.*
>
> Quote from a male, MSM, 40 y.o., Kharkiv

> *Here in Vinnytsia, everything can be checked normally. But again, you need money everywhere. The same [medical] test can cost 1500, 2000 UAH [€34,00, €45,00]. That is, for the same [medical test to check my] liver for which I was prescribed to take pills in the 'medical town' [clinic], the tests to get that pills prescription cost me up to 3000 UAH [€67,00]. And that's not all. There will still be more to do. That is, it seems to be everywhere, but money is needed everywhere. And not small ones.*
>
> Quote from a male, PWID, Vinnytsia

6.2.3. Availability

There were problems with the availability of certain medicines, patients had to look for them in warehouses and abroad. There is also no possibility to urgently buy medicine in the evening due to curfew.

> *During rehab, I was prescribed some medications that I couldn't find. Only those that remained in warehouses, because it was a Russian importer.*
>
> Quote from a male, MSM, 34 y.o., Kharkiv

6.2.4. Geographical access and accommodation

There is not enough medical staff in regional hospitals. In particular, the respondents reported on the problem of lack of equipment and specialists in the Vinnytsia region. Also, in Vinnytsia (city), services for patients are geographically distant. The financial barrier was the transport, not the services themselves.

> *It happened that it was not possible to take a blood test, because there were no money to go to [the clinic laboratory].*
>
> Quote from a female, PLHIV, 17 y.o., Vinnytsia

In Kharkiv, respondents noted limited doctor's office hours. Many respondents from all the regions reported that pharmacies have limited opening hours due to the curfew, then the only alternative is the emergency room (ER). But in such a case it can be difficult to prove that there is a need for an ER call. Also respondents experienced difficulties getting to medical facilities due to sirens and shelling.

> *We were also going to the hospital, explosions started, and the bus did not run at all, and the minibus was stopped.*
>
> Quote from a male, PWID, 49 y.o., Zaporizhzhia

6.2.5. Acceptability and safety

According to the key-populations, doctors do not always know how to work with people living with HIV. Some female respondents in Kharkiv region expressed distrust in the qualifications of most doctors when it comes to HIV. In the second round of FGDs, one female respondent shared a story of criminal malpractice based on discrimination:

> *I had a story with my husband, he is not with us, let him rest in peace. We came to treat his knee, and since the staff didn't understand what he needed to do, they put a subclavian catheter in him, punctured his lung and didn't tell anyone. And the man died within 15 minutes. And then they told me that he is a drug addict! He used methadone! What did you expect? All his organs are already dead.*
>
> Quote from a female, Woman living with HIV, Kharkiv

However, the situation also differs in the regions. For example, interviewed PWID reported that they can talk to their family doctor about drug use or HIV infection without fear.

6.3. STIGMA TOWARDS PATIENTS

Some respondents reported situations where doctors began to treat women living with HIV negatively after they disclosed their HIV status. However, the respondents were also convinced that the confidentiality of their medical data was respected.

Some LGBT respondents reported experiencing stigmatization in the healthcare system. Patients often keep silent about belonging to the LGBT community due to distrust of doctors, especially gynaecologists and urologists. SMT patients in Kharkiv also noted that they experienced stigmatizing treatment from doctors.

> *The level of stigmatization in Ukraine, it remained at a very high level. I'm talking about average doctors.*
>
> Quote from a male, PWID, 44 y.o., Zaporizhzhia

> *If they find out that there is HIV, hepatitis, STD - that's all, you're a second-class person in our country.*
>
> Quote from a male, PWID/SMT patient, 39 y.o., Kharkiv

In Vinnytsia's public medical institutions, PWIDs reported that obtaining blood for analysis was often hindered by difficulties in locating their arm veins, attributed to insufficient equipment and experience. There have been cases of denial of services and fear of contact when disclosing information about being a patient of the SMT program. Also, respondents mentioned that they avoid informing doctors that they are on the SMT program because of stigmatization cases and fear of their recurrence. They described a case when health complaints were not taken into account and were written off as a side effect of the SMT drugs.

> *I am a former drug addict. …And I often come to a regular clinic, I don't always have enough money to go to a private clinic, because prices there are rising every day. But due to the fact that the attitude is not very good, a couple of times it happened, even if the doctor does not say something, he is somehow dismissive. And I simply have no desire to just visit in order not to traumatize my psyche, not to remember anything and not to feel somehow disadvantaged in something. That's why I now prefer to use private doctors.*
>
> Quote from a female, PWID, 38 y.o., Kharkiv

Additionally, adolescents noted in their interviews having anxiety or rejection of STD treatment services due to the need to come to a consultation with their parents.

6.4. HUMANITARIAN AID DISTRIBUTION

Respondents mentioned receiving various medications or reimbursement of their costs, as well as medical supplies, from international humanitarian organizations such as UNICEF, Red Cross, and Caritas. Some state hospitals refer to humanitarian aid, but it is not specified which ones. Some female respondents mentioned that they have a need for nutritional supplements (e.g., vitamins and chondroprotectants) that they could not afford. Most respondents turned to charitable organizations for psychological help and free medicine in the beginning of full-scaled invasion.

> *I turned to a psychologist at the Alliance Global organization for consultation. He helped a lot during our one conversation.*
>
> Quote from a male, LGBT/MSM, 47 y.o., Kharkiv

> *It was at the beginning of the war, I went to Poltava and it seems that it was a request for help to Gender Zed, I needed painkillers. And they sent them by mail too.*
>
> Quote from a female, LGBT, 32 y.o., Kharkiv

During the first round FGDs and interviews with key populations, only one respondent out of 142 participants reported awareness of or having received services from the MdM mobile unit. This respondent, a 18-year-old female belonging to the women living with HIV key population in Vinnytsia region, had received medical services and medication from MdM doctors.

> *I enjoyed the services I received. The doctors treated me well. They supported and helped.*
>
> Quote from a female, Women living with HIV, 18 y.o., Vinnytsia

In the second round of FGDs, conducted with 52 participants, 8 respondents (4 from Zaporizhzhia and 4 from Kharkiv) were aware of MdM services, though none had accessed them.

> *These mobile brigades travel around the communities, yes, it exists. They have a gynaecologist and an endocrinologist. And they give out medicine, yes.*
>
> Quote from a female, PWID, 43 y.o., Zaporizhzhia

The respondents in the Zaporizhzhia region recommended adding the city of Vilniansk and the villages of Zelene, Veselyanka, and Shevchenkove to the mobile brigade's route, as there are "absolutely no medical services" available in these areas.

Overall, most respondents from key populations were unaware of MdM services, with only one individual out of 194 respondents across both survey rounds having ever received services from MdM. This might indicate a slight increase in awareness of MdM services in the project regions. However, there remains insufficient awareness regarding humanitarian aid services, indicating the need for improved promotion of such initiatives.

6.5. IMPACT OF FULL-SCALE INVASION ON HEALTH

Many representatives of key populations noted that since the beginning of the full-scale invasion and constant bombardment, their nervous system is constantly under tension and this has its consequences, such as panic attacks.

> *Because during the war, I realized that I, although I did not suffer from this before, I began to experience panic attacks.*
>
> Quote from a female, LGBT, 41 y.o., Kharkiv

Most of the representatives of key populations interviewed noted worsening of the cardiovascular and nervous system, constant stress, exacerbation of chronic diseases. On the bright side, since the start of full-scale war, according to the majority of the respondents the option of remote and online medical and psychological consultations were launched and improved.

6.6. ACCESS TO INFORMATION ABOUT HEALTH

Among the key sources of trustful information were chosen: the internet, social networks, and acquaintances/friends. Several respondents mentioned a family doctor. Most often, respondents from the LGBT community choose a doctor based on recommendations from friends and reviews on the Internet. During a FGD with female sex workers in Zaporizhzhia, a wish was expressed for the family doctor to have a list of organizations that can be contacted for humanitarian aid.

> *Every family doctor has a computer to work on. They should have this information on medical care. And when people turn to them for help, the family doctor can say, for example: "We have such and such humanitarian medical aid.*

Quote from a female, sex worker, 37 y.o., Zaporizhzhia

6.7. FUTURE PROJECTIONS AND NEEDS

Concerns were expressed about the confidentiality of information and the professionalism of doctors. There is a need for constant training for doctors on various topics with focus on combating stigma and discrimination.

> *When I got to the hospital with a broken leg, when they saw my body; and it was not so good. And they discussed it. Even in front of me, they began to discuss all this.*

Quote from a female, WLHIV, 41, Zaporizhzhia

> *But they already, as it were, you still sat there, and already the whole hospital, they already told the whole hospital that you have this, that, that. And you sit like Cheburashka from the cartoon. Everyone had already passed by and looked at me to see who I was and what, because I came. For what? Where is your medical confidentiality?*

Quote from a female, Sex Workers, 39, Kharkiv

The need for psychological help is expected to grow. Many representatives of key populations have experience of using psychological support services from NGOs that work in harm reduction; they don't trust the qualifications of psychologists in state clinics.

Most respondents admitted that the general population of Ukraine will soon need more information about HIV and primary prevention.

07
Discussion

7.1. INSIGHTS GATHERED AMONG HEALTHCARE PROFESSIONALS

The interviews with healthcare workers were conducted in English by a non-native English speaker, with a Ukrainian translator. This setup may have inadvertently introduced translation bias, potentially influencing the reporting of stigmatization of key populations, either under- or overreporting such biases. This factor should be taken into consideration when analysing the interview data.

7.2. INSIGHTS GATHERED AMONG KEY-POPULATIONS

In each project Oblast, varying numbers of interviews and FGDs were conducted with different proportions of key populations. Four focus groups were held in Zaporizhzhia, one for each key-population. In Vinnytsia, there was one interview and seven FGDs, excluding sex workers due to the absence of CBOs or relevant organizations offering support for sex workers. In Kharkiv, one interview and six FGDs were held with all key-populations. The underrepresentation of key populations, particularly sex workers in Vinnytsia and vulnerable adolescents with limited access to medical services, indicates a sampling bias that may affect the research results.

None of the respondents from key populations live in Hromadas where the MUs operate, and most have never heard of MdM services. Consequently, we lack specific data on experiences with MdM health services. This selection bias arises from conducting interviews only in main cities and not in oblasts, and not asking respondents specifically where they live. This oversight could skew the results.

Data collection took more time than expected as it was impossible to conduct FGDs with key populations online. Offline meetings were disrupted by constant alerts, sirens, and shelling in Kharkiv. This operational bias could affect the results by limiting the amount and quality of data collected.

08
Conclusion

This study aimed to understand the experiences and needs of key populations and healthcare workers, with the goal of improving SRH services, including HIV care. It was found that most medical doctors acknowledge the need for training in counselling and communication techniques regarding HIV and identifying key populations. Some express discomfort addressing these topics, influenced by feelings of shame and societal taboos. MHPSS professionals and midwives are generally more at ease addressing these sensitive issues. Approximately half of the respondents recognize that PLHIV and key populations face social exclusion and stigma within healthcare settings. The choice of words by some respondents subtly revealed prejudices about key populations. However, these respondents did not perceive themselves as stigmatising these groups. This suggests a potential unconscious bias in the use of stigmatising language among the respondents.

Providing HIV rapid tests through the MUs is seen by most healthcare providers and policymakers as a way to reduce testing barriers. Key to this integration is ensuring that staff are trained in pre- and post-test counselling, with clear referral routes to HIV centres. However, concerns regarding patient privacy and increased workloads persist. Some program coordinators therefore recommend supporting existing primary healthcare facilities or NGOs that already provide these services. Policymakers and representatives from the MoH emphasise that, in addition to expanding HIV diagnostic access, it is crucial to enhance health literacy. This includes promoting personal health responsibility through informational sessions and overviews of available services.

It was found that financial and geographic barriers limit access to health services for key populations, especially for urgent or specialised care. Gender differences influence healthcare access: women with HIV tend to use state clinics, some of them resort to private hospitals due to difficulty accessing guaranteed services, albeit at a financial cost. LGBT individuals prefer private clinics or community-recommended doctors. Men who use drugs access services less frequently and distrust psychological assistance. There is a discrepancy between patients' and healthcare workers' experiences with e-consulting: patients find it suboptimal, while healthcare workers believe it is well functioning. Healthcare providers often lack sufficient information and counselling skills to effectively support adolescents, particularly when they seek medical assistance without parental supervision. All key populations expressed a desire for additional support from MdM doctors or other humanitarian organisations. In conclusion, the greater trust placed in NGOs and community representatives over doctors working in state clinics, highlights the importance of involving these organisations in promoting services. MdM services are barely known among key population respondents, highlighting the need for more active promotion of all services offered by MdM. The lack of comprehensive knowledge among doctors regarding community health specifics, such as testing and ART/SMT side effects, emphasizes the need for ongoing education and collaboration between healthcare providers and community leaders.

09 Recommendations

Key populations play a vital role in shaping the landscape of medical service provision. Their experiences and perspectives offer valuable insights into areas for improvement within healthcare systems. In light of their unique needs and challenges during difficult war times, recommendations provided by these key populations serve as invaluable guidance for enhancing the quality, accessibility, and inclusivity of medical services. Based on the gathered insights the following recommendations are made.

RECOMMENDATIONS FOR THE GENERAL HEALTH SYSTEM:

1. **Improve access to secondary level and/or specialized care:** The current appointment system for specialized care is inefficient, leading to long queues and delayed access to essential medical services.
2. **Combat stigma towards key populations:** Addressing stigma within healthcare settings is crucial, particularly regarding people living with HIV and individuals from the LGBT community. Ongoing education initiatives are essential to equip doctors with the knowledge and attitudes necessary for more tolerant and inclusive patient care.
3. **Improve accessibility of MHPSS and healthcare services for key populations:** There is a significant need for psychological assistance among key populations, including people living with HIV and members of the LGBT community. Ensuring free access to medications and improving the availability of free dental services, especially for people who inject drugs, are critical. Additionally, improving access to ART and SMT by making them available through family doctors at patients' places of residence would be beneficial.
4. **Enhance support for adolescents:** Healthcare providers often lack sufficient information and counselling skills to effectively support adolescents, particularly when they seek medical assistance without parental supervision. Additional education programs focusing on adolescent healthcare needs should be considered.

RECOMMENDATIONS FOR MDM (AND OTHER HUMANITARIAN AID SERVICES) TO ENHANCE SRH SERVICES:

1. **Increase awareness of MdM**: There is a notable lack of awareness among individuals within key populations regarding available humanitarian aid services, including those provided by MdM. It is essential to explore more effective methods for disseminating information about these services to ensure they reach those in need.
2. **Improve information provision on available SRH services:** Currently, the SRH services provided by the MUs are under-promoted. It is strongly recommended to increase awareness of SRH services by developing age-appropriate promotional materials for men and women of all ages and information provision through health promoters to boost demand.

3. **Improve access to HIV diagnostics:** To improve access to HIV diagnostics, it is recommended to offer HIV rapid tests through the MUs, provided that all staff are trained in pre- and post-counselling skills and that referral routes to HIV centres are clear in case of a positive test result. Alternatively, capacity of primary healthcare services and/or NGOs already offering these services could be supported.
4. **Improve collaboration between NGOs and CBOs:** By mapping available services and providing an overview for healthcare workers and key populations.

10 References

1. Marta Vasylyev, Agata Skrzat-Klapaczyńska, Jose I Bernardino, Oana Săndulescu, Christine Gilles, Agnès Libois, et al., Unified European support framework to sustain the HIV cascade of care for people living with HIV including in displaced populations of war-struck Ukraine, Lancet, 2022 May 13; 6 (e): 438–48. Available from: https://doi.org/10.1016/S2352-3018(22)00125-4.

2. Yulia Kvasnevska, Mariia Faustova, Kseniia Voronova, Yaroslav Basarab and Yaroslava Lopatina., Impact of war-associated factors on spread of sexually transmitted infections: a systemic review, Front. Public Health, 2024 April 5; 12 2296-2565. Available from: https://doi.org/10.3389/fpubh.2024.1366600.

3. Cairns, G. (2023). *HIV services in Ukraine resilient but starting to feel the strain*. Available at https://www.aidsmap.com/news/oct-2023/hiv-services-ukraine-resilient-starting-feel-strain (Accessed: 25 September 2024).

11 Appendixes

11.1.
CODE TREE INTERVIEWS WITH HEALTHCARE PROVIDERS

Code
Patient profile (people coming to my clinic are mainly)
Asking questions to identify risk profile of contracting HIV (lifestyle factors)
○ Interview does not asks questions to identify this
○ Interviewee does this during every consultation
General patient population
○ Variety in patients
○ Mostly elderly
○ Mostly IDPs
○ Mostly people living with a disability
Most frequent health queries
○ Children's diseases
○ Chronic diseases
○ Heart diseases
○ Internal diseases
○ Mental health
○ Variety
People living with HIV
○ They are not coming to our clinic
Access to care for key populations
Delivering care to key populations
○ No
○ Yes
Knowledge among healthcare workers about key populations with an elevated risk of HIV infection
Knowledge on existence of key communities
○ Interviewee describes all key populations
○ Interviewee describes a few
○ Interviewee is not able to describe
Knowledge on community based organizations supporting key - populations
○ Interviewee does not know such organisations

Code
People being part of a key population with an elevated risk of getting an HIV infection (brought up by interviewee)
Ex-prisoners
LGBTQI+
Medical staff
Military
They are not coming to our clinic
Where are key populations living according to interviewees
Key populations have moved to bigger cities
Key populations live in the whole country of Ukraine
No idea
Type of special services healthcare workers still refer to
For people who inject drugs (clean needles)
For sex workers (routine STI testing, PrEP, HIV rapid testing)
Other
People from the LGBTQI+ community (condoms, PrEP)
Quality of care to key populations
Quality of care could be improved (e.g., by training in counselling skills)
Needs and desires of healthcare workers
Healthcare worker thinks it necessary to receive training regarding this topic
No
Yes
Suggestions for topics in SRHR sensibilization training
SRHR healthcare
Barriers to deliver HIV care at MDM
Privacy of patients
Referral routes are not clear (algorithms)
Time
Condom distribution
At the health facility
Elsewhere
Not at the health facility, healthcare worker doesn't know where to refer to
Contraceptives
Elsewhere
At the health facility

- Code
- **Counselling skills in discussing HIV, and identifying key communities**
  - Doesn’t need to ask, I already know this about my patients
  - Interview has not received special training
  - Interviewee does not feel comfortable discussing HIV, ask questions to identify key communities
  - interviewee feels comfortable discussing HIV, ask questions to identify key communities
  - interviewee has received special training
- **Thoughts about other healthcare workers**
  - Can’t say anything about others
  - Most colleagues feel comfortable discussing this
  - Most of colleagues avoid this topic
- **Do you receive SRH queries**
  - No
  - Not often
  - Yes
- **Guidelines**
  - Health facility doesn’t work with standardized guidelines for people living with HIV and people being part of a key community
  - Health facility works with standardized guidelines for people living with HIV and people being part of a key community
- **HIV diagnostics**
  - At the health facility
  - Elsewhere (referral)
- **STI testing**
  - At the health facility
  - Elsewhere (referral)
- **Access to care in general**
- **Challenges in accessing (and delivering) care in the area (in general)**
  - Disrupted healthcare system
  - Financial barriers
  - High workload for healthcare workers and long waiting times for patients
  - Lack of information on patients medical history (due to being a IDP)
  - Lack of medicine
  - People need to travel long distances

Code
No of patients a day
Between 12 and 20
Between 20 to 25
Support systems
Budget for travel costs provided by MDM in case referral necessary
Team
Doctor, nurse, psychologist
MD, psychologist, midwife, nurse (full)
E-health and referrals via own physician
Doesn't work well according to healthcare worker
Works well according to HC worker
Where does the mobile clinic go
Shelters
Villages
Why do you think you do not see patients of the key population
They are not coming to our clinic because they do not now us
They do not live in my working area
We 'miss' these patients by not asking questions to identify this
HIV incidence
Increasing
Stable
Do key populations face stigma
Hidden stigma (HC worker says no, but we read yes)
No
Yes, by healthcare workers
Yes, by society in general
Offering HIV tests
All patients should be offered an HIV-test

10.2
CODE TREE INTERVIEWS POLICYMAKERS

- **Code**
- **Feedback on SRHR training MdM**
  - Negative feedback
  - Positive feedback
- **Feedback on how to improve SRHR services provided by MdM**
  - Age-appropriate content
  - Health literacy
  - Staff training
- **Should MdM and other NGOs support HIV diagnostics**
  - No
  - Under the condition of…
  - Yes
- **Stigmatization in health system**
  - Confirming statements
  - Rejecting statements
- **Biggest challenges**
- **Barriers in access to care**
  - Geographical barriers
  - Health literacy, responsibility
  - Shortage of MDs, long waiting times
- **HIV rapid test in both NGOs, partner NGOs en health system**
  - No
  - Yes
- **HIV care services in Ukraine**
  - Needs
  - Qualities, positive statements

10.3
CODING OF TOPICS FOR ANALYSIS OF INDIVIDUAL INTERVIEWS AND FOCUS GROUPS DISCUSSION OF KEY POPULATIONS BY *AFEW-UKRAINE*

Code: 1-I/ Code: 1-FG	**Healthcare seeking behaviour**	Звернення за медичною допомогою
Code: 2-I/ Code: 2-FG	**Access to care:**	Доступ до послуг**:**
	2-1-I: General accessibility	**2-1-I:** Загальна доступність послуг
	2-2-I: Affordability	**2-1-I:** Фінансова доступність послуг
	2-3-I: Availability	**2-3-I:** Наявність послуг
	2-4-I: Geographical access and accommodation	**2-4-I:** Географічна та часова доступність
	2-5-I: Acceptability and safety	**2-5-I:** Прийняття та безпека
Code: 3-I/ Code: 3-FG	**Humanitarian Aid Distribution**	Надання гуманітарної допомоги
Code: 4-I/ Code: 4-FG	**Impact of Full-Scale Invasion on Health**	Вплив повномасштабного вторгнення на здоров'я
Code: 5-I/ Code: 5-FG	**Access to information about health**	Доступ до інформації про здоров'я
Code: 6-I/ Code: 6-FG	**Future Projections and Needs**	Прогнози щодо потреб на майбутнє
N-I/ N- FG	**Observations and notes**	Спостереження та нотатки
R-I/ R- FG	**Conclusions and Recommendations**	Висновки та рекомендації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