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Alliance for Public Health

Responding to war:

adaptation and innovation in Ukrainian public health programmes during conflict

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Introduction

Supporting communities in documenting experiences and solutions during the war

Russia's full-scale invasion of Ukraine is having a devastating, ongoing impact on every aspect of Ukrainian society, including public health and the epidemics of HIV, TB and viral hepatitis. This report sets out to document how state and non-governmental organisations and communities continue to provide crucial services for vulnerable populations, adapting or introducing new programmes and solutions in a highly dangerous and rapidly-changing environment. The documented experience is intended to offer generalisable results and lessons learned, that may inform planning and implementation of care provision in an emergency environment.

The Alliance for Public Health (APH) international charitable foundation is a leading non-governmental organization making a significant impact on the epidemics of HIV/AIDS, tuberculosis, viral hepatitis and other socially dangerous diseases in Ukraine. In cooperation with state partners and civil society organizations, it provides financial and technical support to programs, covering over 250,000 representatives of most vulnerable populations. When war started in Ukraine, APH modified its programmes to sustain the impact on the diseases and support affected communities.

Russia's invasion of Ukraine began in 2014, with the illegal annexation of Crimea and occupation of areas of Donetsk and Luhansk oblasts 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. More than 13 million Ukrainians (30% of the population) have been displaced. Over 5 million are internally displaced people (IDPs), while over 8 million are registered in temporary protection schemes in the European Union[2]. Between 24 February and 31 December 2022, nearly one in ten hospitals in Ukraine were damaged, destroyed or looted by Russian forces[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 to reach vulnerable and key populations in new locations or circumstances, while trying to protect staff and patient safety. The 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.

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 hhttps://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

The case studies are based on site visits to Lviv, Warsaw, Kharkiv city and oblast, Krivyi Rih, Nikopol, and Kherson city and oblast in March and April 2023. These site visits and documenting experience were financed with the support of Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, commissioned by the German Federal Ministry for Economic Cooperation and Development. The author would like to thank the dedicated medical and social workers, NGO staff, volunteers, and members of key populations and inhabitants of cities and de-occupied settlements who kindly shared their experience and who continue to work and live under such dangerous and difficult conditions.

Implementing partners of ICF "Alliance for Public Health" in Lviv, Warsaw, 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; 'Kharkiv' 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".

List of Abbreviations

AIDS	Acquired ImmunoDeficiency Syndrome
APH	Alliance for Public Health
ART	Antiretroviral Therapy
CITI/CIRI	Community Initiated Treatment and Retention Intervention
EGG	Electrocardiogram
EU	European Union
GF	Global Fund to fight AIDS, TB and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IRF	International Renaissance Foundation
KP	Key Population
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
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

Russia's full-scale invasion of Ukraine has affected the whole country. The war has killed, injured and displaced millions, interrupted supply routes and overwhelmed or destroyed social and medical services. Russian missiles have targeted healthcare facilities and other civilian infrastructure. Displacement, economic and psychological stress, and poor living conditions 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 continued to work in frontline war conditions, adapting services to overcome challenges and meet new needs. This case study summarises examples and best practices of modification of prevention, testing, treatment and care services in areas of high conflict intensity.

High conflict intensity sites include:

Primary:

- Areas that were liberated from occupation which are now near the frontline and experience regular shelling; 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, Donetsk and Dnipropetrovsk region.

Secondary:

- Cities under fairly 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 on checkpoints.
- Delivering medications directly to patients when medical facilities are closed due to shelling or patients are unable to travel.
- 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 shelling.
- 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 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 system/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 general population (see case study 5).
- Setting up temporary shelters for IDPs: KPs and/or 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 oblasts, 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 oblast), 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 (one injection per 28 days). 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
- HelpBoxes of commodities (condoms, lubricants, syringes, needles, etc.) delivered to KPs who have moved, especially to rural areas

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, coordination and dedication of workers allowed prevention, testing and treatment services to keep functioning in high conflict intensity sites. Nationwide, APH programmes continued to detect new cases of HIV in 2022, with an average detection level of 4.2%, compared to 3.4% the previous year. Over 7,000 people were registered for care, making 57% of overall HIV cases registered in Ukraine.

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.

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

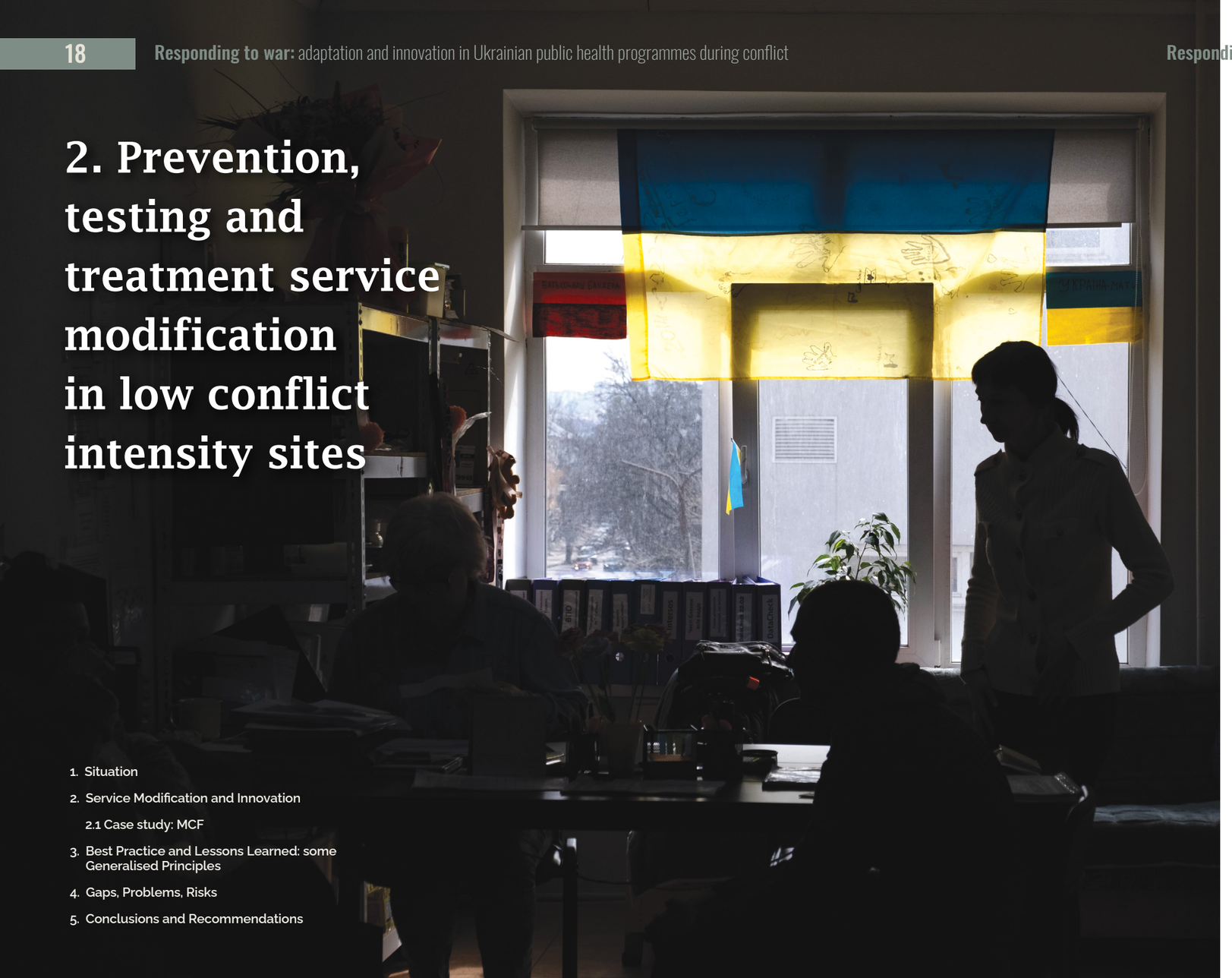
Consider scaling up MCF in areas where roads are not too dangerous, to reach settlements now without health, social or transport services (especially in de-occupied areas).

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

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

The mass displacement caused by the war has had a huge impact on health and social services in low conflict areas further from the frontline, which are now both transit hubs and destinations for IDPs and refugees.

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 oblast of Lviv, is now both hub and destination for people fleeing the war in the east and south, including KPs.

This case study summarises examples and best practices of modification of prevention, testing, treatment and care services in areas of low conflict intensity.

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 risk of interruption caused by displacement.
- 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.
- APH opened an office in Lviv, enabling continuous work and coordination when Kyiv was under immediate threat of invasion. The location close to the border allowed relocated staff to travel abroad more easily to represent Ukraine at international fora.
- 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 oblast to 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 Kherson oblast, 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).

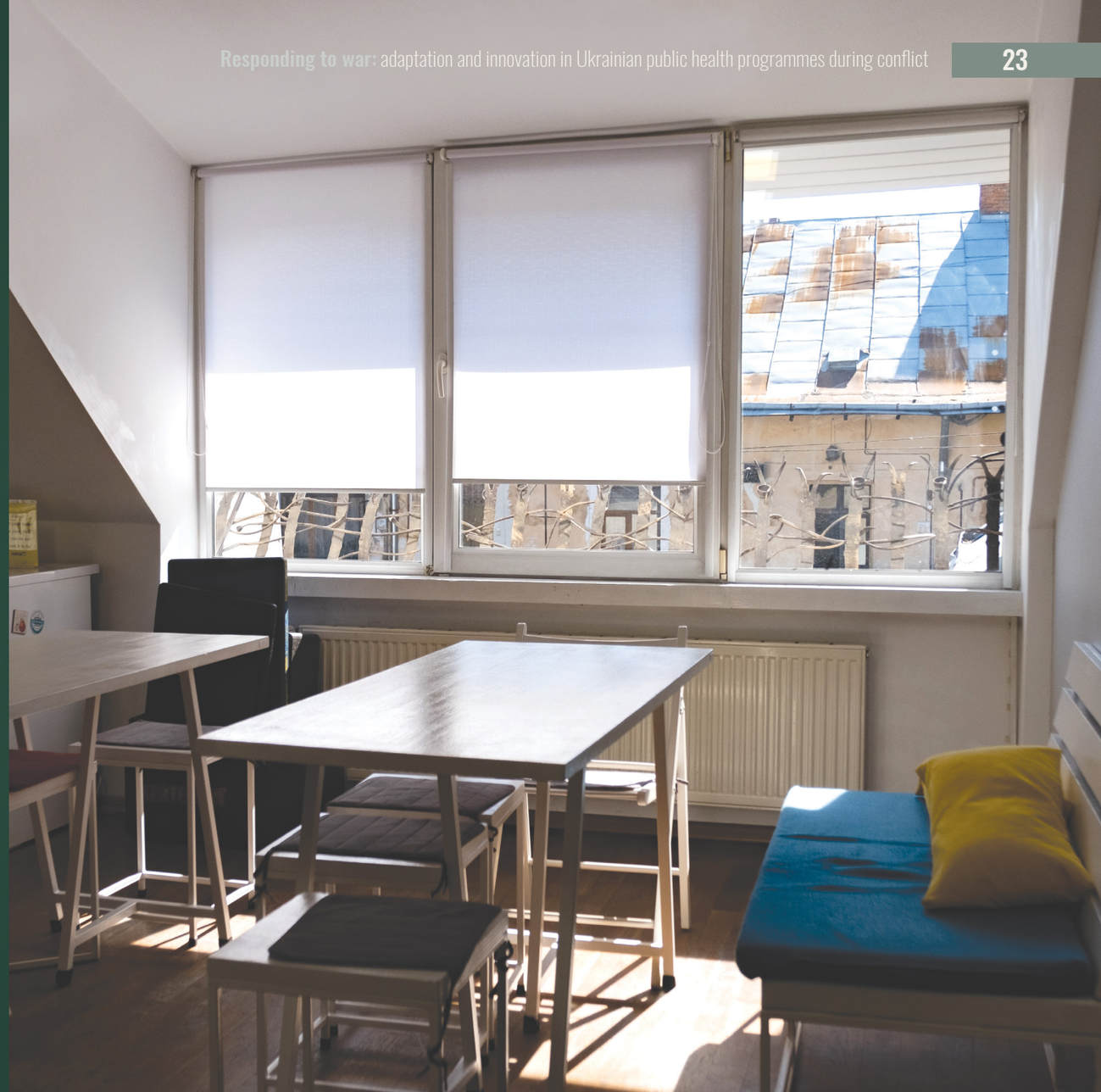
Developing simplified algorithms for transferring patient data and enrolling new patients, to speed up registration of KP IDPs for services in a new location.

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 Lviv 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

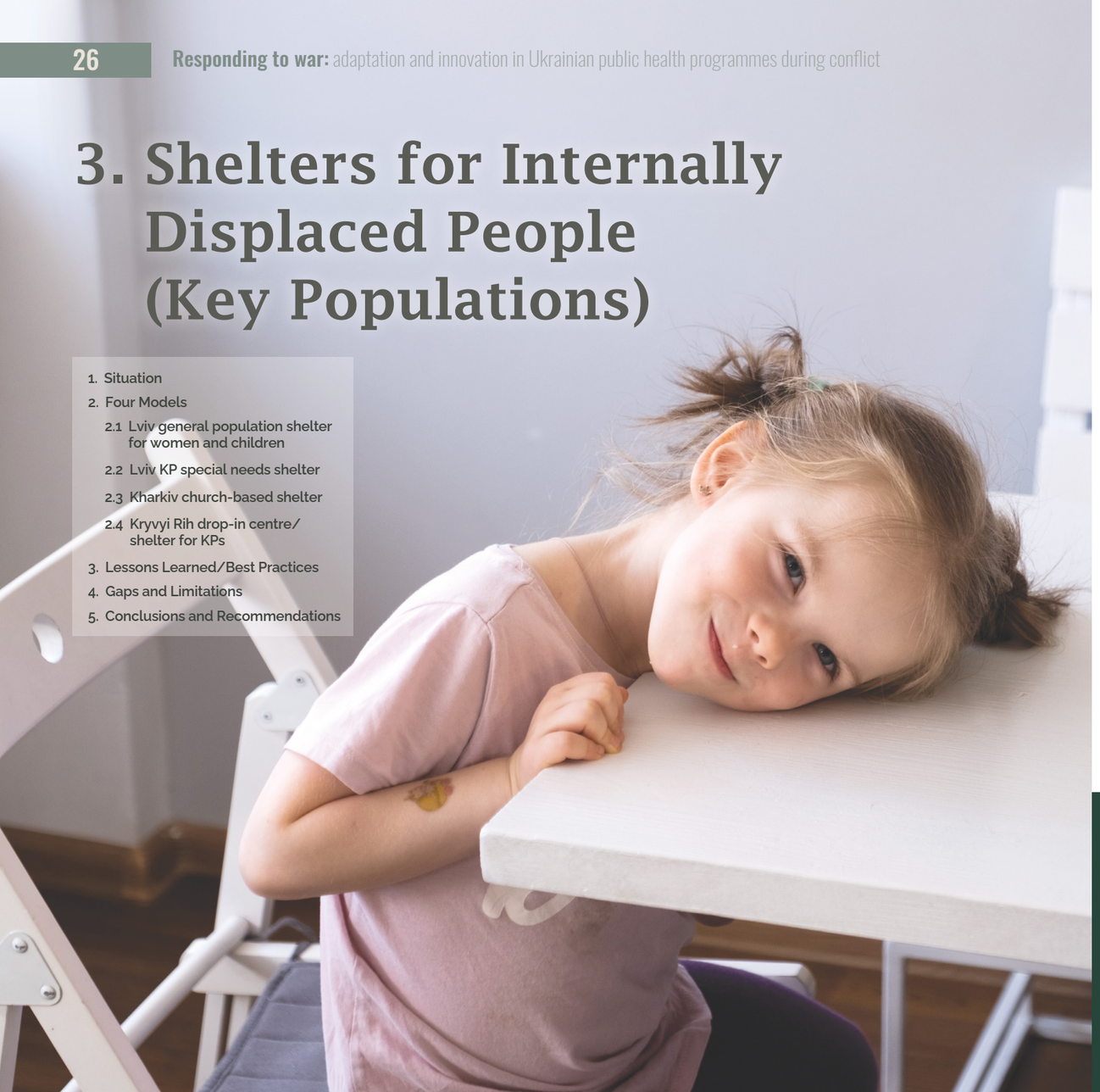
Rapid response and the ability to scale up quickly, flexibility and coordination allowed prevention, testing and treatment services to cope with an influx of new patients and clients in low conflict intensity sites. Nationwide, APH programmes continued to detect new cases of HIV in 2022, and enroll patients in care.

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. Shelters for Internally Displaced People (Key Populations)



1. SITUATION

The war in Ukraine has created a pressing need for temporary accommodation in shelters for those fleeing their homes to escape fighting and shelling. According to UNHCR, since late February 2022 Russia's invasion has displaced more than 13 million (or 30% of the country's population), of whom more than 5 million are IDPs.

IDPs have different needs for shelter. 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.

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)
- The state has pledged to provide accommodation to all people evacuating from frontline regions. Usually such accommodation is 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 case 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 general population shelter for women and children — Safe Place shelter, APH

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.

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 Place 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 how to organise and find partners (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).

> "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**

Some residents: women and children who have fled active shelling 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.

2.2 Lviv 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).

Advertised 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. It is currently making sample uniforms for the Ukrainian Armed forces; if it successfully gets orders this may provide work for some IDPs staying at the hostel.

2.3 Kharkiv church-based shelter

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

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.

2.4 Drop-in centre/shelter for KPs — Public Health Foundation of Kryvyi Rih Shelter

Kryvyi Rih is a hub for IDPs from south and east Ukraine. There are about 100,000 IDPs in the city, mostly housed by the state in schools, sports centres, etc.

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. 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 in to 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.

> "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

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.

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, psycho-social 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 service continuity for refugees from among key groups

1. SITUATION

According to UNHCR, more than 8 million Ukrainians displaced by Russia's invasion are registered in temporary protection schemes in Europe, with the largest numbers in Poland and Germany[5].

Among Ukrainian refugees 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.

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

Some general facts can be noted:

- 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.
- There are significant differences between Ukrainian and other 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 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.

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 clinics-based services for the general population (Mobile Treatment Points)

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

1. SITUATION

Ongoing Russian attacks on healthcare in Ukraine include missiles and shelling, looting, and killing or harming medical workers[6]. 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 ongoing shelling 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 liberated settlements. But locals lack funds to buy medicines, or internet to order free government prescriptions. Lack of public transport makes a trip even to a neighbouring settlement difficult and prohibitively expensive.

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

- Mass population migration and displacement
- Mostly elderly population remaining
- Interrupted public transport, communications, amenities
- Destruction, closure of medical and other state institutions; pharmacies
- Shortage of medical staff and medications
- Mined territory; high risk of shelling
- Poor living conditions
- Few or no sources of income for local people, other than pensions
- Presence of military; checkpoints; curfews
- Stress and psychological trauma of local populations
- Many chronic health conditions; hypertension; diabetes; heart problems
- Less attention to health (too many other issues to deal with)
- Pre-existing tendency to put off dealing with health issues (perception that healthcare is too expensive and people can't afford to take time away from the smallholdings on which they rely)

6 https://reliefweb.int/report/ukraine/nearly-one-every-10-hospitals-ukraine-have-been-damaged-attacks-russias-invasion

2. SERVICE DESCRIPTION

Mobile treatment points (MTP) are a new service introduced by APH to meet the need for primary healthcare among the general population in de-occupied territories near the frontline. A convoy of two mobile clinics, staffed by small teams of doctor/general practitioner, nurse, social worker and driver, visits villages in liberated Kharkiv and Kherson oblasts (south and east Ukraine), bringing basic medical services to people who, despite efforts to reinstate public transport and services, are still isolated from care and support.

The mobile clinics are equipped with an ECG; ultrasound; tonometer; glucometer; pulse oximeter; self tests for HIV, viral hepatitis and Covid; stocks of basic medications; hygiene products. Simultaneously two or three GPs can see people and a nurse can perform cardiograms and ultrasound scans in separate compartments of the vans. The medical team can measure blood pressure and blood sugar levels, prescribe basic medications and refer patients to specialists if necessary for further examination or treatment.

A third van and drivers in the convoy deliver and distribute humanitarian aid (home first aid kits; clothing; bedding; food and hygiene packages; stoves; children's toys; pet food).

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. Patients/beneficiaries are required to provide their names and personal identification numbers.

> "In 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

> "People are happy when we come because we can provide a minimum consultation. There are lots of traumatised people here. Depression, stress, worry, especially among older people, and chronic illnesses getting worse."
>
> **GP with the MTP project**

3. BEST PRACTICE/ LESSONS LEARNED:

Building on/repurposing existing resources to rapidly respond to new needs:

- The vans used for MTPs were already on the balance sheet of APH
- Volunteer drivers come from a pool of people who have been delivering humanitarian aid in APH vehicles all over the country since February 2022.

Coordination with local governments and heads of communities; military; NGO and volunteer groups enables the MTPs to reach and focus on areas with most need and avoid duplication.

Collaboration with NGOs and volunteers allows the project to combine health and humanitarian aid and optimise delivery:

- The humanitarian aid can be provided by other organisations but distributed by the MTP team
- Medics have been found via partner NGOs or volunteer groups

Optimization: In some settlements other volunteer groups or the military have distributed free medications; MTP medics can offer advice about their use and dosage, or suggest follow-up diagnostics and treatment.

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:

- Economic in terms of delivery costs
- With high risk of shelling, people in frontline areas are afraid to gather in large groups for extended periods. Combined mobile delivery means they can collect aid and get health support quickly in one go
- People (especially men) can be reluctant to see a GP. 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. Teams have learned on the hoof some optimum delivery methods and services to reach more people effectively, e.g.:

- Ensuring up to three doctors and a nurse can accept patients simultaneously
- Distributing humanitarian aid in settlements via existing systems (local authorities or volunteers)
- Optimum times to arrive and depart taking into account safety concerns; curfews
- Including services of a cardiologist

4. GAPS, PROBLEMS, RISKS

Risk from shelling, landmines. MTP staff are provided with protective gear (helmets and bulletproof vests) and trained in emergency first aid, conflict and mine safety awareness.

5. CONCLUSIONS AND RECOMMENDATIONS

The MTPs are filling a gap which, until the risk of shelling and active conflict in de-occupied areas near the frontline recedes, cannot be filled by rebuilt state healthcare and other infrastructure. Therefore this project should be continued as long as the need remains.

- **Consider scaling up** the project to include basic dentist and optometrist services.
- **Consider including a mental health component.** Currently the medical staff are providing a basic psychological service just by listening.
- **Continue and scale up collaboration** with other NGOs and international donors, including those outside the traditional health sphere.
- As and if routes become more stable, **consider tailoring the humanitarian aid aspect** to specific needs. There are many other volunteer groups and NGOs providing aid in these areas, which may overlap.

TOGETHER WE ARE STRONG!

The Alliance for Public Health expresses its admiration and appreciation of the incredible work of all our partners, the Ministry of Health of Ukraine, Public Health Center, 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 thanks to governmental institutions, UN agencies and other international organisations.

We express our sincere gratitude for the critical support of our donors — your funding is critical for sustaining HIV and TB response in Ukraine as well as for addressing emerging needs caused by the war. Big thanks to the Global Fund, the US Government and PEPFAR, CDC, USAID, US NIDA, Yale University, FRONTLINE AIDS, Christian Aid, International AIDS Society (IAS), Stop TB Partnership/UNOPS, WHO, UNAIDS, FIND, EATG, Aidsfonds, International Renaissance Foundation, The Foundation to Promote Open Society, Elton John AIDS Foundation (EJAF), Irish Emergency Alliance, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, Payoneer, Initiative France, UNITAID, and all other donors and individuals who provided private donations: Your support saves lives! And our great thanks to the Ukrainian Armed Forces defending not only Ukraine but all fundamental principles of peace, freedom, sovereignty and dignity.

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