INNOVATING UNDER FIRE

Ukraine's Community-Led Health Models for Crisis Settings

Kyiv 2026

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CONTENTS

INTRODUCTION

Supporting communities in documenting experiences and solutions during the war

This collection documents practical public health innovations developed in Ukraine during one of the largest humanitarian crises in Europe. Developed in response to the ongoing war, these community-led models address challenges shared by health systems worldwide: workforce shortages, disrupted services, stigma, mental health needs, continuity of care and digital transformation. Together, they demonstrate how locally developed solutions can inform global health policy and practice.

The Alliance for Public Health (APH) is one of Ukraine's leading public health organisations, with more than 25 years of experience developing community-led responses to HIV, tuberculosis, viral hepatitis and other public health challenges. Over this period, APH has reached and protected more than 5 million people through its programmes and provided technical assistance and consultancy to partners in more than 60 countries. Working in partnership with government institutions and civil society organizations, APH designs and implements innovative public health programmes while contributing to health policy development and strengthening community-led responses.

Following the full-scale invasion in 2022, APH rapidly adapted its programmes to ensure continuity of essential health services while supporting communities affected by the war. In recognition of its contribution to Ukraine's humanitarian response, APH was included in Forbes Ukraine's Top 50 Charities in Ukraine, ranking #7 among the country's largest charitable organizations and #4 among humanitarian assistance providers.

Russia's invasion of Ukraine began in 2014, with the illegal annexation of Crimea and occupation of areas of Donetsk and Luhansk regions in eastern Ukraine. These territories are also some of the most affected by HIV, Tuberculosis, and viral hepatitis. Russia immediately closed down Opioid Agonist Therapy (OAT) programmes in Crimea, and later in occupied areas of eastern Ukraine[1]. APH and its partners sought to continue support for clients of prevention and care services in or from occupied areas.

Since 24 February 2022 the needs and challenges have become acute. Russia's full-scale invasion has killed thousands and displaced millions of people, disrupted supply routes and overwhelmed or destroyed social and medical services and infrastructure across the country. As of July 2026, over 3 million Ukrainians are internally displaced people (IDPs), while 5.9 million have entered other countries[2]. Since 24 February 2022, over 3,000 attacks on Ukraine's health care system have been documented, making Ukraine one of the most dangerous contexts in the world for healthcare workers and for patients seeking medical care[3]. In occupied territories, staff of medical institutions and community organisations have been targeted for repression including forced deportation, torture and murder. Russia withholds life-saving medical treatment from Ukrainians on territory it has occupied unless they take Russian passports.[4]

Displacement, economic and psychological stress, disrupted health services and poor living conditions caused by the war are likely leading to higher incidence of HIV, TB and hepatitis C, and increased risk behaviour such as drug use and sex work.

Prevention, treatment and care programmes have adapted to emergency mode. They have refocused and developed innovations to reach vulnerable and key populations in new locations or circumstances, while trying to protect staff and patient safety. This report is based on site visits to five cities in Ukraine, plus Warsaw in Poland, to observe service delivery in wartime conditions or for refugees. In-depth interviews with medical and NGO staff, social workers, volunteers and members of key populations describe how Ukrainians have risen to the challenges of war, and inform the conclusions and recommendations.

Two case studies examine service delivery and modification in areas of high intensity conflict and low intensity conflict. Although active fighting and occupation is currently in the south and east of the country, the whole of Ukraine is affected, as are other countries which have taken in refugees. Apart from the obvious scale-up required to sustain services, new partnerships and programmes are required which are often broader than the traditional understanding of who constitutes members of vulnerable populations, and what aid must be provided, blurring the traditional line between 'health' and 'humanitarian'.

Flexibility, rapid response, and the ability to think outside the usual divisions of type of assistance or beneficiary, are among the key lessons that can be taken from the Ukraine experience. Three case studies examine new types of response now implemented by Ukrainian civil society and dictated by war circumstances: shelters for displaced people in Ukraine, assistance for key populations and people living with HIV now displaced abroad, and mobile clinics or treatment points offering generalised medical services in frontline and recently de-occupied areas.

Four more case studies were added in 2026 to reflect new developments and learning, in particular widening the scope of projects to include war veterans, younger people and mental health, and innovative new digital models.

It is hoped that these case studies may provide helpful tools and practices for working in war or emergency conditions for a broad range of civil society and medical workers.

1 https://www.bmj.com/content/350/bmj.h390

2 https://data2.unhcr.org/en/situations/ukraine
3 https://reliefweb.int/report/ukraine/nearly-one-every-10-hospitals-ukraine-have-been-damaged-attacks-russias-invasion
4 https://www.themoscowtimes.com/2023/10/09/un-raises-alarm-over-russias-mass-issuance-of-passports-in-occupied-ukraine-a82702

ACKNOWLEDGEMENTS

Case studies 1–5 are based on site visits in Lviv, Warsaw, Kharkiv city and region, Kryvyi Rih, Nikopol, and Kherson city and region conducted in March and April 2023. These field visits and the preparation of the original publication were financed with the support of Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

In 2026, with funding from Sida through Frontline AIDS, the first five case studies were comprehensively revised and rewritten to reflect the latest evidence, programme developments and lessons learned. This included documenting the significant evolution and expansion of the services and approaches described since the original publication.

The same support also enabled the development of four entirely new case studies (6–9). This work included a field visit to the Lisova Polyana (Forest Glade) Ministry of Health Centre for Psychological Health and Rehabilitation in Kyiv, as well as consultations with implementing partners, healthcare professionals and programme teams.Implementing partners of ICF "Alliance for Public Health" in Lviv, Warsaw, Kyiv, Kharkiv city and oblast, Krivyi Rih, Nikopol, and Kherson city and oblast.

Safe Place shelter; Lviv City AIDS Centre; Lviv City OAT site; Charitable Organization "100% Life all-Ukrainian network of PLHA in Lviv"; MCF teams in Lviv and Krivyi Rih; HelpNow Hubs (Poland, Germany and Baltics); Fundacja Edukacji Społecznej; Charitable Organization "Kharkiv Charitable foundation Parus"; Charitable Fund "Blago"; Kharkiv City AIDS Centre OAT site; Alternative clinic; Kharkiv oblast TB hospital; Church-based shelter; MTP teams in Kharkiv and Kherson oblasts; Charitable Organization "Public Health Foundation of Kryvyi Rih"; Kryvyi Rih City OAT site; NGO "Resources of Life"; Charitable foundation "Source of Health"; Nikopol City TB clinic; NGO "New Life"; Charitable foundation "Mangust"; Lisova Polyana (Forest Glade) Ministry of Health Centre for Psychological Health and Rehabilitation, Kyiv.

Text: Lily Hyde. Photographs and illustrations: Iva Sidash (2023) and the Alliance for Public Health photobank (2026 updates).

LIST OF ABBREVIATIONS

AIDS	Acquired ImmunoDeficiency Syndrome
AIDS	Acquired ImmunoDeficiency Syndrome
ADHD	Attention-Deficit/Hyperactivity Disorder
APH	Alliance for Public Health
ART	Antiretroviral Therapy
CAB-LA	Long-Acting Cabotegravir
CBT	Cognitive Behavioural Therapy
CITI	Community Initiated Treatment and Retention Intervention
ECG	Electrocardiogram
EU	European Union
GF	The Global Fund to fight AIDS, TB and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IRF	International Renaissance Foundation
KAT	Ketamine-Assisted Therapy
KP	Key Population
LADB	Long-acting Depot Buprenorphine
LEN	Lenacapavir
MCF	Mobile Case Finding
MSM	Men who have Sex with Men
MTP	Mobile Treatment Points
NGO	Non-Governmental Organisation
OAT	Opioid Agonist Treatment
OCF	Optimised Case Finding
PLHIV	People Living with HIV
PHC	Public Health Centre
PrEP	Pre-Exposure Prophylaxis
PSS	Psycho-Social Support
PTSD	Post-Traumatic Stress Disorder
PWID	People Who Inject Drugs
TB	Tuberculosis
UNHCR	**UN Refugee Agency**
UNODC	United Nations Office on Drugs and Crime

1. PREVENTION, TESTING AND TREATMENT SERVICE MODIFICATION IN HIGH CONFLICT INTENSITY SITES

1. SITUATION

This case study summarises best practices in modifying prevention, testing, treatment and care services in areas of high conflict intensity. They show that adapted services can continue despite active hostilities, interrupted supply routes, and disrupted social and medical services and infrastructure.

War-related displacement, economic and psychological stress, and poor living conditions in Ukraine are likely leading to higher incidence of HIV, TB and hepatitis, and increased risk behaviour such as drug use and sex work.

In areas of high conflict intensity, these problems are especially acute. Prevention, treatment and care programmes have adapted services to overcome challenges and meet new needs..

High conflict intensity sites include:

Primary:

- Areas liberated from occupation which are now near the frontline and experience regular missile and drone attacks; these areas are quite depopulated as people flee to safer areas. Kherson; north and east Kharkiv region.
- Areas near the frontline and under Ukrainian control since the beginning of the war, experiencing waves of attacks and of internal migration. South and east Zaporizhzhia and Dnipropetrovsk region.

Secondary:

- Cities under high risk of missile attack but still major transit hubs and destinations for internally displaced people (IDPs). Kryvyi Rih, Kharkiv, Dnipro, etc.

Key issues affecting provision of prevention, testing and treatment services in high conflict intensity sites:

- Mass population migration and displacement
- Interrupted transport and communications
- Closure of medical and other state institutions; pharmacies
- Destruction and damage to buildings, vehicles, lives
- Martial law
- Presence of military; checkpoints; curfews
- Increased sex work
- Increased drug use
- Psychological trauma
- Less attention to health (too many other issues to deal with)

2. SERVICE MODIFICATION AND INNOVATION: BEST PRACTICES

Healthcare institutions and AIDS-service NGOs have modified services to respond to these challenges. Wartime adaptations and innovations include:

State level:

- Issuing state directives allowing take-home supplies of medications for opioid agonist treatment (OAT), HIV and TB for longer periods. This eased risk of interruption caused by lack of public transport, dangers of travelling, mass displacement, closure of medical facilities.
- Transferring patients to private healthcare facilities for services when public ones are closed.
- Adapting medication delivery methods.

Civil society level:

- Using outreach services/mobile clinics to deliver humanitarian aid or evacuate civilians. Armoured vehicles originally intended for mobile OAT were especially useful.
- Providing bicycles for social workers when public transport does not work and petrol is in short supply. Bicycles can also attract less attention at checkpoints.
- Delivering medications directly to patients when medical facilities are closed or patients are unable to travel.

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- Sending commodities by post (HelpBoxes). This ensures that members of key populations (KPs) who have been forced to move, especially to rural areas far from services and where confidentiality is an issue, still receive prevention means.
- Altering outreach routes to make stops near bomb shelters or in places more protected from aerial attack.
- Shorter working hours due to curfews; risk of shelling.
- Supplying NGO and healthcare facilities and staff with generators in case of power outages; ensuring there is a bomb shelter in or near facilities and offices; providing protective gear; training in emergency first aid, mine and drone safety awareness, etc.
- Coordinating with volunteer groups to provide medications and food for patients when peacetime infrastructure and systems collapse.
- Extending legal support with documents, registration, etc. for a wider group of people/needs – IDPs may have lost all documents and need help to register to get IDP benefits.
- Providing humanitarian aid to KPs and to a wider population group: food and hygiene packages, warm bedding, torches and powerbanks; help to repair windows broken by shelling. Some AIDS-service NGOs applied for additional mini-grants for this purpose, or cooperated with other NGOs, local authorities and volunteer groups.
- Quickly developing referral systems/contacts for evacuating KPs to find help and services elsewhere.
- Developing closed social media chat groups sharing information about services to reach KPs who no longer gather e.g. in gay clubs or streets (sex workers) due to safety issues; curfews.
- Extending screening services to places where IDPs gather; to the armed forces.
- Introducing mobile primary health services (consultation with a GP; free medications) for the general population (see case study 5).
- Setting up temporary shelters for IDPs: KPs and/or the general population (see case study 3).

2.1 Case study: OAT access

OAT provision can be particularly problematic in wartime. The medications (narcotic drugs) need special licenses and armed transit. Patients depend on regular intake to avoid excruciating withdrawal syndrome which may make them turn to street drugs. Clients are often stigmatised. In the Russian Federation OAT is banned, and in the Russian-occupied Ukrainian territories of Crimea and parts of Donetsk and Luhansk regions, OAT programmes were closed in 2014.

Several innovations and adaptations ensured OAT continuity in high conflict intensity sites in Ukraine in 2022–3.

When Kharkiv was attacked in the first days of the full-scale invasion, the city's state drug treatment centre closed, as did most private clinics. The Ministry of Health of Ukraine and the state Public Health Centre (PHC) signed an agreement to transfer Kharkiv's OAT patients on state programmes to Alternative, a private clinic that remained open. Medication stocks were transferred from state sites to the Alternative clinic, where volunteers

from NGO Parus stayed round the clock to protect them from looting. Staff from state OAT sites also moved to Alternative, ensuring continuity of treatment. Transferred state patients continued to receive their doses free of charge, and doctors continued to get their state salaries.

In Nikopol (Dnipropetrovsk region), delivery of methadone was threatened when the regular delivery service refused to bring it to this frontline city. An agreement with local police, who picked it up from a midway point, resolved the issue.

A quickly signed order from the health ministry eased problems of client access to OAT by allowing sites nationwide to provide doses for up to 30 days, compared to 10 days previously. This meant clients could evacuate to safer areas, or avoid travelling in situations when there was likelihood of shelling or no public transport.

To ease initiation of IDP OAT patients to new sites, some doctors agreed to initiate dosage based on phone/messenger information from treating doctors at the previous sites, if documents were unavailable.

PHC introduced trial use of Buvidal – injectable long-acting buprenorphine (see case study 7 Long-Acting Medicines for Continuity of Care in Crisis Settings). This can help clients without easy access to OAT sites, including those who need to travel through checkpoints as even with documentation as an OAT client, transporting doses can be problematic.

Trials of OAT delivery via mobile clinic for TB/HIV+ clients who cannot reach sites ('home-based hospital' project) are underway.

3. LESSONS LEARNED: SOME GENERALISED PRINCIPLES

Coordination and flexibility across a wide range of partners — state, local governments and heads of communities; military, emergency and security services; NGOs and volunteer groups. Examples::

- State directive to give out stocks of medications for a longer period to patients.
- Volunteers bringing food and helping doctors to reach work enabled the oblast TB hospital in Kharkiv to keep its in-patient department open even after the PHC had recommended to close it.
- An agreement with local police facilitated methadone delivery to Nikopol.

Broader response to include more general services (humanitarian aid) and general population. This entails **thinking outside traditional divisions** between healthcare and other social support and between target and general population groups in terms of funding, services and assets. Examples:

- Repurposing mobile clinic vehicles for evacuation and humanitarian aid delivery.
- NGO Mangust in Kherson set up an 'invincibility point' for KPs where they can get tea and coffee, charge their phones, and get aid like torches and thermoses in return for testing for HIV.
- A church-based drug rehabilitation centre in Kharkiv now doubles as a shelter for IDPs.

Mobility, alternative delivery and communication methods keep services available to clients despite risk of shelling, displacement, and transport/communication disruption. Examples:

- Mobile Case Finding (MCF) – this mobile clinic-based service existed before the invasion but is even more relevant now, enabling social workers to reach clients in different locations and register them for care if they test positive, transporting them to healthcare facilities if necessary. The system uses financial incentives to encourage KPs to test and refer others; in dire wartime economic conditions this is very useful help for KPs (see case study 2)
- 'Home-based hospital' mobile OAT service
- Digital information and support channels linked with physical services including boxes of commodities (condoms, lubricants, syringes, needles, etc.) delivered to KPs who have moved, especially to rural areas (see case study 9 Reaching Beyond Traditional Outreach: A Digital Funnel for HIV Prevention and Integrated Care in Ukraine).

4. GAPS, PROBLEMS, RISKS

There is a big risk of **danger to life** in areas of high conflict intensity. NGO staff are provided with protective gear (helmets and bulletproof vests) and receive training in emergency first aid and mine safety awareness. Many services (outreach and stationary needle exchange/testing) rely on collecting people together in one spot, which can be an additional risk, as there have been many cases of Russian shelling of humanitarian aid points. Adaptations include moving outreach stops to near bomb shelters; using MCF mobile clinics to go directly to clients' addresses.

Communication; documentation; lost clients. The war exacerbates existing problems of communication with KPs, many of whom don't have smartphones and are now displaced or live in areas that are occupied/with limited phone signal and internet. Clients lost to services is a problem. There is a risk of losing client databases if office buildings are bombed. In occupied Kherson, Russian occupying forces tried to seize NGO Mangust's database, and confiscated project membership cards from clients.

5. CONCLUSIONS AND RECOMMENDATIONS

Rapid response, flexibility, effective coordination and the dedication of frontline workers enabled HIV prevention, testing and treatment services to continue functioning despite active hostilities. Over four years of full-scale war, APH and its partners identified 17,426 new HIV cases, accounting for 42% of all newly diagnosed HIV cases in Ukraine and demonstrating the resilience of community-led service delivery in crisis settings.

Due to migration, poor economic and living conditions and stress, large military presence, and damaged healthcare systems, cases of HIV, TB and hepatitis are likely increasing in high conflict areas, as well as risk behaviour.

In this light, continued support for these programmes is vital.

Continue funding and supporting projects in high conflict intensity areas as long as is feasible. As well as providing vital services for key and general populations, the projects provide the only source of income for staff. However, it is also important to recognise when risk to life outweighs the potential benefit of a programme.

Consider scaling up a mental health component – online and in-person consultation with psychologists. Both staff and clients are living in conditions of high stress. Mental state has a direct impact on health and adherence to treatment.

Ensure NGO staff are fully equipped and trained in frontline safety. Ensure there are evacuation plans in place.

Ensure safe (cloud-based) backup of documentation, databases.

Consider scaling up MCF in areas where roads are not too dangerous, to reach settlements now without health, social or transport services (especially in de-occupied areas).

Continue and scale up collaboration with other NGOs and international donors, including those outside the traditional health sphere.

2. PREVENTION, TESTING AND TREATMENT SERVICE MODIFICATION IN LOW CONFLICT INTENSITY SITES

1. SITUATION

Mass displacement caused by war and crisis can have an impact on health and social services in areas less affected by active conflict, which become both transit hubs and destinations for IDPs and refugees. This case study summarises examples and best practices of modification of prevention, testing, treatment and care services in areas of low conflict intensity.

A geographical peculiarity of the war in Ukraine is that the areas most affected by conflict are also those with the highest rates of HIV and TB and the largest groups of KPs. In contrast, west Ukraine, the lowest conflict intensity area bordering on European Union countries, has the country's lowest infection rates, and also a more traditional culture (including a strong church influence) which may be less tolerant of KPs. This region, and particularly the city and regionof Lviv, is now both hub and destination for people fleeing the war in the east and south, including KPs.

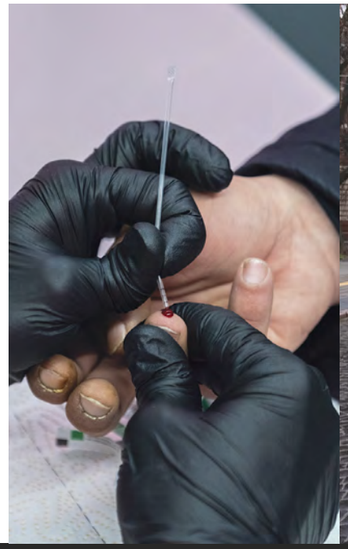
Key issues with a bearing on provision of prevention, testing and treatment services in low conflict intensity sites:

- Rapid, mass influx of IDPs/ refugees both transiting and settling
- Wide range of needs of IDPs and their families, including KPs: accommodation; humanitarian aid; help with documents, employment, social integration
- KPs tend to be more vulnerable (financial precarity, lack of documents, health issues, stigma)
- Overload of local HIV/TB/OAT facilities; additional workload; shortfall of medication
- Differing regional standards of treatment and patient reception
- Martial law; curfews
- Increased sex work
- Increased drug use
- Psychological trauma
- Cultural and other conflicts between local populations and IDPs

2. SERVICE MODIFICATION AND INNOVATION

Healthcare institutions and AIDS-service NGOs modified services and introduced new ones to respond to challenges. Wartime adaptations and innovations include:

- On a national level, the Ministry of Health and Public Health Centre issued state directives allowing take-home supplies of medications for OAT, HIV and TB for longer periods. This eased the risk of interruption caused by displacement. Long-acting PrEP medication and buprenorphine for OAT were introduced (see case study 7 Long-Acting Medicines for Continuity of Care in Crisis Settings).
- On a local level, doctors in Lviv reduced take-home medications for a short period to prevent potential shortages as AIDS centres, TB clinics and state OAT programmes were overwhelmed with displaced patients at the beginning of the full-scale invasion.



Civil society opened new, transferred or scaled up offices and projects:

- Local NGOs coordinated with volunteers and local authorities, and took on extra staff to deliver humanitarian aid to KPs and facilities like hospitals and care homes.
- In the early days of the war NGO 100% Life set up a temporary headquarters at Lviv AIDS centre, to assist with providing medications and humanitarian aid including meals for IDPs who were queueing to get medications.
- Existing legal and psycho-social support was scaled up to provide wider assistance to a wider group of IDPs: finding accommodation, registering with GPs; registering to get IDP status; other documentation.
- Screening services were extended to places where IDPs gather; to the armed forces.
- To reach relocated MSM, NGO Alliance.Global opened a PrEP service point and delivery in Lviv to cover the city and region.
- A Mobile Case Finding coordinator and vehicle relocated from Kherson and assembled a new team to reach, test and treat and take into care primarily IDP KPs in Lviv.
- APH and 100% Life opened temporary shelters for IDPs.
- Abandoned houses in villages were repaired and equipped to help accommodate IDPs.
- Social workers and medics started sending medications to patients who had moved to smaller settlements or abroad (via social workers or delivery services).
- NGOs and medical staff quickly developed a referral system/contacts for evacuating KPs to find help and services elsewhere.
- New commercial OAT sites opened in response to new demand.
- Medications and commodities storage hubs were established, and delivery from them to other territories was organised.

2.1 Case study: MCF

A mobile case finding (MCF) project displaced from occupied Kherson regionto Lviv is helping locate KPs among IDPs, as well as among Lviv natives, and bring them to services. The MCF team provides HIV and hepatitis testing, counselling and referral to OAT and other services. Those who test positive are enrolled for comprehensive psycho-social support (PSS). From dealing with local populations in the Kherson region, the team has adapted to reaching out to IDPs, who do not know where to go for services and commodities in a new place. The van is based several times a week near the railway station, where many shelters and hostels are located and where homeless people congregate. Via a personal referral system and monetary reward, those who test positive and are taken into PSS are encouraged to invite up to five other people to visit the van, where as well as testing they can get a prevention package including syringes and wipes. The team also comes on call to where clients are located, providing case management which can range from taking patients to the AIDS centre or TB clinic, to helping them replace lost documents – vital support for IDPs unfamiliar with the city and having to register for benefits; healthcare, etc.

3. BEST PRACTICES AND LESSONS LEARNED: SOME GENERALISED PRINCIPLES

National and local coordination with authorities and heads of communities, NGOs and volunteer groups enabled provision of humanitarian aid, support to find accommodation, employment, etc. for KP IDPs.

Broad response to include new, non-prevention or treatment specific services (e.g. humanitarian aid; shelters) and wider population. It entails thinking outside traditional divisions between healthcare and other social support (which already informs the complex approach of the case management system) and between target and general population groups. Important in terms of general humanitarian principles, it also helps to prevent resentment/stigma if it appears one group is being helped more than another.

Move services to where they are now most needed, as locations have been impacted by the conflict. e.g. the demand for PrEP decreased in some areas as people fled, and increased in other areas which were destinations for IDPs; music festivals that attracted stimulant users were replaced by all-night apartment parties to get round curfew restrictions. Reach out to local networks to deliver safety support in these new modalities and locations.

Alternative, enhanced and mobile delivery methods to provide IDP KPs with medications and other services (sending medications by post; MCF; long-acting medications).

Developing simplified algorithms for transferring patient data and enrolling new patients, to speed up registration of KP IDPs for services in a new location.

Storage of medications and humanitarian aid and its organised transportation to less safe areas.

4. GAPS, PROBLEMS, RISKS

Stigma. KPs find it hard to find accommodation both in shelters and more long-term, because of stigma. NGO 100% Life's shelter in Lviv which provides space for KPs is one solution (see case study 3). Overall, mass population movement and changes are likely to cause social tension. The traditional view of west Ukraine as a low incidence area for HIV and TB, and east and south Ukraine – where most IDPs are from – as high incidence can be an additional source of tension and prejudice.

> *"We try to fight prejudice. But now because of the hard economic situation I think prejudice has got worse, even towards 'ordinary' people. And now we have so many drug users and IDPs as well."*
>
> MCF coordinator, Lviv

Communication; documentation. The war exacerbates existing problems with communication with KPs, many of whom don't have smartphones, are displaced and have no permanent address. Patients are required to be registered with a GP and have a smartphone before they can start antiretroviral therapy (ART).

Identification of new clients. While many IDP-KPs find their way to services due to national networks of NGOs and medical facilities, some are falling out of care systems, and are not covered or reached by existing harm reduction and outreach services in their new locations. Particularly, prices in cities are high so people seek more affordable accommodation in smaller towns and villages which are not covered by services. Linking testing and treatment to other support (shelters, legal aid) is one way of reaching new clients.

Variations in standards of treatment and patient reception. e.g. patients for Lviv AIDS centre have to schedule an appointment, while in other places patients could just turn up to get medications; Lviv state OAT sites prescribe lower doses than sites in some other cities.

Additional workload, risk of burnout for medical staff and social workers.

No long term accommodation solution for IDPs including KPs without family/ financial possibilities and with special needs. Shelters provide a temporary solution but there is a huge need for institutions like care homes, sheltered housing and hospices (see case study 3).

5. CONCLUSIONS AND RECOMMENDATIONS

Rapid response and the ability to scale up quickly, flexibility and coordination allowed prevention, testing and treatment services to cope with an influx of new patients and clients in low conflict intensity sites. Over four years of the full-scale war, APH and its partners identified 17,426 new HIV cases, accounting for 42% of all newly diagnosed HIV cases in Ukraine, while ensuring continuity of prevention, testing and linkage to care despite mass displacement.

Due to migration, poor economic and living conditions and stress, large military presence, and damaged healthcare systems, cases of HIV, TB and hepatitis are likely increasing nationally, as well as risk behaviour. In western regions, detected cases of TB have increased almost three-fold compared to 2021. Waves of IDPs both passing through and settling in west Ukraine are likely to continue.

In this light, continued support for programmes answering a wide range of needs is vital.

- **Consider scaling up MCF** to reach other settlements with large IDP populations.
- **Continue and scale up collaboration with other NGOs and international donors**, including those outside the traditional health sphere. Link prevention, testing and treatment services to wider support and humanitarian aid.
- **Support scale-up of both public and private OAT.** Currently state sites are oversubscribed with IDPs, including those moving from commercial sites because of displacement, but also for economic reasons.
- **Include measures to tackle stigma** and increase awareness and tolerance of (people living with) HIV and TB: prevent this issue becoming linked negatively in people's minds to IDPs.
- **Consider supporting the social enterprise model** (for example 100% Life's sewing workshop, see case study 3) to both support projects and provide work places for IDPs.

3. COMMUNITY-BASED SHELTERS FOR INTERNALLY DISPLACED PEOPLE

1. SITUATION

Wars and humanitarian crises can create a pressing need for temporary accommodation for those fleeing their homes. Some are seeking a temporary stop before moving on to more stable accommodation abroad or within the country, and may have had a chance to plan their journey. Others, forced to leave everything behind, are destitute and have no idea about further steps. Short-term shelter is also needed by refugees coming back temporarily from abroad to deal with legal or social issues, who need time to wait for new documents or resolve health issues. This case study presents several models for shelters developed in Ukraine to meet the different needs.

Displacement has affected every social group in Ukraine. However, some general principles influencing IDP flows and needs can be noted:

- IDP flow is not regular or one-way
- IDPs can receive state benefits if they register (and may need help to do so)
- State accommodation for people evacuating from frontline regions is usually in state facilities like schools or sports centres, which provide little privacy or comfort
- With some exceptions, men aged 18—60 are not allowed to leave the country under martial law
- Displaced men aged 18—60 are required to register with the military recruitment office in their new place
- KPs tend to be more vulnerable (financial precarity, lack of documents, health issues, stigma)
- Prejudice/popular conceptions about HIV and TB or about KPs mean KPs may be turned away from shelters (if their status becomes known)
- IDPs face some key difficulties on top of short-term accommodation: documents (replacing those lost during evacuation, registering for benefits, etc.); registering for local healthcare/GPs; finding more long-term accommodation; employment

2. SHELTER MODELS

AIDS-service NGOs have opened new or adapted existing facilities in order to meet the need for shelters in Ukraine. This study looks at four models in the low conflict intensity site of Lviv and medium conflict intensity sites of Kharkiv and Kryvyi Rih cities.

All the shelters:

- are free
- provide hostel-style accommodation in shared rooms or family rooms; shared bathroom and (limited) kitchen facilities
- provide additional free services from lawyers, psychologists, health and social workers
- work in coordination with local authorities, NGOs and volunteer groups

2.1. Lviv

Lviv, in west Ukraine, is both a main destination and a transit hub for IDPs from all over Ukraine. There is a huge demand for both temporary and long-term accommodation, and housing prices have soared.

GENERAL POPULATION SHELTER FOR WOMEN AND CHILDREN – SAFE SPACE SHELTER, APH

War equalises the needs of different kinds of groups. AIDS-service organisations may see an imperative to expand services beyond the needs of KPs and PLHIV to overall population groups who are in a very vulnerable position.

The Safe Space shelter is a pilot project from APH. The shelter is for any IDPs, with priority given to women and children who have just fled frontline areas.

- **Advertised** on social media platforms. Guests apply in advance via an online Google form.
- **Central location** near to administrative centres for renewing documents, etc.
- **Places**: 24 beds.
- **Maximum stay** is two weeks.
- **Funded by** Christian Aid.
- **Services:** Run by IDPs with a good understanding both of the psychological and practical needs of clients, and of organisation (the director has experience in local self-government). A psychologist, lawyer, social worker and doctor (two are IDPs) provide free consultations. Local authorities and volunteer groups deliver free meals and help with adaptation (entertainment for children; city tours; employment advice).
- **Some residents:** women and children who have fled active hostilities in south and east Ukraine; a woman recovering from an operation in a Lviv hospital who can't go home because it is occupied; a refugee woman returned from abroad to process documents before going back.

> *"You feel like second class citizens when you're camping out in a sports hall. I just wanted some comfort for people: hot water, heating, a space for children. I've lived through it myself, and I wish all hostels were as comfortable as this one."*
>
> Shelter Director Viktoria Bobrinok

KP SPECIAL NEEDS SHELTER – 100% LIFE HOSTEL

The special needs of KPs, related to drug use or popular perceptions related to identities, are rarely addressed by mainstream shelters. Sometimes the residents of mainstream shelters are not happy with KP residents and conflicts occur; it may be a good idea to establish special shelters for KPs to avoid tensions.

This hostel is run by Lviv 100% Life PLHIV Network. Open to everyone, but offers a place for KPs who may be, or have been, turned away from other shelters. The hostel does not accept single men unless they have disabled status. Although the connection with an AIDS-service NGO is not advertised, it has proved off-putting to some guests (who e.g. noticed the name "PLHIV Network" on the form all guests fill in).

- **Advertise**d via local authorities and volunteers; word of mouth.
- **Located** near the railway station; IDPs are often referred here directly from the station.
- **Places:** about 150.
- **Maximum stay** is a month, but some people have been there six months or longer.
- **Funding and services:** the NGO (funded by the Global Fund to fight AIDS, TB and Malaria) covers running costs plus meals. Lawyers, social workers and a nurse offer free consultations; local volunteer groups and authorities help with humanitarian aid, socialisation, etc. Staff are social workers from 100% Life.
- **Some guests:** man evacuated from east Ukraine and diagnosed with severe TB, the hostel housed his wife while he was in hospital and has now allocated the couple a room with space for his oxygen concentrator; a young IDP man, orphan and HIV+ with some learning difficulties. Both have been there for several months.

100% Life is aware that IDPs need long-term support to find work and accommodation. The NGO runs a social sewing enterprise, which opened just before the invasion to provide work to project clients and co-funding for the NGO.

2.2 Kharkiv

Kharkiv city is a destination mainly for IDPs from Kharkiv and Luhansk region(occupied, recently de-occupied, or in the active conflict zone).

CHURCH-BASED SHELTER

Churches can play an important role during wartime, opening their doors to all in need. Churches have accommodated refugees, and provided them with food, clothes and moral support. They use their connections globally to attract additional help and resources for communities at war.

This church-based former drug and alcohol rehabilitation centre now also provides accommodation for those who have lost their homes. It is for men only (a women's block still functions as a rehab centre). The shelter takes in single men, which many other IDP hostels don't. Guests cook for everyone on a rota system.

- **Places:** 30.
- **Funded by** a protestant church and individual donors and relatives of residents. The centre is also supported by partner NGO Blago under a UNODC grant.
- **Referral:** The shelter offers places to (homeless) people at the railway station and central market, where shelter residents provide free food once a week. Police also refer people, as does a network of similar rehab centres.
- **Maximum stay:** as long as needed, but there is a strict church-based abstinence regime.
- **Services:** humanitarian aid; help with HIV/TB/hepatitis testing, treatment and management, legal issues, resocialisation, employment. These services are based on NGO Blago's existing case management project and partnerships with other NGOs and local authorities.
- **Some residents:** most people have some past connection with alcohol or drug problems. IDPs from Kharkiv region whose homes have been bombed; PWID who had previously quit with the help of the rehab centre but started using again because of war stresses; a military serviceman dealing with addiction issues.

2.3 Kryvyi Rih

Kryvyi Rih is a hub for IDPs from south and east Ukraine, mostly housed by the state in schools, sports centres, etc.

DROP-IN CENTRE/SHELTER FOR KPS – PUBLIC HEALTH FOUNDATION OF KRYVYI RIH SHELTER

Services like drop-in centres for KPs may be expanded to accommodate food and overnight needs of KPs. This is an easy expansion based on existing services.

NGO Public Health Foundation of Kryvyi Rih opened the shelter in December 2022 (it ran a smaller one at the railway station previously), and is still gradually renovating the building which it rents at 50% discount; it is trying to get local authorities to subsidise utilities. The shelter was set up to provide accommodation specifically for KP IDPs. About 80% of guests are HIV+/have TB.

- **Referral:** mostly IDPs are referred by other AIDS-service NGOs, Kryvyi Rih humanitarian aid hub, police, AIDS/TB/drug treatment clinics, prisons. The Public Health Foundation of Kryvyi Rih has helped some KPs to evacuate from frontline areas. Other residents have come out of hospital or prison and can't go home because it is now occupied.
- **Places:** 60 places.
- **Maximum stay** is two weeks but some residents have been there six months.
- **Services:** authorities, NGOs and volunteers provide food supplies and other humanitarian aid. Staffed by social workers. All residents are tested for HIV/TB/hepatitis on arrival, and taken into the NGO's existing case-management system. Help with medical and harm reduction services, documents.

The NGO plans long-term to develop the shelter into both a social enterprise where people can learn skills, work and earn, and a rehab centre for war-related trauma.

- **Some residents:** HIV+ man from occupied Kakhovka who was referred here by an NGO in Kherson which also helped him and his uncle to evacuate; pregnant woman from Kherson whose parents died in shelling, Public Health Foundation of Kryvyi Rih evacuated her to the shelter.

> *"In school buildings where IDPs are housed there is still stigma, so our KPs leave, or start stealing. At our shelter they don't have to steal. But next they need work and case management, in a strange town that is so hard to get around."*
>
> Oleksandr Lee, deputy director, Public Health Foundation of Kryvyi Rih

3. LESSONS LEARNED/BEST PRACTICES

Coordination with local authorities, volunteer hubs and NGOs enables shelters to start running quickly, link directly with IDPs or organisations evacuating them, and receive additional help for IDPs – humanitarian aid; local orientation/integration; access to registration, health services, etc.

A variety of ways of promotion through media and social media; networks of volunteers, IDPs, KPs; social, medical and law enforcement services enables those in need to find the shelters.

Building on or integrating existing projects by NGOs, in particular case management by social workers. The case-management model is applicable not just for KP-IDPs; most IDPs have complex needs.

Additional services of lawyers, psychologists, social and medical workers helps IDPs to resolve issues quickly and register in a timely way for health, education, employment services.

Flexible funding to respond to new needs; co-funding by local authorities, other NGOs.

Involving IDPs into the running of hostels and services ensures a better understanding of resident's needs, as well as employment opportunities for IDPs. Involving KPs if they are the primary residents.

Different models suit the different needs of IDPs; there is no one-size-fits-all solution.

Dealing with stigma is an issue when considering shelters for members of key populations. The shelter that has tried consciously to be open to all (100% Life Lviv) has had some limited problems when residents realised there was a connection with HIV. This can be an awareness-raising opportunity: social workers have tried to use this experience to broach the subject in discussion with IDPs.

Connection to a social enterprise or plans to develop one help shelters to become sustainable and provide long-term assistance to IDPs.

4. GAPS AND LIMITATIONS

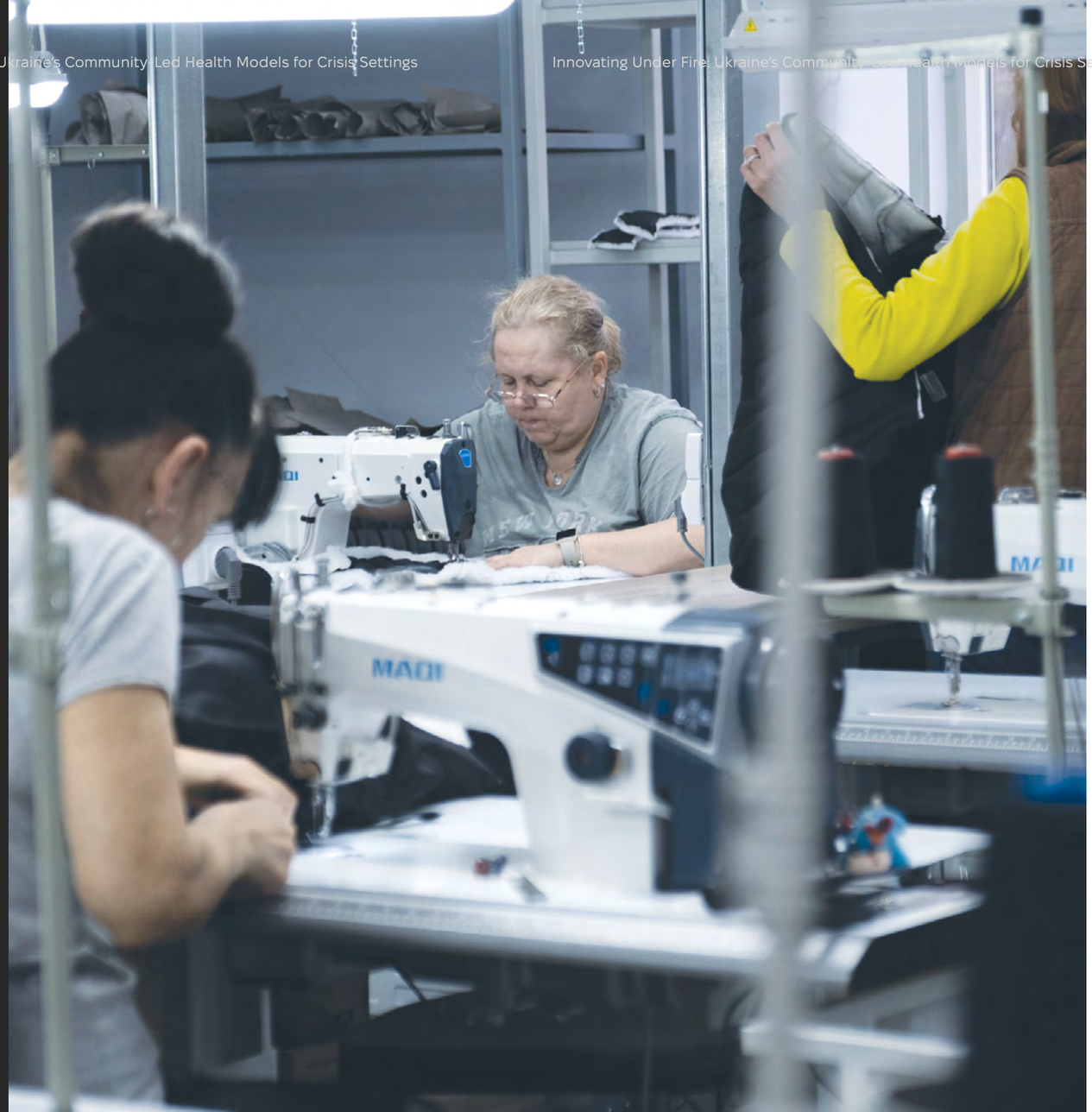
Time Limit. All these shelters are designed to fill a gap for temporary accommodation. Three of four have fixed time limits for stay, which NGOs say are imposed by the donor. However the key shortcoming mentioned at all four locations is the time limit.

- Two weeks is not long enough to get new or replacement documents, one of the main issues facing IDPs
- Some IDPs are having to move from shelter to shelter every few weeks
- there is little to no provision in Ukraine for IDPs genuinely without other options/financial possibilities and with special needs, including elderly people without family, and the disabled. Such people often end up at the shelters run by 100% Life, Public Health Foundation of Kryvyi Rih and the church in Kharkiv because other shelters refuse to take them, and have been at these shelters for months with no solution for where they might go long term. There is a huge need for institutions like care homes, sheltered housing and hospices to fill this gap. This was a gap before the 2022 invasion that has now become acute, because even existing institutions are over-full and have sometimes been requisitioned for use as general shelters.

Accessibility. Three of the four shelters are located on upper floors with no lift. Thus their use is limited for those with mobility issues.

Registration. The Safe Space shelter has a pre-registration system via a Google form, which one elderly resident said had stopped her accessing the hostel until a more technology-savvy friend helped her with the form.

Some of the hostels require male IDP guests aged 18–60 to register with the local military enlistment office. This is mandatory for male IDPs according to martial law. However, it has dissuaded some residents from staying in the shelters.



5. CONCLUSIONS AND RECOMMENDATIONS

IDPs have different needs and are in different life circumstances. Therefore there is a need for different types of shelters, which these four models help to meet.

- **Continue to support different models** as long as the need for temporary IDP accommodation continues in Ukraine.
- **Consider lengthening short stays** of two weeks to one month, to allow people to register and receive new documents and solve other issues.
- **Scale up links** with local authorities, NGOs and businesses to provide IDPs with job opportunities, psychosocial support.
- **Consider the social enterprise model**. Some shelters in Ukraine for example have opened a space for a social cafe or restaurant: residents practice cooking skills and invite local people for meals on a pay-what-you-can basis, any profits support the shelter's running costs and such projects contribute to integration of IDPs into local communities. 100% Life's sewing enterprise is another model.
- **Consider long-term solutions** for IDPs with additional needs and nowhere to go. The need for sheltered housing/care homes/hospices is acute.

4. SUPPORTING CONTINUITY OF CARE FOR REFUGEES FROM KEY POPULATIONS

1. SITUATION

Among refugees from war and crisis are members of key populations, who need rapid help to enable them to keep up treatment and monitoring for HIV and TB or continue OAT without interruption. While some people could plan their journeys and take necessary paperwork and supplies of medications, others fled with nothing. Regardless of level of preparedness, most face some difficulty in navigating new healthcare systems and continuing treatment.

Ukrainian refugees and AIDS-service organisations faced this issue in 2022. According to UNHCR, more than 8 million Ukrainians displaced by Russia's invasion were registered in temporary protection schemes in Europe in 2023, with the largest numbers in Poland and Germany.[5]

5 https://data2.unhcr.org/en/situations/ukraine

Some general points:

- There are significant differences between countries' healthcare systems and treatment standards.
- Some receiving countries have high levels of stigma towards HIV and TB, while having different epidemic profiles.
- KP-refugees tend to be more vulnerable (financial precarity, lack of documents, health issues including need for uninterrupted treatment; stigma).
- Many KPs are reluctant to disclose their status and register for local healthcare, because they fear stigma (especially as refugees who are uncertain generally of their rights) or because they think they will soon return home.
- Healthcare may not be top of the list of problems for refugees, who have to resolve their legal status and find accommodation and employment. At the same time, these issues are often interlinked.
- Many refugees experience mental health problems and depression which, together with loss of social structures (work, family) can influence their attitude to their health; adherence to treatment.
- Ukrainian healthcare facilities can provide stocks of TB and HIV medications to patients for six months.
- Most countries in the EU have protection schemes in place that allow Ukrainian refugees to register relatively quickly with local health services.

2. MODELS

2.1 HelpNowHUB virtual hubs and information portal

This online service was set up by APH in March 2022 to help KPs/PLHIV navigate health services abroad and coordinate with doctors back in Ukraine in order to continue treatment and access to services. The service consists of:

- **Resource portal**: online platform (HelpNow.aph.org.ua): comprehensive information for KPs in destination countries; referral to other services.
- **Three virtual hubs** in Poland, Germany (the most popular destinations for refugees) and the Baltic states: Ukrainian-language info-line; psycho-social support (sometimes in-person); legal and translation assistance. There are also local representatives in some other countries.
- **Clinical consulting hub**: online clinical consultation service developed on the basis of the existing APH virtual medicine platform Help24.

- The service was set up quickly based on existing APH contacts and partners in the target countries, and APH staff who had themselves become refugees.
- Uses rapid and accessible technology: webpages; social media; messenger groups; bots. The Polish hub also advertises via posters/fliers in places refugees gather, such as railway stations.
- Collected and built on existing experience (including from local partner NGOs) updated and actualised with new experience of refugees. e.g. Ukrainians in the Baltic states before the war had already had issues with ART because Covid made it difficult for them to travel back to Ukraine for new supplies of medicines; there were already a lot of Ukrainians living and working in Poland.
- Over time, HelpNow has developed patient algorithms providing a step-by-step guide for refugees, from leaving Ukraine with the required documents to registering for support and services abroad.
- Ukrainian patients can get medical records transferred from the Ukrainian Ministry of Health and medical facilities. HelpNow volunteers can help organise documents transfer and translation.

- Focus is on KPs and helping them navigate health systems abroad, but in practice HelpNow is helping a wider group and with wider issues, as it is impossible to divide target health issues from other issues like housing, legal status, etc. Very complex cases are often referred from local NGO partners. Hub volunteers end up implementing a case management system similar to that practised in Ukraine.

Main requests from KPs:

- Support in accessing primary treatment (access to ART, TB and hepatitis treatment, OAT)
- Integration into healthcare services
- Psychological support
- Financial and other social support
- Language support

> *"If you compare the overall number of consultations about therapy and those about social issues, social issues are twice as many. They are just all connected. Someone calls asking about where to get ART, and then the first question is: 'Have you got refugee status?' 'No, how can I get it?' And so on, and then: 'I came with children, how can they start kindergarten?'... You can't separate all these issues."*
>
> Volunteer,
> HelpNow PL Hub

- Inter-country coordination: based on their collected knowledge and input from partners, HelpNow volunteers can recommend where services are more accessible. e.g. It may be better for OAT clients to go to the Czech Republic because OAT sites in Germany are over-subscribed and more difficult to enrol in.

2.2 Medical and social support from within Ukraine

Many refugee KPs do not wish to register and start treatment with state health systems abroad, or find it impossible to do so (e.g. in Turkey people have to have been resident for a year before they can get state-prescribed ART). To assist in such situations:

- HelpNow clinical hub provides online medical consultation for PLHIV refugees and IDPs with doctors still in Ukraine.
- Medical staff and social workers from AIDS-service projects and NGOs in Ukraine send medications to patients abroad on an ad-hoc basis (individual agreement) via various delivery systems. Patients use private clinics abroad to measure CD4 and viral load and send the results back to doctors in Ukraine via online messengers. This is often seen as an extension of the case management system within optimized case finding (OCF) and Community Initiated Treatment and Retention Intervention (CITI CIRI) programmes, where social workers assist their clients to collect medications and perform regular testing and monitoring.

3. LESSONS LEARNED/ BEST PRACTICES

- **Rapid response** - HelpNow hubs were set up very quickly drawing on existing resources to respond to needs in real time.
- **Coordination** with partner NGOs in target countries and across regions helped to link refugees to the hubs and to in-country support to resolve health-related and other linked issues, like housing and humanitarian aid. Referral is two-way – hubs refer people to local NGOs for in-country services; NGOs refer complex cases to hubs for Ukrainian language/psychological and cultural assistance.
- **Learning from existing experience** of Ukrainian workers and immigrants in Europe who had already successfully navigated healthcare systems.
- **Effective IT solutions** - online access; bots; promotion through social media; easy referral and navigation between HelpNow services.
- **Development of generalised algorithms** provides step-by-step guidelines to help KPs organise their departure from Ukraine and arrival in a new country, ensuring they have the required documents, know their rights and obligations, etc.
- **System of rapid documents and medications issue and transfer** from medical institutions in Ukraine to destination countries.
- **Involving refugees and KPs** ensures a peer approach with better understanding of needs.
- **The case management system** in Ukraine means that social workers are already used to helping their clients with a range of issues. This practice has proved useful where KP-refugees have new urgent problems related to documents transfer or reissue, housing, registration, etc., or to organise delivery of medications from Ukraine.

4. GAPS, LIMITATIONS, RISKS

- **Client group:** Some problems with people who don't understand who the target group of HelpNow is, or what the hubs can offer, and complain when they don't get the help they expect.
- **Workload** and demand is close to overwhelming. Some HelpNow workers are volunteers, sometimes without training in social work or counselling. High risk of burnout; no clear boundaries in place in terms of hub worker-client relations and the range of services offered.
- **Sustainability:** initially governments reacted quickly, but now (emergency) funding for Ukrainian refugee services is running out and volunteers are experiencing burnout. Need to think long-term both about the sustainability of HelpNow, and about programmes and services in European countries.
- **Stigma** or fear of stigma is a strong barrier deterring KPs from registering with health services abroad. While getting medications delivered from Ukraine/online consultation with Ukrainian doctors is a good way of enabling people to continue treatment without disclosing their status, it is not sustainable, and could deter KPs from taking the necessary step to register.

- **Dependence on the case management system.** Hub volunteers and Ukrainian social workers and medics all note the gap between the Ukrainian case management system for KPs and EU social and healthcare systems, where there is no equivalent. Refugee KPs can be very passive when it comes to resolving issues abroad, because they are used to relying on their case managers.

> *"Case management is a process of leading people by the hand. In some ways it's wonderful, but in other ways it's a problem. Now when clients go abroad, they just sit and wait for someone to help them."*
>
> Volunteer, HelpNow PL Hub

- **Risk of creating a parallel system** of support for Ukrainian KP-refugees, which could hinder their integration into health and social systems in their destination country. Sometimes HelpNow volunteers appear to want not so much to help clients adapt to/ navigate local healthcare systems, as to change the systems. A long-term question is whether the hubs themselves should be better integrated into EU health and social services.

5. CONCLUSIONS AND RECOMMENDATIONS

Rapidly-organised support in the form of HelpNowHUB, or on a more ad-hoc basis from medical and social workers in Ukraine, has been crucial in supporting service continuity for KPs forced to flee abroad from the war. Systematization of this support in virtual hubs and information portals, working in collaboration with NGOs in target countries, has enabled development of efficient algorithms of assistance for KPs, and should be ongoing. It's hard to predict how refugee flows will change in future, but we can assume that large numbers of Ukrainian KPs will stay in other countries and need to integrate into local health and social systems.

- **Systematise HelpNow staff and services; guidelines** and algorithms for what is and is not achievable. Establish boundaries in terms of staff-client relations and help offered; provide training and psychological support for volunteers and staff.
- **Consider adding a mental health component/hub**, as psychological support is one of the key requests from KP-refugees and mental state has a direct impact on health and adherence to treatment.
- **Look for funding** from sources in target countries.
- **Look for ways to integrate the HelpNow hubs** into the health and social systems of target countries, to avoid the risk of setting up an unsustainable parallel system.
- In some countries e.g. Poland and Estonia, far right political parties and media have begun to exploit the issue of 'Ukrainian refugees bringing HIV/overwhelming our medical systems'. **Working with partner NGOs and governments in target countries to challenge this narrative** and work towards more tolerance and understanding of people with HIV/TB (wherever they are from) might be a long-term consideration.

5. MOBILE TREATMENT POINTS: BRINGING INTEGRATED HEALTHCARE TO FRONTLINE COMMUNITIES

1. SITUATION

When traditional healthcare structures are disrupted, mobile health services that travel to communities can be an effective and flexible solution, taking aid to where it is most needed.

Russian attacks on healthcare in Ukraine are ongoing. In some occupied areas, local populations have had little or no access to medicine since the end of February 2022. Mined territory, destroyed roads and buildings and shelling and drone attacks all stand in the way of restoring healthcare infrastructure in liberated areas near the frontline. Pharmacies and primary medical centres, where a doctor or nurse may work once or twice a week, are slowly reopening in some settlements. But locals lack funds to buy medicines, or cannot use the internet to order free government prescriptions. Lack of public transport makes a trip even to a neighbouring settlement difficult and prohibitively expensive.

1. Situation
2. Service description
3. Best practices/ Lessons Learned
4. Gaps, Problems, Risks
5. Conclusions and Recommendations

https://www.instagram.com/mtp_aph.org.ua/

Some key factors affecting health and healthcare provision in de-occupied areas near the frontline:

- Mass population migration and displacement
- A predominantly older population remains
- Interrupted public transport, communications and essential services
- Destruction or closure of healthcare facilities, pharmacies and other public institutions
- Shortage of healthcare workers, medicines and medical supplies
- Mined territory; high risk of shelling and drone attacks
- Continued attacks on healthcare infrastructure and repeated disruption of services
- Poor living conditions
- Few or no sources of income for local people, other than pensions
- Presence of military; checkpoints; curfews
- Stress and psychological trauma among local populations
- High burden of chronic diseases, including hypertension, diabetes and cardiovascular conditions
- Growing need for diagnostics, long-term disease management and follow-up care
- Increased demand for integrated healthcare, including TB, HIV, sexual and reproductive health, and mental health services
- Large numbers of low-mobility and bedridden older people unable to travel to healthcare facilities
- Less attention to health due to competing survival priorities
- Pre-existing tendency to postpone seeking healthcare because of cost, limited accessibility and competing livelihood needs

2. SERVICE DESCRIPTION

Since their launch in December 2022, APH's Mobile Treatment Points (MTPs) have evolved from an emergency primary healthcare intervention into an integrated mobile healthcare model delivering comprehensive medical, diagnostic and preventive services to remote frontline and recently de-occupied communities. By the end of June 2026, mobile teams had completed 1,003 field days, reaching more than 35,300 people in 552 hard-to-reach settlements across eight frontline and border regions of Ukraine. Mobile clinics are equipped with portable diagnostic and laboratory equipment, including ECG and ultrasound systems, glucometers, portable biochemical and hematology analyzers, immunofluorescence analyzers, rapid tests for HIV, hepatitis B and C, syphilis, COVID-19 and cardiac markers. TB services are delivered using portable X-ray and GeneXpert systems in cooperation with regional TB services. Depending on local needs and the configuration of each team, the programme also provides sexual and reproductive health services, mobile dentistry and home-based visits for older people and bedridden or low-mobility patients.

Mobile teams work as multidisciplinary units consisting of family physicians, nurses, laboratory specialists, social workers and, where appropriate, TB specialists, dentists and gynaecologists. They cooperate closely with local healthcare facilities to ensure referral, treatment initiation and continuity of care. Humanitarian assistance remains integrated where needed through partnerships with local authorities and humanitarian organisations.

Routes and destinations are agreed with local authorities (and military if necessary), volunteer groups, and heads of communities who inform local populations via phone, social media and word of mouth when and where the convoys will come. Patient information is collected in accordance with applicable medical documentation, reporting and data-protection requirements.

"In the seven months since de-occupation, a doctor has been here once. We're trying to persuade them to come once a week [...] We really need medicines. It's such a painful issue. We are getting humanitarian aid, we have electricity and so on, but the big problem is medicine. People have nowhere to turn."

Former village head, Kharkiv region

"Our mobile clinics deliver lifesaving care to frontline, hard-to-reach villages where medical services no longer exist. This is about survival, not just medicine."

Anna Korobchuk,
Alliance for Public Health (2026)

3. BEST PRACTICE/ LESSONS LEARNED

- **Building on/repurposing existing resources** to rapidly respond to new needs:
  - The initial MTP model was launched rapidly by repurposing vehicles and operational resources already available to APH;
  - Drivers were initially recruited from a pool of experienced volunteers who had been delivering humanitarian assistance across Ukraine in APH vehicles since February 2022.
- **Coordination** with local authorities, community representatives, relevant military actors, NGOs and volunteer groups enables MTPs to prioritise areas with the greatest unmet needs and avoid duplication.
- **Collaboration** with NGOs and volunteers allows the project to combine health and humanitarian aid and optimise delivery:
  - Humanitarian assistance may be provided by partner organisations and, where operationally appropriate, delivered in coordination with MTP visits;
  - Medical personnel have been recruited with support from partner NGOs and volunteer groups.
- **Optimization:** In some settlements, medicines have already been distributed by other organisations or authorised providers. MTP clinicians can review patients' existing treatment and recommend follow-up diagnostics or care.

- **A broad response combining humanitarian and health-related services** is achieved through such coordination and collaboration. Similar collaboration in terms of donor funding is important. Advantages:
  - More cost-efficient use of transport and delivery resources;
  - With high risk of shelling, people in frontline areas are afraid to gather in large groups for extended periods. Coordinated delivery can reduce the time people spend travelling or waiting, provided that crowd-management, confidentiality and security risks are properly assessed;
  - People (especially men) can be reluctant to see a general practitioner. Having the medical service in the same place and time as humanitarian aid delivery can sometimes help persuade them to use the service as it is convenient and they have come/are waiting anyway.
- **Mobility and flexibility.** The MTPs can move and adapt quickly, which is vital in a highly volatile security environment. Through field experience, teams have identified effective approaches to service delivery, including:
  - Organising patient flow so that several clinicians and a nurse can receive patients simultaneously;
  - Distributing humanitarian aid in settlements via existing systems (local authorities or volunteers);
  - Selecting optimal arrival and departure times based on security conditions and curfews;
  - Recruiting family physicians with additional specialist expertise to better respond to identified community needs.
- **Integrated healthcare delivery.** The model has progressively expanded beyond basic primary care into a comprehensive integrated service. Depending on the team and location, patients may receive medical consultations, laboratory diagnostics, TB screening, HIV and hepatitis testing, sexual and reproductive health services, dentistry and referrals through a coordinated mobile service, reducing multiple barriers to access.
- **Bringing diagnostics closer to communities**. Introducing portable laboratory equipment, GeneXpert diagnostics and ultra-portable X-ray systems has enabled advanced diagnostics to be delivered directly in frontline communities where access to fixed health facilities remains limited, unsafe or unavailable.
- **Reaching the most vulnerable**. The project has increasingly focused on older people, persons with disabilities and people with limited mobility through home-based medical visits, ensuring continuity of care for populations unable to reach even mobile clinics.

4. GAPS, PROBLEMS, RISKS

Shelling, drone attacks and landmine contamination remain major risks. MTP staff are provided with protective equipment, including helmets and body armour, and are trained in emergency first aid, conflict and mine-risk awareness. Ensuring long-term sustainability remains a major challenge. The programme depends on continued donor support while demand for services remains high and healthcare facilities in many frontline areas are still unable to resume normal operations. Referral pathways also remain difficult in areas where secondary healthcare facilities have been damaged or where transport infrastructure is limited, making follow-up specialist care challenging for many patients. Staffing shortages, particularly for specialised medical roles, and frequent changes in the security situation can delay team deployment, disrupt routes and lead to the postponement or cancellation of visits.

5. CONCLUSIONS AND RECOMMENDATIONS

MTPs complement the public health system by bridging critical access gaps that fixed healthcare facilities and transport infrastructure cannot fully address under current security conditions. Therefore, this project should be continued as long as the need remains.

- **Continue expanding integrated mobile healthcare services**, including dentistry, sexual and reproductive health, TB diagnostics and home-based care, based on community needs.
- **Further strengthen mental health and psychosocial support within mobile healthcare services,** including supportive communication, psychological first aid, identification of patients requiring specialised support, referral pathways and telemedicine.
- **Continue and scale up collaboration** with other NGOs and international donors, including those outside the traditional health sphere.
- Where routes and security conditions become more stable, humanitarian assistance should be tailored to **identified needs and coordinated with other actors to minimise duplication**.
- **Institutionalise the integrated mobile healthcare model** within Ukraine's post-war health system and promote its adaptation as a best practice for humanitarian and conflict settings globally.

6. EXPANDING MENTAL HEALTH CARE: DIGITAL TOOLS AND INNOVATIVE TREATMENTS FOR VETERANS, CIVILIANS AND KEY POPULATIONS

1. SITUATION

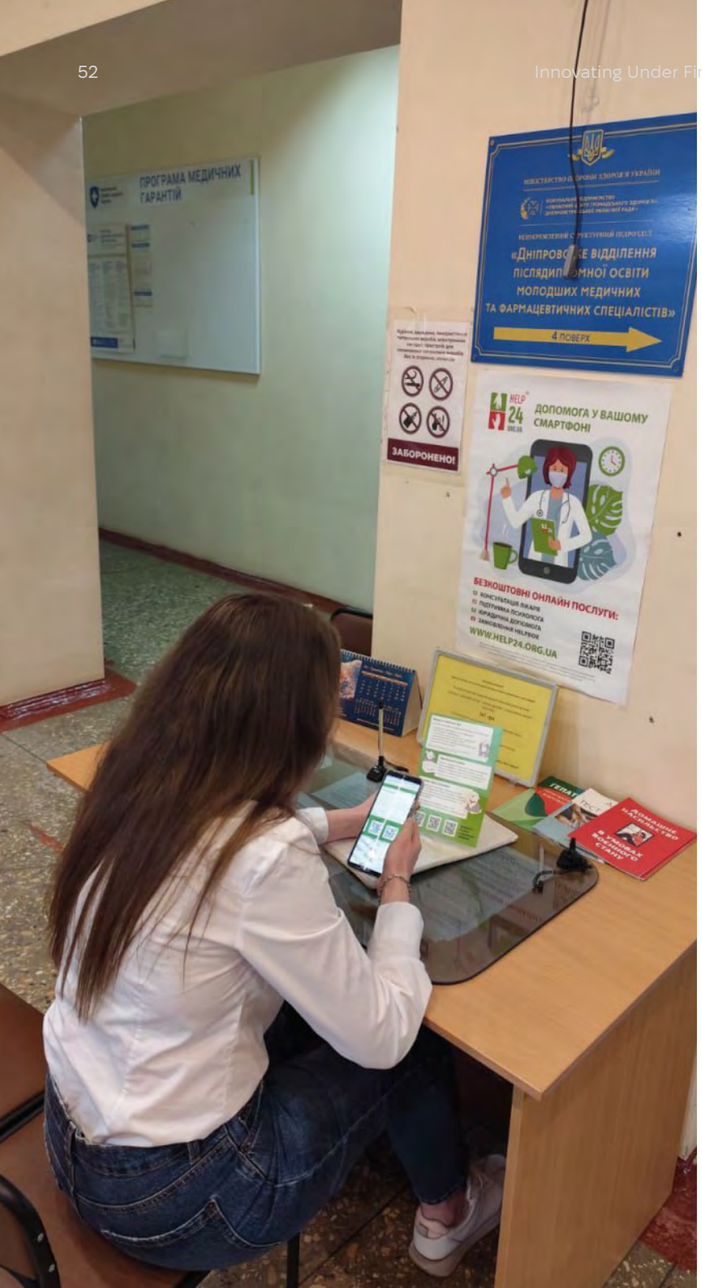
Mental health is one of the most neglected components of humanitarian response worldwide, despite profoundly affecting physical health, treatment adherence, recovery and long-term resilience. Humanitarian crises consistently lead to a sharp increase in psychological distress while simultaneously disrupting access to mental health services.

The war in Ukraine has caused a crisis of mental health. Displacement, loss and bereavement, repeated exposure to violence, economic hardship, and disrupted family and community support networks have contributed to an epidemic of anxiety, depression, post-traumatic stress disorder (PTSD), substance use, sleep disorders, and other conditions. WHO estimates that over 9 million Ukrainians may be affected by a mental health condition. The number of Ukrainians seeking medical care for mental disorders has doubled since 2022 (Ukrainian National Health Service).

Even before the full-scale invasion, access to quality mental health information and support was limited by stigma, geographical barriers and a lack of mental health professionals. **The war has exacerbated problems with service delivery while dramatically increasing demand.**

Mental health is inseparable from public health, as psychological wellbeing directly influences management of chronic diseases, adherence to HIV treatment, tuberculosis care, opioid agonist treatment (OAT), employment, family relationships, and overall resilience. **People living with HIV and members of key populations may have a greater need for accessible and integrated mental health support** since they traditionally experience more social stigma and higher barriers to healthcare.

APH began integrating mental health services into its existing services in the first months after the full-scale invasion. One rapid emergency response in 2022 was to procure and distribute courses of antidepressant treatment to OAT clients experiencing a sharp increase in psychological distress. Since then, APH has been systematically **building mental health services into both new and existing public health delivery models, to strengthen continuity of care for vulnerable populations during war and humanitarian crises**.



2. MODELS

2.1 Expanding existing services

APH **expanded its digital or hybrid platforms** to provide a range of mental health services. As these platforms were **already widely used and trusted**, the Alliance was able to **rapidly increase access to psychological care and awareness without creating additional barriers** or separate referral pathways.

help 24 telehealth

- **Help24.Telehealth** is a digital health platform established before the full-scale invasion to improve access to health and social services for people living with HIV and key populations. Help24 now provides **free psychological counselling and facilitates access to psychiatric consultations** for users, alongside the existing access to harm reduction commodities, HIV self-testing, telemedicine consultations, and other health-related support through a single digital entry point. Additional activities include **mental health self-screening tools, psycho-educational materials and awareness campaigns** designed to encourage early help-seeking and improve mental health literacy.

drugstore

- **Drugstore,** established in 2018, is a comprehensive harm reduction, sexual health, and mental health programme aimed at vulnerable young people who use psychoactive substances, engage in high-risk sexual behaviours or face mental health challenges. Mental health is fully integrated into this broader prevention model. Users can access **free psychological consultations**, psychotherapeutic and psychiatric assistance, receive reliable information and use the Free2Ask mobile application to **support emotional wellbeing and self-care**. Mental health topics are incorporated into educational materials, blogs, workshops, and community events, recognising the **close relationship between psychological wellbeing, substance use, and sexual health**. By **embedding mental health within a comprehensive youth-oriented harm reduction programme**, Drugstore reduces stigma and encourages young people to seek support before more serious health problems develop. The integrated approach enables users to address both physical and mental health needs through one platform, improving continuity of care and strengthening links between community services and specialist mental health support.

digital TWIIN assistant

- **TWIIN** is the AI-assisted digital assistant developed by APH in 2025. **Mental health is one of the platform's key thematic areas**. Users can access information on common mental health conditions and psychological self-care specifically adapted to the needs and experiences of key populations. TWIIN **offers supportive conversations which do not replace psychologists or psychiatrists, but serve as an accessible first point of contact**, helping users identify potential mental health needs and encouraging timely referral to appropriate services. In future the platform will integrate validated mental health screening tools to enable users to assess symptoms of common mental health conditions and receive personalised recommendations for further support.

2.2 New treatment options

INTEGRATED ADHD DIAGNOSIS AND TREATMENT IN SERVICES FOR PEOPLE WHO USE STIMULANTS

Attention-deficit/hyperactivity disorder (ADHD) remains substantially under-diagnosed among adults in Ukraine. Evidence suggests that **some people, particularly young people, may start using illicit stimulants to self-medicate symptoms of untreated ADHD** such as persistent difficulties with attention, impulsivity, emotional regulation, and executive functioning. However, because the underlying disorder often remains undiagnosed, both ADHD and stimulant use continue untreated, contributing to poor health and social outcomes.

APH introduced a **pilot programme** integrating systematic ADHD screening, diagnosis, and treatment into specialised services for people who use stimulants. Rather than focusing directly on stimulant use (for which there is currently no widely available evidence-based pharmacological treatment option), the programme **addresses an underlying condition that may contribute to ongoing substance use.**

Clients are screened for ADHD and, where clinically indicated, receive comprehensive psychiatric assessment followed by evidence-based treatment with methylphenidate. Treatment is accompanied throughout by clinical monitoring and psychosocial support. By reducing ADHD symptoms, the treatment can support social reintegration and potential reduction or cessation of illicit stimulant use.

APH also introduced a **Cognitive Behavioural Therapy (CBT) programme for people who use stimulants** and who often experience psychological, behavioural, and social challenges that extend beyond substance use itself. Initially CBT was intended to complement the ADHD and methylphenidate pilot, by offering practical psychological tools to participants to reinforce and maintain treatment outcomes. However, the programme is also available to other people (not part of the methylphenidate pilot) who use stimulants and who may benefit from evidence-based psychological support. In phone or online sessions with psychotherapists, participants learn practical techniques to understand the relationship between thoughts, emotions, and behaviours, strengthen coping strategies, and address challenges related to stimulant use and everyday functioning.

KETAMINE-ASSISTED THERAPY

Ketamine-assisted therapy (KAT) is a **treatment for persistent treatment-resistant depression**. Available in some private clinics in Ukraine, a **pilot KAT programme for veterans and military personnel** who will not return to active combat roles has also been introduced at Lisova Polyana (Forest Glade) centre, a Ukrainian Ministry of Health centre of excellence for psychological and neurological rehabilitation for what the centre calls 'hidden wounds'. Here the therapy is used for treatment-resistant cases, over a number of sessions during residential stays of 3-4 weeks. Clients undergo comprehensive psychiatric assessment before being offered the option, and are guided through the process by a multidisciplinary team of specialists, that include psychiatrists and psychotherapists. Ongoing clinical monitoring ensures safe and effective care.

> *"It's not so much ketamine, as the psychotherapy that goes with it. KAT makes it easier to access the experience. It gets the client to the required level where they can begin to process [the experience] very quickly and in a safe environment."*
>
> Lesya Bondarenko,
> Deputy Director for Psychological Programmes, Lisova Polyana rehabilitation centre

> *"Ketamine was new and acted immediately... it hasn't completely removed all the issues, but it helps to start recovery... It's like getting your sense of taste back, like back in childhood, it returns the colours to life."*
>
> Veteran and former prisoner-of-war taking KAT at Lisova Polyana centre

APH supported KAT for 20 patients at Lisova Polyana centre, and a further 100 in other clinical centres in Kyiv and Lviv. The project aims to expand access to the therapy for veterans and military personnel (40 clients in the implemented programme) and civilians (80 clients) experiencing treatment-resistant depression, while also evaluating the potential role of KAT in addressing symptoms of PTSD. Geographic expansion of KAT, supported by APH, is planned to Odesa where Lisova Polyana is currently establishing a centre.

Additionally, APH is planning to explore the possibility of expanding ketamine-assisted therapy to people who use stimulant drugs experiencing co-occurring depression, with the aim of evaluating whether improving depressive symptoms can also contribute to better substance use outcomes and support long-term recovery.

BEST PRACTICES AND LESSONS LEARNED

- **Existing digital health platforms can be expanded to include mental health services**. If digital infrastructure and literacy are in place, the services are widely accessible and reach an existing base of users (including people living with HIV and key populations), encouraging continuity of care. Integrating mental health within broader health assistant models reduces stigma and encourages users to seek support.
- **Digital services complement, rather than replace, face-to-face mental health care**. Digital tools combined with community outreach provide multiple entry points into health services and strengthen referral pathways to specialised services.
- **Co-occurring mental health conditions can be diagnosed and addressed within public health and harm reduction programmes** to strengthen broader recovery outcomes. Programmes like APH's for stimulant users in fact provide an access point to reach people with underlying mental health conditions such as ADHD.
- Models **expanding access to innovative psychiatric treatments** such as KAT strengthen services for individuals with treatment-resistant mental health conditions, including veterans, military personnel, and civilians affected by war. Such models can be implemented safely in multidisciplinary settings combining psychiatric assessment, medical supervision, and psychological support.
- **Ongoing clinical evaluation** is important to guide future implementation and policy development around use of psychedelics in mental health settings.

GAPS, PROBLEMS, RISKS

- **Stigma around use of psychedelics** for mental health treatment. There is some opposition from state medical and governance bodies, and patients themselves can be reluctant to try something they perceive as a controlled substance.
- No standardised training or certification for practitioners to provide ketamine-assisted therapy in Ukraine.
- KAT and similar treatments **should not be considered a silver bullet** and must be incorporated into comprehensive clinical and psychiatric settings.
- Digital and AI-assisted mental health services **must incorporate qualified in-person care (which can be provided remotely)**. There is a risk of users becoming overly attached to and influenced by AI-assisted platforms.
- In wartime and other emergency settings, as well as rural areas, **digital infrastructure may be disrupted or unavailable**. Digital services also exclude sections of the population such as those who cannot afford smartphones, or older people.

CONCLUSIONS AND RECOMMENDATIONS

War and humanitarian crises have a huge mental as well as physical impact on those living through them, while mental health services are often already hard to access, insufficient and surrounded by stigma. Effective mental health responses during humanitarian crises require both adaptation and innovation. Building responses into existing services can be relatively quick and guarantees reaching an existing base of people. Rather than creating isolated mental health programmes, APH integrated mental health across its broader portfolio of HIV, harm reduction, and public health services – an approach that recognises the close relationship between mental wellbeing, treatment adherence, substance use, physical health, and social reintegration. Together, these initiatives provide multiple entry points into mental health care, ranging from digital information and psychological support to specialised and innovative psychiatric treatments and structured psychological interventions.

- Ensure that digital mental health tools are linked throughout to professional services and are not used as a substitute.
- Ensure that military and civilian authorities are informed about the evidence base behind innovative treatments.
- Support further research into psychedelic assisted treatments for PTSD and for co-occurring depression among people who use drugs.

7. LONG-ACTING MEDICINES FOR CONTINUITY OF CARE IN CRISIS SETTINGS

1. SITUATION

War and other humanitarian crises can be disastrous for patients on long-course medical therapies that require strict adherence, like antiretroviral therapy for HIV, TB treatment, and opioid agonist treatment (OAT). When clinics are hard to reach, supply chains are disrupted, and patients and medical professionals are displaced, the **risk of treatment interruption is extremely high**. Anxiety and emotional and mental distress caused by the uncertainty of maintaining treatment also take their toll on patients' adherence and general state of health.

Ukrainian organisations responded to this threat by issuing state directives allowing ten or more days' take-home supplies of medications, adapting delivery methods, and developing quick referral systems throughout the country and even abroad (see case studies 1 and 4). Another innovative response is **long-acting medications, which require far less frequent dosing** and can be quickly introduced. This case study examines two models: long-acting HIV pre-exposure prophylaxis and long-acting opioid agonist treatment.

2. SERVICE MODIFICATION AND INNOVATION: MODELS

2.1 Long-acting PrEP

Ukraine had around 10,000 people using HIV pre-exposure prophylaxis (PrEP) in 2022. Many of these clients who were using daily oral PrEP (which is self-administered at home and typically dispensed for one to three months at a time) were scattered through the country after Russia's invasion, losing regular contact with medical institutions and personnel. In response APH, together with the Ministry of Health, the Public Health Centre and WHO, developed a service delivery model for long-acting injectable PrEP options using long-acting injectable cabotegravir (CAB-LA) for men who have sex with men (MSM) and their sexual partners.

National regulatory documents and training for healthcare professionals were developed so that the CAB-LA programme could be introduced in most regions of Ukraine. As of March 2026, more than 650 clients had initiated long-acting cabotegravir for HIV prevention, more than 500 clients remain on treatment and receive scheduled injections every two months.

APH now plans to introduce lenacapavir (LEN), a new long-acting PrEP option administered only twice a year, which has demonstrated exceptionally high efficacy in clinical studies.

Ukraine is one of the first countries in Eastern Europe and Central Asia to implement these programmes. The goal is to scale up the model across Ukraine and other countries in the region.

2.2 Long-Acting OAT

Long-acting depot buprenorphine (LADB) is an injectable formulation of **buprenorphine administered weekly or monthly for people on OAT.** The dose is injected under the skin where it forms a deposit or 'depot' which is slowly absorbed by the body. Unlike daily oral opioid agonist treatment, LADB **reduces frequent clinic attendance** and can **improve treatment adherence, stability, and quality of life for some patients**.

Ukraine began implementing a LADB programme (with a first batch of medications donated by the manufacturer) in 2023, as a war response to ease difficulties in accessing OAT when medical and transport services are disrupted. Patients do not have to risk carrying narcotic medications in high-risk and militarised environments, as the treatment is administered in clinical settings once or twice a month. It is offered to clients as an option alongside traditional OAT medications, as LADB is not suitable for everyone.

APH in collaboration with Frontline AIDS is **now supporting LADB studies** in Kyrgyzstan and Egypt, **bringing transferable experience from Ukraine** that shows that introducing long-acting medications into routine OAT services can be quickly and inexpensively implemented. The studies are designed to generate evidence on whether long-acting injectable buprenorphine can be successfully integrated into OAT in low and middle income countries. Focus groups among patients about their concerns and expectations informed them how the therapy was introduced and managed, and an important part of the programme's introduction in Kyrgyzstan was a visit by an LADB patient from Ukraine, who talked about her experience to OAT staff and patients, NGOs, stakeholders and communities. This generated interest and trust in a new form of treatment which some patients had feared was a kind of experiment on them, or would be painful to transition to from traditional treatment.

> *"Our patients [on LADB] are very happy with it. One told me: 'Now I won't have to lie at work anymore about why I have to take time off every ten days'."*
>
> Doctor, drug treatment clinic, Krivyi Rih, Ukraine

3. BEST PRACTICES AND LESSONS LEARNED

- Long-acting medications reduce the need for travel and clinic visits, improve employment opportunities, and allow for greater flexibility and confidentiality
- Simple to introduce into existing programmes as an additional option for patients
- Low cost, as it requires less intensive presence of healthcare staff
- Can be applied and scaled up in many contexts
- Patients should be involved in programme design and given full information so they can decide whether long acting medications are right for them

4. PROBLEMS, GAPS, RISKS

- Some patients do not want to lose the 'daily dose' of regular OAT or are worried about injection
- There is less opportunity for regular clinical monitoring for patients with co-infection
- less opportunity for regular social and psychosocial support at drug clinic settings
- long-acting medications do not suit all clients and should be one of several treatment options
- LADB is a new type of medication, so information about withdrawal symptoms is still being collected

5. CONCLUSIONS AND RECOMMENDATIONS

When war and other crises disrupt medical provision, transport and supply chains, long-acting medications can be a life saver for people on long-course therapies that require strict adherence. Innovations in drug formulation coupled with a joint response from NGOs and state health bodies show that programmes can be put in place quickly and with minimum new resources to reduce treatment interruption among populations affected by displacement, poor or disrupted infrastructure, and scarce resources. Fewer visits to clinics allow patients more confidentiality and freedom to work, travel and build family relationships. There is less opportunity for treatment interruption and missed doses, as well as for medication diversion.

-LADB programmes should be accompanied with psychosocial support as, although some patients may welcome less contact with clinics, others miss the regular interaction that helps them feel there is greater accountability and structure to their treatment.

8. REHABILITATION FOR VETERANS AND CONFLICT-AFFECTED CIVILIANS

1. SITUATION

The full-scale war has injured hundreds of thousands of Ukrainian combatants as well as civilians. Ukrainian President Volodymyr Zelensky in 2025 put the number of combat injuries at almost 400,000. State medical services, together with projects funded by a mixture of state, private and international funds, are doing extraordinary work in treating poly trauma and providing prosthetics. But there is still a **huge shortfall in provision of rehabilitation** that enables individuals left with often lifelong disabilities to operate and reintegrate in society. The need to rapidly scale up such services for veterans and war-injured is huge and urgent.

Ukraine is continuing to overhaul its social care system to bring it in line with its national strategy for creating a barrier-free environment 2030. Currently there is **no national rehabilitation training framework** and a **shortage of trained specialists and rehabilitation centres**. Although there is a good deal of goodwill and activity in the civil sector, in general **society is unprepared**, from an almost universal lack of accessible public spaces to public perceptions of stigma around disability.

Non-governmental organisations that traditionally straddle the bridge between medical and social care and that have worked with stigmatised, hard-to-reach communities can very usefully assist in this area.

SOME KEY ISSUES:

- Veterans and war victims often suffer polytrauma
- Rehabilitation is cross-disciplinary – physical, mental, social. Habilitation covers the stage between medical rehabilitation and returning to society
- Often requires long stays and is an ongoing process
- Aims to equip participants with skills and resources to recover and lead independent, active, dignified and fulfilling lives in society
- It can be hard to reach veterans and/or their families and persuade them to participate. No referral system, logistic issues, fear and self-stigma are reasons for reluctance. Because of little public visibility of people with disabilities, veterans may not realise that there are skills they can learn that can enable their full participation in society

This case study summarises two new rehabilitation project models: residential courses for blind and sight-impaired veterans, and a habilitation centre or half-way house for injured veterans and civilians.

2 SERVICE INNOVATION: MODELS

2.1 Rehabilitation for blind and sight-impaired veterans and civilian victims of war

Some estimates put the number of Ukrainian combatants who have suffered full or partial sight loss through injury at 1000–2,500. The National Health Service of Ukraine has recorded a significant rise in cases of vision loss and deterioration since 2022. Many sight-impaired veterans have additional trauma: concussion, loss of hearing and sense of smell, amputations, complex and nerve injuries.

In Ukraine, there were no established state programmes or standards for rehabilitation for blind and partially sighted adults or veterans and victims of war. Individual community initiatives attempted to fill the gap.

APH worked with two NGOs to pilot multi-day residential courses: Contemporary View, whose head is sight-impaired, began working with blind veterans in 2019 and emphasises a holistic peer approach. Levenya Centre, Lviv has over 30 years experience in providing inclusive education for blind and deaf and blind children, and takes a more pedagogic approach.

These pilots were the basis for **developing a national programme** together with the Ministry of Education and Science of Ukraine which comprises a training programme, service description, instructions for professionals and a tool for calculating the cost of services. A separate mechanism developed with the Ministry for Veterans Affairs allows for state funding of rehabilitation for veterans.

The intensive courses include:

- **physical and mental therapy, and practical skills that enable self-sufficiency:**
  - Orientation, spatial awareness, mobility
  - Occupational therapy
  - Computing; assistive technology; Braille
  - Physiotherapy, massage, tactility, motor skills development, dance-movement therapy
  - Group and individual sessions with a psychologist
  - Communication – role-playing, asking for help, etc.
- **Introduction to possible careers and retraining** opportunities; how to set up a business and access grant opportunities
- **Legal support:** claiming benefits and social services, etc.

Family members and life partners also attend, learning not only how to assist their relative but also how to grant them more independence. Partners/relatives are blindfolded and attend orientation and occupational therapy sessions, experiencing a little themselves what their blind family member is going through. They are also offered group and individual sessions with the psychologist.

The courses include a strong social element, with shared meals and evenings together, local excursions. This offers **opportunities to form mutual support networks and exchange experience**, as does the **peer approach**. Some coaches are also partially sighted or blind, providing inspiring role models. First-time participants are mixed with those who have already undergone some rehabilitation, so that people can form mentor-mentee or 'buddy' partnerships.

> *"I could never imagine that you have to learn how to guide a blind person. You have to do it properly, so that the person is at ease and can trust you. A person who lives with a blind or sight-impaired person also needs this rehab."*
>
> Mother who attended a course together with her blind son

> *"I really didn't want to go to rehabilitation at first. I didn't know what to do with myself, how to talk with people. And now these people are like my family. Now I'm a mentor for the other guys. You have to find the right approach, the right key for each person."*
>
> Mentor and veteran who lost his sight through injury

After completing the in-person training, all participants with vision loss receive further support from specialists in their place of residence to help develop travel routes, adjust space and home equipment, etc.

GUIDE DOGS FOR THE BLIND

Guide dogs can be an invaluable emotional as well as practical support for people with sight impairment. APH raised funds to train a guide dog for one blind veteran from the rehabilitation programme. There is currently no tradition of guide dogs in Ukraine, or legislation to provide guide dog access to all public spaces; however, emotional support dogs and other animals are increasingly common.

2.2 HAB Lviv Habilitation* Centre

** habilitation – the next step after treatment and physical or psychological rehabilitation; enhancing the skills and abilities of people with disabilities by providing appropriate resources*

Established in 2023, HAB is the first habilitation centre in Ukraine, acting as a **halfway-house between** what can be years of **medical treatment or rehabilitation, and returning to society**. Set up by a team that includes war veterans with disabilities, it offers a **completely accessible residential space, physical and psychological support** for war veterans and civilian war victims.

The centre takes its philosophy from the Japanese art of kintsugi – mending broken ceramics with precious metals so that the break is not hidden but becomes a feature of strength and beauty.

Clients come to HAB's residential habilitation programmes via partner rehabilitation centres, veterans' organisations and assistants, local authorities, social media and word of mouth.

Courses are completely free for participants, funded through a combination of public funding, donor support and partnerships. Together with the Ministry of Veterans Affairs, HAB has **developed a government mechanism that allows habilitation services to receive public funding**. This experimental programme is already being used by eight centres across Ukraine.

- **Residential** stays of up to 21 days
- **family members can stay** and participate in activities
- **peer-to-peer support**
- **Therapies** including art, physio, occupational, hippo
- **Individual and group psychotherapy**. The centre uses associative cards as a therapeutic tool, which provide an accessible way for participants to reflect and communicate without feeling they are participating in a formal psychological intervention
- Adaptive sports and social activities
- Career guidance and employment support

Creating connections between veterans and the wider community, focused on family support and helping communities understand how to support veterans returning to civilian life. This contributes to reducing stigma around disability.

Improving accessibility by developing accessible routes and training professionals such as Veterans' Assistants and local administrative services staff. This is absolutely vital as Ukraine has almost no housing and public space for wheelchair users and people with other disabilities.

HAB plans to launch a Habilitation School to train teams from communities that want to develop similar services. The goal is to share administrative knowledge along with the practical approach and the philosophy of habilitation.

BEST PRACTICES AND LESSONS LEARNED

Involving family members. Rehabilitation courses offer a much-needed break for relatives who are usually acting as full-time carers, and ensure that rehabilitation is a shared process.

Involving the community – e.g. participants of blind rehabilitation courses visit local schools to give talks; HAB involved veterans in supporting local youth projects like robotics activities. The goal is not only to support veterans directly, but to prepare communities to welcome them and create inclusive environments.

Involving veterans themselves as professionals, mentors and peer supporters.

Building strong teams and internal expertise so that initially small projects can scale up and become a basis for national models.

Transferring service provision skills and experience. For example APH used its experience in developing national programmes that include a peer approach for groups that are stigmatised and hard to reach. Veterans are highly vulnerable to substance use to cope with trauma, so rehabilitation courses could potentially connect to other prevention and support services.

GAPS, PROBLEMS, RISKS

Funding: The current mechanisms enabling state funding do not cover everyone who needs support - for example, habilitation for people who experienced captivity, or rehabilitation for civilians with conflict-related sight impairment.

CONCLUSIONS AND RECOMMENDATIONS

Social rehabilitation services fill a vital gap between medical treatment and rehabilitation and returning to society, especially in countries where society and infrastructure is ill-adapted to people with disabilities. Experience of these two models shows that they can be a true lifeline for people who, when discharged from medical facilities, often feel that 'nobody needs them'. Small, one-off projects developed in the civil sector and largely funded and even run by volunteers and donations can be scaled up to become national models and form the basis for state guidelines and best practice. Experience of working with traditionally marginalised and stigmatised groups and bridging the gap between health and social services can be usefully transferred.

The need for rehabilitation services will continue long after the hot phase of the war is over. For example, with an ageing population, sight impairment is going to increase in Ukraine independently of the war. Rehabilitation should be embedded into health and social services at the local level, with local trained instructors to make it more accessible for all.

Signposting: develop a referral system from healthcare institutions, to avoid the gap after discharge from medical treatment, when many who need rehabilitation can lose heart. An example could be the UK's Eye Care Liaison Officers based in hospitals to provide signposting to services and organisations. Referral should also be embedded into social and volunteer services.

Work with society through education, accessibility improvements and stigma reduction. Rehabilitation and habilitation needs to be based on people and communities, not only institutions.

9. REACHING BEYOND TRADITIONAL OUTREACH: A DIGITAL FUNNEL FOR HIV PREVENTION AND INTEGRATED CARE IN UKRAINE

Photo: Viacheslav Ratynskyi / Reuters

SITUATION

Ukraine's full-scale war has fundamentally changed both the delivery of health services and the patterns of HIV vulnerability. Displacement, damaged infrastructure, workforce shortages and security challenges have reduced access to traditional healthcare and outreach, while new behavioural patterns have emerged among populations at increased risk of HIV. These include younger people experimenting with synthetic stimulants, people engaged in transactional sex or sexualised drug use, and vulnerable military personnel and veterans. Many do not identify themselves as members of traditional key populations and therefore remain beyond the reach of conventional HIV programmes.

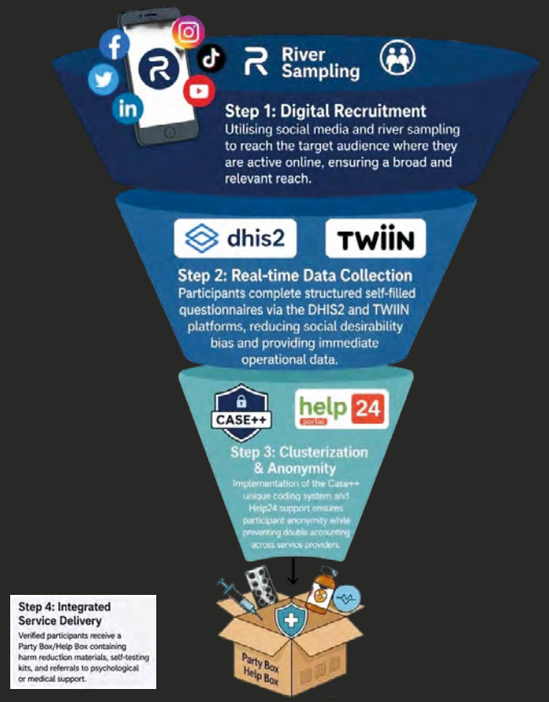
These changes have created an urgent need to strengthen the earliest stages of the HIV prevention and care cascade. The 2025 WHO review of Ukraine's National HIV Programme highlighted the need to improve the first "95" of the global 95-95-95 targets, noting that approximately **40% of HIV infections are still diagnosed at a late stage.** The Ministry of Health has likewise identified earlier engagement with vulnerable populations as a national priority for expanding timely access to prevention, testing and treatment.

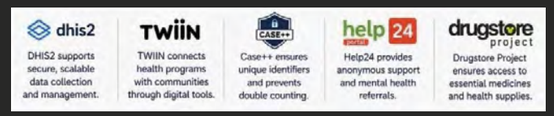
Traditional outreach remains indispensable but faces growing challenges in identifying and engaging these emerging vulnerable groups. Community programmes increasingly encounter people who seek information online long before they are

willing to visit a clinic or speak with an outreach worker. Others experience multiple overlapping vulnerabilities — including mental health problems, substance use, social exclusion and stigma — that require more personalised and differentiated approaches than conventional service models can provide.

Recognising these changes, the Alliance for Public Health redesigned the way vulnerable populations enter HIV prevention and care. Rather than digitising existing services, it developed a Digital Funnel — a hybrid service delivery model that combines digital engagement, operational research and differentiated service delivery into a single coordinated pathway. The model creates a broad, anonymous entry point capable of engaging large populations at relatively low cost, while progressively identifying those at greatest risk and connecting them with increasingly specialised support. By integrating digital tools with community outreach and clinical services, the Digital Funnel expands the reach of HIV programmes, strengthens early engagement and improves continuity of care in both emergency and routine settings.

The digital funnel: Bridging Health Gaps for Underserved Populations





SERVICE MODIFICATION AND INNOVATION

To respond to changing patterns of vulnerability and reduced access to conventional services, APH developed three complementary digital solutions that strengthen community-led HIV prevention and care. Each addresses different populations and health needs while supporting a common objective: expanding access to reliable information, increasing uptake of services and maintaining continuity of care despite the disruptions caused by war.

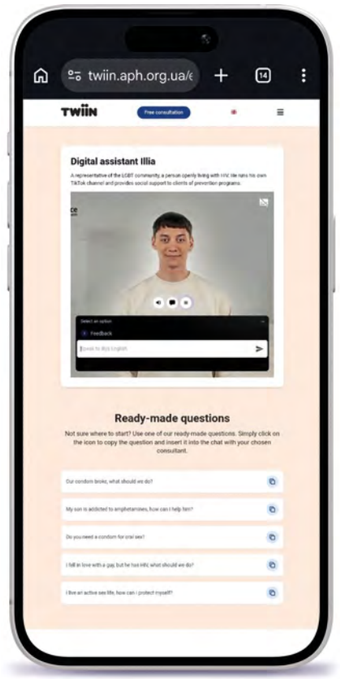
Together, the three platforms illustrate a digitally assisted approach to outreach and service delivery. Broad digital engagement creates opportunities for early contact with people who may never otherwise interact with health services. Depending on their needs and level of vulnerability, individuals can then access more specialised support through tailored prevention, telehealth and referral services. This approach complements rather than replaces traditional outreach, extending its reach to underserved populations while making more efficient use of community and clinical resources.

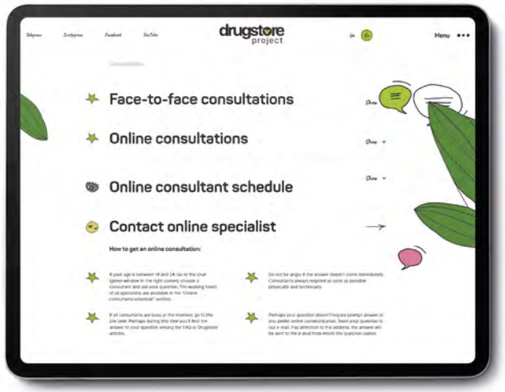
TWIIN: AN AI-POWERED DIGITAL GATEWAY TO HEALTH AND SOCIAL SERVICES

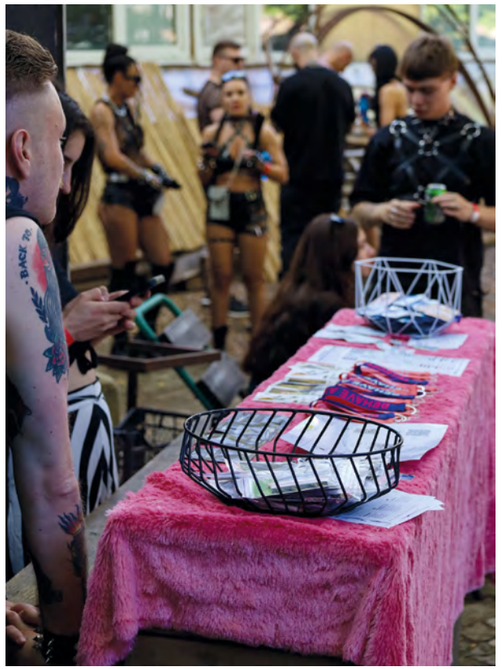
TWIIN was developed to address one of the biggest barriers to HIV prevention: many people seek information online but never contact health services. Available anonymously 24 hours a day through a website, mobile application and Telegram messaging app, TWIIN provides evidence-based information on HIV prevention, testing and treatment, harm reduction, sexual and reproductive health, mental health and social services. Unlike conventional chatbots, it uses AI-powered digital humans capable of supporting natural written and spoken conversations, making information more accessible and engaging for diverse audiences.

The platform is designed not only to answer questions but also to guide users towards appropriate services. Rather than functioning as a standalone source of information, TWIIN actively supports informed decision-making, reduces barriers to care and facilitates referrals to both online and offline services. As users' needs become clearer during conversations, they can be directed to specialised support through Drugstore, Help24 or other relevant community services. Future development will further strengthen referral mechanisms, introduce integrated screening tools and improve follow-up to increase conversion from digital engagement to service utilisation.

Since its launch in July 2025, TWIIN has demonstrated rapid growth as a digital entry point to health services. By mid-2026, the platform had attracted 468,288 website users, reached more than 2 million people through social media communication, supported 73,139 unique chat users, generated 120,987 chat sessions, and facilitated 1,112 referrals to the Help24 TeleHealth platform. These figures demonstrate that AI-supported digital engagement can successfully move beyond information provision and encourage meaningful uptake of health services.







DRUGSTORE: HYBRID PREVENTION SERVICES FOR VULNERABLE YOUNG PEOPLE

Drugstore is a hybrid prevention platform specifically designed for young people who use psychoactive substances, engage in transactional sex or sexualised drug use, and other vulnerable young people who often remain outside traditional HIV programmes because they do not identify themselves as members of established key populations. The platform combines digital communication with field outreach, behavioural screening and differentiated prevention services tailored to the realities of this population.

Drugstore promotes safer behaviours through objective, non-judgemental information on psychoactive substances, HIV prevention, sexual and reproductive health and mental health. Clients can access online and offline consultations with psychologists, psychiatrists and substance use specialists, while PartyBoxes provide individually tailored combinations of condoms, lubricants, HIV and STI self-tests, drug-checking reagents and educational materials. Operational research integrated into routine implementation enables continuous assessment of behavioural risks and supports increasingly differentiated service delivery.

The platform demonstrates both substantial scale and sustained demand. During **2025**, Drugstore attracted **232,536 website visitors**, delivered **11,908 counselling sessions**, distributed **2,133 PartyBoxes**, and reached **7,766 participants** through outreach activities in 60 high-risk nightlife venues. During the first half of 2026, it had already recorded **99,225 website visitors, 7,457 counselling sessions**, distributed **1,376 PartyBoxes,** organised **41 educational events reaching 1,178 participants,** and provided outreach services in **43 nightlife venues**, engaging **4,971 participants**. The programme consistently reaches new clients, with approximately two-thirds accessing HIV prevention services for the first time, demonstrating its ability to engage populations that are rarely reached through conventional approaches.

HELP24 TELEHEALTH: DIGITALLY ASSISTED HEALTH SERVICES FOR KEY POPULATIONS

Help24 TeleHealth provides comprehensive digitally assisted access to health services for people living with HIV and populations at greatest risk of HIV infection, including people who inject drugs, sex workers, men who have sex with men and transgender people. Developed in response to disruptions caused by COVID-19 and subsequently expanded during the war, the platform combines telemedicine with community-based support to maintain continuity of care despite displacement, damaged infrastructure and safety concerns.

Through an integrated online platform, clients can access doctors, psychologists, social workers and initial assessment consultations, receive HIV prevention and treatment support, order individually tailored HelpBoxes containing prevention and harm reduction commodities, and obtain referrals to additional community and clinical services. By combining digital consultations with postal delivery and offline referral, Help24 extends access to essential services while maintaining strong links with the broader health system. In recognition of its contribution to continuity of care, the WHO 2025 review of Ukraine's National HIV Programme recognised Help24 TeleHealth as a key national innovation.

The platform continues to operate at substantial scale. During 2025, Help24 provided 16,830 medical consultations, 1,683 psychologist consultations, 5,018 social worker consultations, and dispatched 20,494 HelpBoxes. During the first half of 2026, it had already delivered 3,232 medical consultations, 1,115 psychologist consultations, 1,165 social worker consultations, and 5,097 HelpBoxes, demonstrating sustained demand for digitally assisted health services among key populations and people living with HIV.

BEST PRACTICES AND LESSONS LEARNED

The Ukrainian experience demonstrates that digital technologies are most effective when they complement, rather than replace, community-led health services. The greatest value of digital solutions lies not in transferring existing services online, but in expanding access to people who would otherwise remain beyond the reach of conventional programmes.

Early engagement. Many people at increased risk of HIV first seek information online, often long before they are ready to contact a healthcare provider or outreach worker. Providing anonymous, non-judgemental access to reliable information helps establish trust at an earlier stage and creates opportunities to encourage timely uptake of prevention, testing and treatment services. This is particularly relevant for younger people experimenting with psychoactive substances or engaging in high-risk sexual behaviours who do not perceive themselves as members of traditional key populations.

Differentiated service delivery. Different population groups have different patterns of vulnerability, motivations and preferences, and therefore require different approaches. Drugstore demonstrates the value of tailoring services specifically to vulnerable young people, while Help24 provides comprehensive digitally assisted care for established key populations and people living with HIV. Rather than offering a single package of services to everyone, the model allows interventions to be adapted to individual needs while maintaining strong referral links between platforms and offline services.

Integration of **operational research into routine programme implementation**. Behavioural screening and continuous analysis of programme data provide real-time insights into emerging risks and unmet needs, allowing services to evolve alongside changing epidemiological and social trends.

Digital approaches can strengthen the resilience of community-led health services during crises. By combining online engagement, telemedicine, postal delivery of prevention commodities and referral to community and clinical services, digital platforms helped maintain continuity of HIV prevention and care despite displacement, damaged infrastructure and restricted access to healthcare during the war. The same principles are applicable in non-emergency settings, where digital solutions can improve efficiency, reduce barriers to care and expand access for underserved populations.

help 24 telehealth

h24.org.ua

digital TWIIN assistant

twiin.aph.org.ua

drugstore

drugstore.org.ua

SUSTAINABILITY AND TRANSFERABILITY

The three digital platforms were developed in response to the extraordinary challenges created by the COVID-19 pandemic and later the full-scale war in Ukraine. However, the problems they address are not unique to humanitarian settings. Across many countries, HIV programmes face similar challenges: changing patterns of vulnerability, increasing demand for mental health support, shortages of healthcare professionals, geographical barriers to services, and growing expectations for accessible digital communication.

An important strength of the model is that it **builds upon existing community-led health services rather than creating parallel systems**. Digital tools support outreach organisations and healthcare providers by expanding their reach, facilitating earlier engagement and improving navigation through available services. Community workers, psychologists, physicians and peer counsellors remain central to service delivery, while digital platforms increase their capacity to reach more people and provide support more efficiently.

The three platforms are also **modular and adaptable**. Countries do not need to adopt the complete package in order to benefit from the approach. Depending on national priorities and available resources, individual components can be introduced independently or gradually integrated into existing HIV, sexual and reproductive health, mental health or harm reduction programmes. This flexibility makes the approach suitable for different epidemiological contexts and health system capacities.

Another important element of sustainability is the integration of **continuous learning into routine implementation**. Digital platforms generate real-time information about users' needs, emerging behavioural trends and service utilisation, allowing programmes to adapt quickly to changing circumstances. Operational research is therefore not an additional activity but an integral part of programme improvement, supporting evidence-informed decision-making and more responsive

that digital innovation should be viewed as an investment in stronger and more resilient health systems rather than as a temporary emergency solution. By expanding access to trusted information, supporting earlier engagement with vulnerable populations and strengthening links between digital and community-based services, these approaches have the potential to remain valuable long after the immediate consequences of the war have passed. Their adaptability and integration within existing health systems make them relevant for countries seeking to modernise community-led HIV prevention and care while ensuring that no population is left behind.

CONCLUSIONS AND RECOMMENDATIONS

Ukraine's experience demonstrates that digital technologies can significantly strengthen community-led HIV prevention and care when they are designed to complement, rather than replace, existing services. By combining trusted digital engagement with specialised prevention, telehealth and community-based support, the Alliance for Public Health has expanded access to populations that are often missed by conventional approaches while maintaining continuity of care during a period of unprecedented disruption.

The three digital platforms described in this case illustrate different but complementary approaches to digitally assisted service delivery. TWIIN broadens access to reliable information and supports navigation to appropriate services. Drugstore provides tailored prevention, harm reduction and behavioural support for vulnerable young people who are often beyond the reach of traditional programmes. Help24 TeleHealth ensures continued access to multidisciplinary health services for people living with HIV and established key populations. Together, these approaches demonstrate how digital technologies can strengthen every stage of community-led service delivery—from first contact to long-term care.

Several considerations may support adaptation in other settings:

- **Use digital tools to complement existing services**, not replace community outreach and healthcare providers.
- **Design platforms around the needs of specific populations**, recognising that different groups require different approaches, communication styles and service packages.
- **Integrate digital engagement with referral pathways** so that online interactions lead to timely uptake of prevention, testing, treatment and psychosocial support.
- **Embed operational research within routine implementation** to enable continuous improvement based on changing patterns of vulnerability and service utilisation.
- **Maintain flexibility and modularity**, allowing digital solutions to evolve alongside national priorities and available resources.

Although developed in response to the COVID-19 pandemic and the full-scale war in Ukraine, these approaches address broader challenges facing health systems worldwide, including changing patterns of HIV vulnerability, workforce shortages, barriers to accessing services and increasing demand for confidential digital support. Their experience demonstrates that digitally assisted, community-led services can improve resilience, expand access and strengthen the effectiveness of HIV programmes in both emergency and routine settings.

TOGETHER WE ARE STRONG!

The Alliance for Public Health would like to express our admiration and appreciation of the incredible work of all our partners, the Ministry of Health of Ukraine, Public Health Centre, Network 100% Life, all implementing partners, community and civil society networks, NGO staff and social workers, doctors and nurses: You are amazing! All the great things we have achieved, we have achieved together! Our gratitude to governmental institutions, UN agencies and other international organizations.

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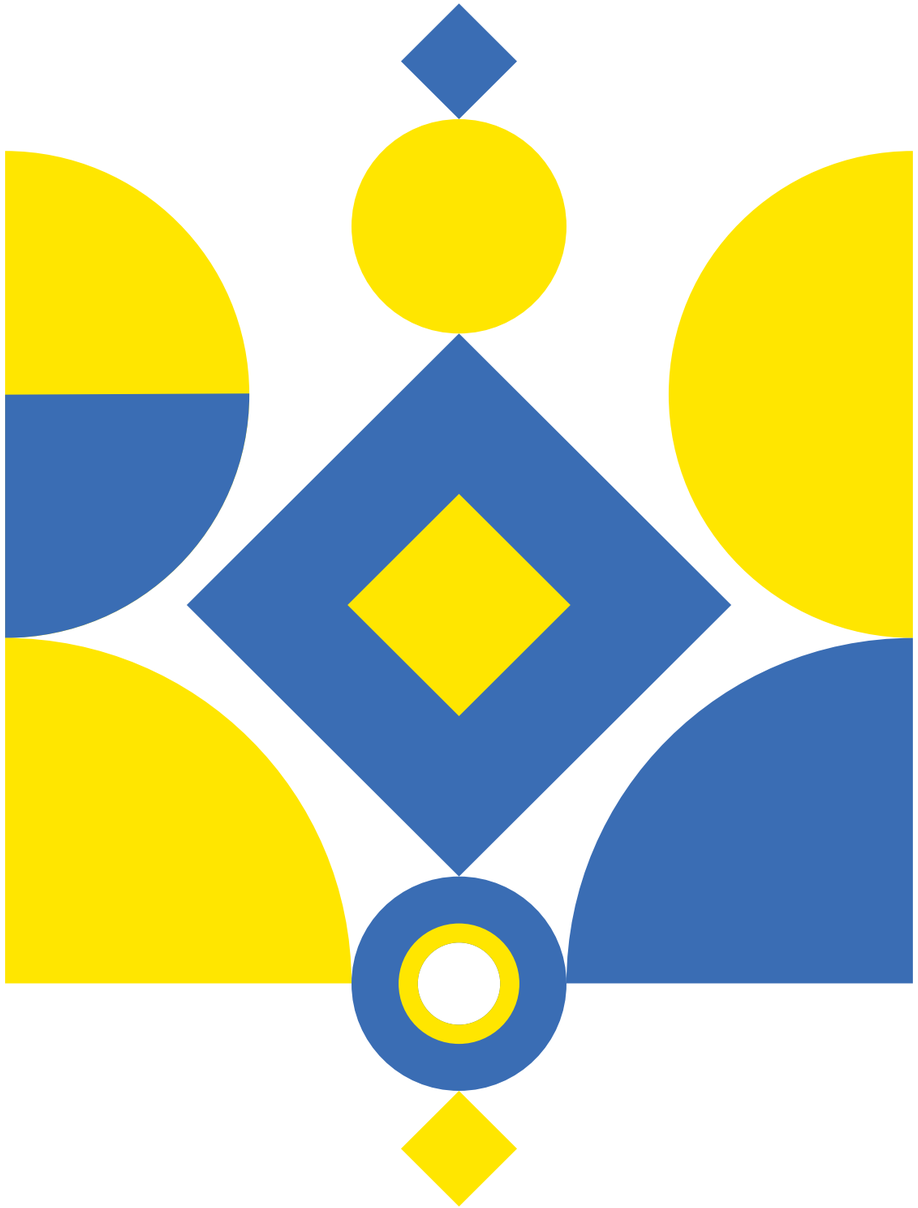

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